11.40 - Interprofessional working - what the literature does and doesn't tell us

Andrew Booth, Director of Information Resources & Reader in Evidence Based Information Practice, ScHARR and Anna Wilkinson, Information Specialist (Special Projects), ScHARR for the eeicc team

Acknowledgements

- To members of the EEICC team - **Lorraine Ellis, Pam Enderby, Anna Moran, Susan Nancarrow, Stuart Parker, Tony Smith** and to Mike Campbell, Ruth Wong & Ron Akehurst

- To the NHS Service Delivery & Organisation Programme for funding this literature review as a component of the project **SDO/214/2008 - Workforce - (T4) Patients' experiences of care and the influence of staff motivation, affect and well-being (Lead Investigator: Professor Pam Enderby)**

Context

- Growing emphasis on interprofessional team [IPT] (esp. educational requirements)

- Little evidence on most effective way to deliver IPT.

- Compounded by multifactorial nature of team working:
  - Skill Mix
  - Setting of Care,
  - Service Organisation and Management Structures.

- Wide range of outcomes of interest including:
  - Patient Wellbeing and Satisfaction (Patient care)
  - Length of Stay; Service Costs (Service);
  - Measures of Staff Satisfaction (Staff)

Review Aims:

Three principal aims:

1. To explore, qualitatively, different approaches to interprofessional working to develop a typology of interprofessional practice.

2. To examine, qualitatively, the different approaches to implementing workforce change

3. To explore quantitatively the outcomes of different interprofessional staffing models for patients, staff and services.

Methods - Systematic literature review

Published and unpublished studies (1994 – 2007).

Three-step search strategy:

1. Initial search MEDLINE/CINAHL - analysis of text words from titles and abstracts plus index terms

2. Search using identified keywords and index terms across included databases.

3. References list of identified reports/articles for additional studies. Databases searched include:

   AMED; British Nursing Index; CINAHL; Cochrane Database of Systematic Reviews; Centre of Reviews and Dissemination (CRD); EMBASE; ERIC; Healthstar; King's Fund Library Database; MEDLINE; PsycINFO; Web of Knowledge; TRIP (Turning Research into Practice)

Results limited to English language articles.

Issues

- Review 1 - **problematic** - difficult to establish existence of model/conceptual framework from screening abstracts. Citation (backward) chaining used to follow lines of argument backwards to chart development.

- Review 2 - **even more challenging** - terminology for tools/instruments of workforce change lacks precision for retrieval. Identified names/descriptions of change tools/instruments from expert opinion, web sites and scoping literature. Searched for named tools on bibliographic databases and Internet.

- Review 3 – **less problematic** - quantitative studies documenting outcomes of different staffing models. "Thinness" of description - difficult to attribute outcomes to particular model. Possible contribution of "lower" study types but problem with causality.

What the literature does tell us

Results – Review 1

- 145 identified studies (1994-2008)

- Majority by nursing lead authors (cp Blue & Fitzgerald, 2002 - nurses overwhelming majority of research on nurse–doctor relationships)

- Most represented journal – *Journal of Interprofessional Care (22 refs)*

- *Other multiples: J Adv Nurs, J Clin Nurs. + nursing management/admin journals*

- Almost none written by interdisciplinary teams!

Crossprofessional working (Thylefors et al, 2005)

- **Multiprofessional** - focused on task, not collective working process. Contributions made either in parallel or sequentially to each other with minimal communication. Each contribution stands alone and can be performed without input from others. Independent contributions have to be co-ordinated. Physician has traditionally taken responsibility.

- **Interprofessional** – ('product is more than simple sum of its parts''). Outcome requires interactive effort and contribution of professionals involved. Implies high level communication, mutual planning, collective decisions and shared responsibilities. Everyone involved in process must take everyone else's contribution into consideration.

- **Transprofessional** - opposite end of continuum from multiprofessional. Team uses integrative work process and disciplinary boundaries partly dissolved.

Illustrative Example (Rehabilitation)

- MDT: Each profession/discipline has specific area of expertise that interacts sequentially with patient over course of a day: nurse coaches person in regaining skills of self-care in personal hygiene, physical therapist supervises series of exercises to strengthen specific muscle groups, orthotics specialist fits person with functional artificial limb.

- Might become IDT when it gathers with patients and families as team members to plan for discharge home. [*Many call these "multiprofessional"/"interprofessional" to avoid confusion when "discipline" used synonymously with "specialty" within a given profession*].

Mitchell (2005)

"Individual philosophies" of teamwork

- Impact on team communication and role understanding:

    - "**Directive**", (generally members of medical profession who view their role as team leader).

    - "**Integrative**", (notions of collaborative care and team player - most likely therapists, social workers and some nurses)

    - "**Elective**", values liaison (preferred by those who work autonomously, maintain role distinctions and favour brief communications e.g. Mental health workers) May equally apply to professionals in consultative role.

Freeman et al 2000

Interprofessional team working requires:

- Personal qualities; (1)
- Commitment of staff; (1)
- [Open] Communication within team; (1, 2, 3)
- Opportunity to develop creative working methods within team; (1)
- Shared Goals (3)
- Common Purpose (3)

- Respect for other team members; (2, 3)
- Understanding of their roles and expertise; (2)
- Being open to learning; (2)
- Effective Facilitative Leadership (3)
- Cohesion (3)

1. Molyneux (2001); 2. Dieleman et al (2004); 3. Mickan & Rodger (2005)

12 C's Defining Teamwork:

- Communication (sine qua non of teamwork)
- Cooperation (empowerment of team members)
- Cohesiveness (team sticks together)
- Commitment (investing in team process)
- Collaboration (equality in the team)
- Confronts problems directly

- Coordination of efforts (ensuring actions support a common plan)
- Conflict management
- Consensus decision making
- Caring (patient centered outcomes)
- Consistency (with one another and environment)
- Contribution (feeling this is being made)

Wiecha and Pollard (2004)

Barriers to Interprofessional Team Working:

- Patriarchal Relationships (1)
- Time (1)
- Gender (1)
- Lack of Role Clarification (1)
- Culