CHAPTER 10 INTERPROFESSIONAL COLLABORATION WHEN WORKING WITH OLDER PEOPLE

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NMC STANDARDS FOR PRE-REGISTRATION NURSING EDUCATION

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NMC ESSENTIAL SKILLS CLUSTERS

This chapter will support the following ESCs:

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CHAPTER AIMS

By the end of this chapter, you will be able to:

- Accurately define interprofessional collaborative practice
- Develop strategies to communicate with other professional groups and the older patient in a collaborative and respectful manner;
- Demonstrate an awareness of the importance of being able to articulate one's own professional role and that of other professional groups when caring for an older person;
- Engage the older person as a central member of the interprofessional team;
- Recognise that conflict is a normal part of interprofessional working and be able to develop strategies to resolve this;
- Understand and apply some key principles of interprofessional leadership;
- Understand some the principles of team functioning that enable effective interprofessional collaboration.

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[A] INTRODUCTION

As people get older, the likelihood of developing multiple and longer-term needs increases. Collaboration between a wide range of professionals and organisations is required to address these. An ageing population in many western countries means that a large number of patients will be older (Soule A, Babb P, Evandrou M, Balchin S 2005) and the need for collaboration between professionals will become increasingly important. Healthcare professionals must therefore develop the knowledge and skills required to collaborate effectively at an interagency and interprofessional level.

This chapter explains the meaning of interprofessional collaboration and its benefits to older people. It then describes the key interprofessional collaborative competencies healthcare professionals must develop if they are to care effectively for this population group.

[A] BENEFITS OF INTERPROFESSIONAL WORKING

The way in which healthcare is delivered has become increasingly dependent on team and interagency working and it is reassuring that evidence suggests that interprofessional teamworking does improve patient/client outcomes. (Borrill et al. 2001), for example, in a study of healthcare teams, concluded that there is a significant and negative relationship between the percentage of staff working in interprofessional teams and patient mortality. In other words, the more people who are members of an interprofessional team, the better the outcomes for the patient. This may be attributable to the variation and mix of skills and knowledge that each member brings to the team, increasing its innovativeness and creativity. Similarly, in a systematic review of interprofessional working around older people in the community, (Trivedi et al. 2012) found that well integrated and shared models of care between different agencies reduced the levels of hospital and nursing home use.

[A] WHAT DOES INTERPROFESSIONAL COLLABORATIVE PRACTICE MEAN?

The World Health Organisation defines interprofessional collaborative practice as occurring when *"multiple health workers from different professional backgrounds provide*

comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings'. (WHO, 2010, p13).

Collaboration can occur between different professionals within one organization or increasingly between professionals who belong to a range of organisations from the public, private and third sectors. Collaboration is not necessarily only required between health workers. Social workers, police, lawyers, teachers, probation officers and charity workers, for example, are also part of the wider interprofessional team involved in the support of an older persons needs.

[BOX START]

CASE STUDY PART 1 CHARLOTTE AT HOME

Mary has just retired. She and her husband live in a small village along the South Coast of England. Mary's mother, Charlotte is 85 years of age and lives alone in bungalow a few miles from Mary, Mary's father having died 6 years ago.

Charlotte is not in good health. She has angina, diabetes, is hard of hearing having suffered with mastoids as a child, and has a severe prolapse, which is inoperable because of her general health. Charlotte and her husband had a traditional relationship, Charlotte having stayed at home to care for Mary and her brother, Mary's father going out to work and taking responsibility for the family finances.

She describes her relationship with Charlotte as being far from a good mother/daughter one and describes a level of resentment, having recently retired from a busy job, and that her mother now expects her to drop everything to be her full time carer. Mary describes feeling guilty about feeling this way but sees her experience as Charlotte's main carer as one of frustration.

About 6 months ago, Mary began to worry more about Charlotte, noticing she has stopped washing herself. Mary is concerned that her mother no longer cares what she looks like and no longer dresses in nice things. She wishes she would take pride in her

personal appearance again and take more pride in her bungalow. Mary is concerned that her mother appears to have given up on herself and may be lonely.

Mary describes herself as a good organizer and has become a key coordinator of Charlotte's care. She organised to have a sit in shower fitted for Charlotte that has worked well. She realized her mother is not able to do the cleaning of the bungalow physically anymore, so she managed to get Charlotte to agree to a cleaner for 2 hours a week and a gardener for 2 hours every fortnight.

Mary has done some research on the benefits available to her mother. She has found out Charlotte is entitled to the high rate of Attendance Allowance, although she has difficulty persuading Charlotte to claim this money.

Mary has contacted numerous agencies to support Charlotte including Age UK, Social Services, the local GP Surgery and local church groups. She has experience of doing this having learnt from her experiences of looking for support for her adult son who has learning difficulties.

All the agencies she has approached have been very helpful. They have summed up Charlotte's needs and looked into Mary's needs also. They have carried out assessments offering suggestions for how Charlotte can get out and about, what care she needs and general helpful information. Mary describes the various professionals having always had a caring, listening ear and been sympathetic to what she is saying but comments that sometimes they do not see the full picture: *"They see my mother as an archetypal old lady with silver hair in a bun and a willing smile. If only they knew"* says Mary. Sometimes Charlotte appears not to co-operate. She insists, when meeting with agency representatives, that she does not need help, does not get lonely or depressed. She has rejected the offer of a 'befriending' service offered by one of the local Age Charities but privately admits to Mary that she is very down.

[BOX END]

[BOX START]

ACTIVTY 1

Read through the Case study Part 1 and reflect on the following questions:

Identify the agencies involved in supporting Charlotte, the professionals that might work within these and the sectors they represent?

What role does Mary play in the care of her mother?

[BOX END]

Charlotte has a number of physical conditions (e.g., angina and diabetes). She is also lonely and is showing early signs of depression. Health professionals, social workers and third sector organisations are required to provide support to improve her physical and mental wellbeing and, practical day-to-day living. The publication of the National Service Framework for Older People (Department of Health 2001) recognised this need for multiple agency involvement in the care of an older person and the provision of coordinated care across this range of services. It encourages better collaborative practice across organizational and professional boundaries..

Mary, Charlotte's daughter talks of the number of public and third sector organsations that she has contacted and who have assessed her mother, and for whom a level of integration is required to ensure that professionals work collaboratively together to maximse Charlotte's wellbeing. However, interprofessional and interagency working is not always optimal, and there are several well known quoted incidences where failures in collaborative practices have lead to serous errors in care (Laming 2003; Laming 2009; Kennedy 2001). Although, nothing as serious has happened to Mary and her mother, they are aware of the frustration that a lack of collaboration between and professional groups services can cause. As Mary says below:

[BOX START]

CASE STUDY PART 2 MARYS EXPERIENCE OF CO-ORDINATED SERVICES IN THE COMMUNITY

Mary reports that the care of her mother and the services provided have been excellent. There has always been support for her and for Charlotte with suggestions as to the way forward. However, communication between the agencies could have been better. She believes they would have worked better if they were better able to network and give more support to one another. On several occasions, appointments have been confused because one service had not liaised with another. Mary also reported some contradictions in the diagnosis of her mother's prolapse that had confused Charlotte unnecessarily, especially as she often had to repeat the same information over and over to different people. *"Don't they have any shared records about who's seen my mother, when and what the outcome has been?"* asks Mary.

Mary also recalls an earlier event talking to the GP when Charlotte had a fall, cutting her back badly. The GP prescribes an antiseptic cream. Mary attended the consultation and was able to point out that her mother would not able to administer the cream herself in her physical condition. At Mary's insistence the GP refers to a district nurse to attend.
[BOX END]

[BOX START]

ACTIVITY 10. 2

What examples of poor communication can you observe in the Case Study Part 2?
What could have happened to Charlotte as a result of this poor communication?

[BOX END]

Healthcare students need to learn to work collaboratively with the patient and her family, with other professional groups and across organizational boundaries if serious errors in the care of an older person are to be avoided and her wellbeing and that of her family optimised. In the rest of the chapter, we explore a range of interprofessional competencies that healthcare professionals should develop to achieve this.

[A] INTERPROFESSIONAL COMPETENCIES

Interprofessional competencies are the skills and knowledge required by a professional if they are to collaborate effectively with other professionals, with a range of organisations

and with different patient groups. Orchard & Bainbridge (2010) describe six interprofessional competency domains. These relate to:

1) interprofessional communication
2) patient -centred care
3) interprofessional role clarification
4) interprofessional conflict resolution
5) interprofessional collaborative leadership
6) interprofessional team functioning

We explore each of these competencies in relation to our case study to illustrate where these competencies have or have not been demonstrated and how these might be developed by the healthcare professional involved.

[A] INTERPROFESSIONAL COMMUNICATION

[BOX START]

COMPETENCY STATEMENT: Workers from different professions should be able to communicate with each other in a collaborative, responsive and responsible manner (Orchard & Bainbridge, 2010)

[BOX END]

[BOX START]

CASE STUDY PART 3 CHARLOTTE IN HOSPITAL

A few months later, Charlotte was admitted to hospital with a severe cough and following examination, she is diagnosed with advanced, aggressive lung cancer. She was scared and lonely. She told staff that whatever the diagnosis, she did not want any treatment or resuscitation, but would accept pain management.

Shortly after Charlotte was admitted, Mary and her husband, James visited her in hospital. A young nurse greeted them warmly. She asked them about how Charlotte was feeling and if she was coming to terms with her diagnosis. Mary and James were taken a back not having been aware of Charlotte's recent diagnosis. The nurse looked nervous, halted her conversation and excused herself rapidly. James and Mary were left alone shocked and upset about the unexpected news.

[BOX END]

Case Study Part 3 describes a breakdown of communication between the oncologist and the ward nurse on whether the family has or should be told of Charlotte's diagnosis. There needed to be consultation between these two professionals before the family visited. Time could be ring fenced for formal and regular briefing and debriefing sessions between nursing and medical staff to improve team communication. Hereby, each professional could volunteer and requests information on each patient. This should be a two-way exchange of information between professional groups. The medical staff might describe Charlotte's diagnosis and the nursing staff provide a more holistic picture of

Charlotte's family circumstances and general wellbeing. At such a meeting, the nurse could volunteer that Charlotte had family involved in her care. This could have prompted the oncologist to inform the nurse that the family was yet to be informed of the diagnosis. Briefing sessions should be facilitated in such a way that all members have the confidence to voice their concerns or queries.

An essential skill within the domain of interprofessional communication is the ability to actively listen to other team members. The oncologist may well have shared with her colleagues the information that Charlottes's family had not been informed, but in the rush of handover or during particularly busy times on the ward, the nurse in this case study may not have registered this. Professionals should therefore make a conscious effort to actively listen as well as talk to other professional groups, understanding that others may have different priorities and ways of expressing themselves. Each profession should consciously strive towards communicating with each other in language that is free of jargon and acronyms. This ensures that all members of the team share a common understanding of care decisions.

The healthcare professional should pay particular attention to actively listening to the patient also. For older people, this may mean that the healthcare professional be aware of the need to speak louder and more slowly. Charlotte would have been able to inform staff, if they had actively listened to her, whether her family knew of her diagnosis and in fact, if she wished them to know.

Active listening may be hindered by prejudice. Unfortunately, ageist prejudice (Department of Health 2001; WHO 2004; WHO 2007) and discrimination against older people (Liu *et al.* 2012) prevents healthcare professionals from active listening and leads to misunderstandings such as that described in this case study. Stereotypes are not always extreme. In Case study Part 1 *Charlotte in the Community*, professionals characterised Charlotte as a nice grey haired old lady. This stereotype may have prevented them from seeing her true needs and loneliness, a fact she was only able to share with Mary. Professionals should reexamine their own attitudes and prejudices towards older patients and make an effort to actively listen to them. If the nurse had actively listened to Charlotte or her family, when she was in hospital, (Case study part 3)

she may have picked up cues earlier that the family did not know the diagnosis and have taken time to break this to them more gently and with Charlotte's consent. Taking time to actively listen both to other professionals within the team, as well as the older patient and their family, leads to the building of empathic and trusting relationships within the team, a factor that facilitates better team functioning and patient outcomes (Adamson 2011).

It is worth remembering that, both in interactions with other professional groups and the older patient, communication is non verbal as well as verbal. Resentment and prejudice towards particular patient groups and/or professional groups are therefore hard to disguise. Healthcare professionals should reflect on why they feel this way and think of strategies to overcome these. Building trust with the older patient and other professional groups, practicing one's listening negotiating, consulting, interacting, discussing or debating skills will help. This takes time but, as with all skills, the more one practices the better you become. Mutual respect and trust also builds through consistently sharing information in a way that promotes full disclosure and transparency during interactions with other team members. If the nurse lacks the confidence to speak up in an interprofessional case conference, for example, she is inadvertently not disclosing the in depth knowledge she has of the patient's personal circumstances with the rest of the team (Reid 2012).

The nurse in this case study could consider other novel ways of sharing information with other professional groups using information and communication technology. The use of social media as a means of sharing information between professionals to promote shared, interprofessional decision making and sharing responsibilities for care across team members shows increasing popularity (McNab 2009). For example, doctors in a Canadian hospital were assigned individual and team Smartphones with which they could contact each other and share information. Nurses and other staff could make direct calls or send email messages to team Smartphone via an online webpage site from computers on the wards. Although not without complication, this was successful in facilitating the transfer of information between doctors, nurses and other medical staff (Lo *et al.* 2012).

[A] PATIENT -CENTRED CARE

[BOX START]

COMPETENCY STATEMENT: Healthcare practitioners should be able to seek out**,** integrate and value, as a partner, the input and the engagement of the patient and their family (Orchard & Bainbridge, 2010).

[BOX END]

This competency highlights why the narrower definition of interprofessional working has been expanded from

"how two or more professional may work together effectively in the interests of continuous care and the patient" (Freeth *et al.* 2002).

to one that includes the older person and their family. The patient and their family should be seen as part of the team centrally involved in common goal setting and shared decision-making. In other words, interprofessional working should be defined as a range of different professionals "*working with p*atients, their families, carers and communities to deliver the highest quality of care across settings"(WHO 2010, p13). This is in keeping with a humanistic approach to care that puts an emphasis on the lived experience and personal history of the older patient, embodying the life goals and values of the patient rather than a professional focused definition of problem based care. The older person should be considered as part of the interprofessional team rather than the recipient of the actions of this team. If interprofessional teams are to include the patient's voice then practitioners must try to understand the value maps not only of other professionals but the values, priorities and mind maps of the older person themselves (Clark 1995).

[BOX START]

ACTIVITY 3

Why do you think, in Case study Part 1, that Charlotte does not appear to cooperate with the services offered to her?

[BOX END]

Healthcare professionals should view Charlotte and her family as an integral part of the interprofessional team and include them in planning and implementation of services or care. Mary has shown that she has an in depth awareness of the complexity of her mother's needs beyond just an understanding of her physical wellbeing. When Charlotte was still at home, Mary contacted a number of charities and public sector organisations to help Charlotte with her garden, she had explored a brefriending service to counteract Charlotte's loneliness and had researched the financial allowances available to support these services. Mary was able to give the organisations/professionals supporting Charlotte greater insight into her needs and acted as a key gatekeeper coordinating the numerous services and professionals who visited her mother.

Health professionals should share information with Charlotte and Mary in a respectful manner. They should do so in a way that is understandable, allows discussion and promotes shared decision-making. The GP, for example, in the consultation after Charlotte's fall, should share information with Mary and Charlotte in a way that allows them both to engage as equals in the consultation.

The healthcare professional should think of the education the patient and their family may require. As Charlotte has not been responsible for the finances in her married life, she will need additional educational support to help her understand the allowances available to her, how to claim these, and what services these may purchase. This is particularly relevant in the UK with the increased personalisation of health and social care services, and the award of individual budgets managed by the client/patient to achieve this (Department of Health 2005; Forder *et al.* 2012).

Healthcare professionals should listen respectfully to the expressed needs of all parties in shaping and delivering care or services. Both the needs of Mary and Charlotte need to be

considered in this scenario. Mary's relationship with Charlotte is a complex one. Mary has many competing commitments with a husband and disabled son who also require her attention. Before Charlotte entered hospital, Mary found caring for her mother tiring and frustrating. Her physical and emotional wellbeing should be taken into account when engaging her in Charlotte's care. If this is not compromised, she is a valuable member of the team.

[A] ROLE CLARIFICATION

[BOX START]

COMPETENCY STATEMENT: Healthcare professionals should understand their own role and the roles of those in other professions, and use this knowledge appropriately to establish and achieve better patient outcomes (Orchard & Bainbridge 2010).

[BOX END]

[BOX START]

CASE STUDY PART 4 THE HOSPITAL EXPERIENCE:

Mary visited Charlotte regularly when she was in hospital. She reported the wards as being understaffed, although the nursing staff did what they could to make Charlotte comfortable. Most of the patients on her unit were elderly and in need of a high degree of care. On a number of occasions, when visiting, the wards smelled of urine and worse. Some patients wandered around with gowns, which were ill fitting and undignified. There were individual mobile side trays at every bed and it was noticeable that food and drinks remained on the trays for a considerable time. Charlotte had a yoghurt drink and a ham sandwich on her tray at one afternoon visiting session, which was still in situ and untouched during the evening visit. No attempt seemed to have been made to actually assist her to drink or eat, nor to give her water to keep her hydrated. She incurred a urinary tract infection as a result and became delirious and somewhat unmanageable.

[BOX END]

[BOX START]

ACTIVITY 4

Whose role was it help Charlotte with her nutrition and hydration?

[BOX END]

Healthcare professionals should be able to clearly and accurately describe their own role and that of others. They should be able to recognise and respect that there many other health and social care roles, responsibilities, and competencies. They should consider the impact that performing their role may have on other professionals groups and recognize that other professions may view the world differently to them.

Understanding one's own and other professionals' roles and responsibilities is not always as easy as it might seem as with increased interprofessional working, boundaries between professional roles and responsibilities can become blurred, leading to potential confusion of which profession should perform a particular task and when. This is illustrated in our case study where Charlotte was not helped to eat her meal, which was then left untouched for several hours. Who was responsible for the task: the healthcare assistant (HCA), the nurse, the family?

Healthcare assistants and other assistant practitioners were introduced to fill the gaps in the nursing NHS workforce, and free up nursing time for more specialized roles. The introduction of these roles is what Nancarrow & Borthwick (2005) call vertical role substitution in which tasks traditionally done by nurses were delegated to a less qualified professional, the HCA. Horizontal substitution can also occur when roles are interchangeable between professionals of similar training level. Vertical substitution is illustrated in a study by Thornley (2000) who, in exploring the perceived roles of the HCA, showed a large overlap between the tasks these professionals were performing and those performed by registered nursing staff. Similarly, Wakefield *et al.* (2010) in a review of assistant practitioner (AP) job descriptions found that the boundaries between nurses and assistant practitioners roles, such as the HCA, are blurred and claim that this lack of clarity over what the AP role is can cause conflict and confusion in practice.

In our case study interprofessional communication between the HCA and Nurse is essential in order that they clarify their roles, in this case on who should check that the patient is eating and if she requires help in doing so. The nurse and HCA need to reflect on their own and others' professional role and clarify who is accountable for each particular task. All professionals have competencies specific to their particular training but there are shared competencies also. Where competencies are unique to one profession, the other professions need the skills to be able to access these unique competencies through consultation or referral to these groups. This requires a level of humbleness and appreciation of the skills of other groups or alternatively the confidence and sometimes courage to seek advice. Perceived professional hierarchies within healthcare may also make this difficult. Serious errors in care occur, however, when a professional has lacked the confidence to speak up in emergency situations (Reid 2012).

Professionals also need to understand what competencies are shared, where there is potential overlap, and potential for either horizontal or vertical substitution, and how these might be managed.

[A] **CONFLICT RESOLUTION**

[BOX START]

COMPETENCY STATEMENT: Healthcare professionals should be able to actively engage themselves and others, including the patient and their family, in positively and constructively addressing disagreements as they arise (Orchard & Bainbridge, 2010).

[BOX END]

Various reasons for conflict between professional groups(Orchard & Bainbridge, 2010).: One relates to professionals not understanding each other's roles and accountability. Conflict may have arisen between the HCA and the nurse as to whom was responsible for helping Charlotte eat her lunch, for example. The other relates to different members having different goals related to their different approaches to care as well as their own individual beliefs and philosophies. These different ways of viewing the world is what Clark (1995) refers to as different mind maps of the world. This is because different professional groups throughout their training are socialized in different ways, learning

different rules and ways of practicing peculiar to their particular professional training. The most obviously different mind maps is illustrated in medicine and social work. In medical education there is an emphasis on the scientific basis of medicine and the biology of illness. Social work education on the other hand takes a more holistic approach to the client/patient, a less reductionist and more humanistic approach. These very different systems may lead to poor communication. It is potentially resolved, not necessarily through a change in philosophy, but understanding that other professionals have different perspectives of client care and that the contribution of each of these perspectives should be equally valued (Drinka & Clark, 2000).

[BOX START]

CASE STUDY PART 5

After a month in the hospital, the bed was needed and so the NHS arranged for Charlotte to move to a nursing home. Within ten days, Charlotte improved beyond recognition. She was eating and drinking well, regained mobility and was being cared for by wonderful staff who treated her with respect and dignity. Although her dearest wish was to return to her own flat, she was lucid enough to realise that this was not possible, that she needed a high degree of care and pain management and she seemed happy with her treatment at the nursing home. She was encouraged to join in with the variety of entertainment on offer at the home and on several occasions Mary arrived to find her laughing or singing with the other residents.

Charlotte passed away peacefully in the nursing home after two months. Mary knew that she and her family had done their best for her towards the end of her life and was grateful for the nursing home staff for their care, support and kindness to her mother. They had kept the family informed every step of the way as to who had visited, changes in medication, what she was eating, whether she had managed to get up that day, when they were arranging a bath, massage, visit to the hairdresser, manicure, pedicure and so on. Mary reports total communication and consultation on all levels from all the staff. *"It is so important to keep the family informed and involved with the care of their loved ones"* says Mary.

Conflict not only arises between professional groups but between the family, the patient

and the healthcare team as well. Charlotte wanted to be discharged from the hospital and return home. Her family and the medical team wanted her admitted into a care home. Charlotte's goal is to return to a place in which is comfortable and familiar. For Mary and the medical team the goal was to have Charlotte in a location where she could be cared for appropriately and be safe. In resolving professional-professional or professional-patient conflicts, the healthcare professional should acknowledge that conflict is not necessarily a bad thing. With different groups holding such different ways of looking at things and with the multitude of different skills and life experiences each individual has to offer, it is natural that different approaches to care exist. In fact, these different opinions add to the innovativeness and creativity of a team. However, professionals should learn to be on the look out for situations where conflict may arise and develop strategies with which to deal with these. In the HCA/nurse conflict, for example, role ambiguity was caused conflict and could be overcome through open transparent discussion between HCA and nursing staff about what tasks need to be achieved and who was responsible for these. Both parties should work together to develop procedures with which the causes of conflict are identified early on and processes put in place whereby these may be resolved. As transparency is essential in interprofessional communication, conflict resolution should take place in a safe environment, free of a blame, in which all are free to express their view and feel themselves to have had a voice, regardless if the resolution is in their favour or not.

[A] INTERPROFESSIONAL LEADERSHIP

[BOX START]

[A] COMPETENCY STATEMENT

Healthcare professionals should understand and apply leadership principles that support collaborative practice. They should also be aware of the principles of shared decision-making. They should be ale to work collaboratively to determine who will provide group leadership in any given situation (Orchard & Bainbridge, 2010).

[BOX END]

There are many models of leadership and different people and professional groups may view leadership very differently. Miller *et al.,* (2001) identified, through observations of interprofessional teams, three different team philosophies of working within them: a directive, integrative or elective philosophy. A directive philosophy was frequently held by members of the medical profession and non-specialist nurses. It was characterised by a need for a hierarchy within a team and a clear leader. In contrast, an integrative philosophy described the views of team members who saw collaborative working and being a team player as central to interprofessional teamworking. Members understood the importance and complexity of communication and the need for effective discussion. This was a philosophy often held by therapy and social work professions. Lastly, the authors described an elective working philosophy demonstrated by professionals who prefer to work autonomously and refer to other professionals only when they perceive the need. Miller *et al.* (2001) used mismatches in these philosophies among members of the interprofessional team to explain team conflict and poor team outcomes.

To achieve some consensus on leadership in healthcare, the Clinical Leadership Competency Framework in the UK (Leadership Academy 2011) was developed which supports a model of shared or distributed leadership *"a universal model such that all clinicians can contribute to the leadership task where and when their expertise and qualities are relevant …"*p6 (Leadership Academy 2011). The framework lists these leadership competencies as being able to demonstrate:

- The development of particular personal qualities (including self awareness and continuous personal development).
- The ability to work with others (including building interprofessional relationships and encouraging the contribution of team members from other professional groups);
- The ability to manage services (including skills in planning and managing resources, people and performance).
- The ability to improve services (including being able to encourage improvement, innovation and organisational change);
- The ability to set future direction (including being able to apply professional knowledge and research evidence to support change and then evaluating its impact).

[A] **ACTIVITY 4**

[BOX START]

Write your own case study, based on Charlotte's experience of the hospital ward, where the nurse demonstrates interprofessional leadership?

[BOX END]

The clinical leadership framework resonates with altruistic and servant leadership models promoted in the interprofessional literature. In the former, the above leadership competencies need to be demonstrated in such a way that leaders of interprofessional teams are able to see beyond their own interests and that of their own professional group or organisation and *"be willing to give up parts of their territories if necessary"* in the interests of better interprofessional or interagency collaboration (Axelsson & Axelsson 2009). In our case study Part 1 *Charlotte in the Community*, this would have been essential when the duties of age related charities and public sector services overlapped in the delivery of Charlotte's care.

Similarly, in servant leadership models, leadership has *"less to do with directing other people and more to do with serving their needs and in fostering the use of shared power in an effort to enhance effectiveness in the professional role"* (p427; Neill *et al.* 2007). This servant leadership would be demonstrated if the nurse suggested an interactive debriefing session with HCA staff in which to reflect on the pressures faced by the HCA staff and to explore all staff roles and responsibilities related to the nutrition and hydration of the patient.

Closely related to these models of leadership, is the concept of interprofessional shared decision-making described as the *"reciprocal flow of medical and personal information,* [between individuals], *discussion of preferences, wishes and options, conjoint deliberation and decision-making process."*(p1; Körner *et al.* 2012). These processes should occur first between the professionals involved in the different dimensions of patients care, jointly agreeing together as a team a care plan for the patient. Secondly these processes should also occur between each of these different professionals and the

patient themselves (Körner *et al.* 2012). The decision to move Charlotte to a care home, for example, should be a three way affair in which the "preferences, wishes and options" of both the hospital staff, the care home staff, Charlotte and her family are consulted and her move to the care home agreed collaboratively.

[A] **TEAM FUNCTIONING**

[BOX START]

Healthcare professionals should understand the principles of teamwork dynamics and group/team processes to enable effective interprofessional collaboration (Orchard & Bainbridge, 2010).

[BOX END]

Healthcare professionals need insight into how teams form and function. Various models are available to explain these, the most commonly cited being the stages of group development (Tuckman 1965) and the concept of Team Roles (Belbin, 2012.). In the team development model, team functioning and the behavior of team members are described in terms of a team life cycle of Forming, Storming, Norming Performing and Adjourning. In the forming phase, the team has newly come together, and is getting to know each other. Skills related to interporfessional role clarification will be important here. In the storming phase, differing individual or professional views are shared which will often lead to conflict. If the team is able to move past this phase, and not all teams are able to do so, the team enters a norming phase where conflicts are resolved and new common ways of working as a team are agreed. The skills of conflict resolution, interprofessional communication, interprofessional leadership and shared decision making will be important in moving the team through into this phase of its life cycle. Once the interprofessional team has agreed its norms/rules, it enters the performing phase where members collaborate optimally under these agreed conditions. This model helps the healthcare professional understand that teams are units that need to be actively developed as they pass from one phase to the next. However, the model rests on the premise that teams are fairly stable and identifiable structures. The professsionals from the range of services supporting Charlotte, when she was living at

home, might not describe themselves as a team but still need to collaborate. In the complex and interagency/interprofessional organization of health and social care services, the idea of a team and its functioning may be more fluid (Bleakely, 2012) with professionals coming together only temporarily around a particular task before disbanding again. Other models to understand team functioning in these instances are described elsewhere (Bleakley 2012).

Another commonly used model to describe team functioning is that of Belbin's team roles that proposes that individuals within a team have a tendency towards playing one (or sometimes several) of 9 main roles, each of which contributes to the success of the team. A team will work best if a balance of roles is achieved within it. When working as an interprofessional team member, therefore, health care professionals should regularly reflect on the functioning of this team, considering the phase of its development and the differing roles that different members are fulfilling, whether a balance has been achieved and if not, whether roles need to be altered or new staff introduced to take these functions. For example, one of the nine team roles is that of coordinator, described by Belbin as a mature, confident individual, who is a good chair person, that clarifies goals, promotes decision making and delegates well. This role is particularly important in the coordination of an interprofessional team. Although this role may be filled by one of the healthcare professionals themselves, Begun *et al.* (2011) suggest that interprofessional teams import health care administrators to perform this function, leaving other roles to be fulfilled by other team members.

[A] **SUMMARY**

This chapter explored the increasing need for interprofessional working in the healthcare of an ageing population. It presented the most up to date and international definition of interprofessional collaboration and outlined six competencies that healthcare professionals must develop if they are to best deliver interprofessional care for an older patient. The first of these competencies is the ability to communicate across professional and organisational boundaries and with different patient groups. This involves an awareness that other groups communicate in different ways and that one's own communication strategies need to adapt to take this into account. The patient and their

family must be at the centre of the interprofessional team and be engaged as active team members in shared decision-making. Active listening is key. Healthcare professionals need to be able to describe their own role and that of others. They should recognise the unique competencies of others as well as where role overlap may cause confusion about who does what and when. Conflict and conflict resolution is a normal and central skill in working interprofessionally around an older patient and some of the reasons for interprofessional conflict are highlighted. Shared or distributed Interprofessional leadership is important in the functioning of an interprofessional team and models that promote servant or altruistic leadership styles and interprofessional shared decision making are preferred. Finally, two common models of team functioning are highlighted that enable the professional to reflect and act on how team processes may be explained and improved.

ACTIVITIES: BRIEF OUTLINE ANSWERS

Activity 1

Mary enlisted a large number of organisations to help her mother. General Practitioners, , district nurses and social workers from public sector will all need to interact and collaborate with qualified professionals (potentially social workers and healthcare professionals) as well as volunteers in the third sector (e.g. AGEUK) or religious leaders (from local religious groups). Collaboration, with Charlotte at its centre, is therefore required between a range of very distinct groups who vary by sector, professional group and professional status.

Mary plays a key coordination role in her mother's care. She has a holistic view of Charlotte's needs that is not confined to her poor physical health alone. Through her experience with her son, she has a good knowledge of the range of services and support available, how to access these and she is able to draw together a wide range of services from gardening and cleaning services to health and social care. Mary and Charlotte are vital members of this broad team of people supporting them, as they hold vital information on who is doing what and how. Professionals should use this information to prevent duplication or oversights in the multiple services provided and for the different

organisations and professionals to collaborate better in the interest of the patient.

Activity 2

Poor communication has occurred between different organization when Mary is referred between one service to another and a mix up in appointments has occurred. More seriously, there has been confusion around what can be done about Charlotte's prolapse. Mary story suggests that different professionals have not shared or agreed a common approach to her condition leading to Charlotte being confused and distressed. Poor communication is reported also in the GP consultation when Charlotte cut her back. If Mary had not been there as an advocate, Charlotte may have left, not wanting to be a nuisance or make a fuss, and have withheld that she would not be able to apply the cream by herself.

Activity 3

Charlotte comes from a generation where privacy was highly valued. She may find asking for help from strangers uncomfortable. A befriending service may be a good idea to both Mary and the other professionals but for Charlotte be seen as undignified and intrusive. Professionals should consider these intergenerational differences and consult the patient on their personal preferences. In other words, they should try to understand the mind map of their older patient.

Activity 4:

NHS careers (http://www.nhscareers.nhs.uk/explore-by-career/wider-healthcare-team/careers-in-the-wider-healthcare-team/clinical-support-staff/healthcare-assistant(http://www.nhscareers.nhs.uk/explore-by-career/wider-healthcare-team/careers-in-the-wider-healthcare-team/clinical-support-staff/healthcare-assistant/) describe the role of the HCA as defined by washing and dressing, feeding, helping people to mobilise, toileting, bed making, generally assisting with patients' overall comfort and monitoring patients' conditions by taking temperatures, pulse, respirations and weight. This suggest that it may have been the responsibility of the HCA to help Charlotte eat and hydrate but research by Wakefield *et al.*, 2010 and Thorley (2000) indicate that

differentiating roles between the groups can be difficult and this may have lead to Charlotte being neglected in this way.

Activity 5

The Nurse on Charlotte's ward could demonstrate interprofessional leadership by proactively engaging medical, fellow nursing staff, and assistant practitioners in a service improvement project aimed at improving the dignity of older people on her ward. After actively listening to Mary's account of experiences of the ward cleanliness, she decides to focus on the personal hygiene domain of the dignity framework described in a recent report she is reading (Magee et al., 2008). She reads regularly as part of her own professional development as a nurse. She works collaboratively to plan, implement and evaluate a strategy in which staff offer patients choice in the level of assistance in personal hygiene they require as well as who delivers it. They offer patients the choice of using their own toiletries and take extra measures to ensure the bathroom facilities on the ward are clean and welcoming. The nurse evaluates the impact of the project on patient experiences of the ward.

FURTHER READING

- Hammick, M. Freeth, D.S., Goodsman, D. and Copperman, J. (2009) *Being Interprofessional,* Cambridge: Polity Press

USEFUL WEBSITES

- IPE PORTAL on MedEd for interprofessional education and practice articles and research - https://www.mededportal.org/ipe/
- Centre for the Advancement of Interprofessional Education www.caipe.org.uk
- Theoretical frameworks in interprofessional education and practice: http://www.facebook.com/groups/IN2THEORY

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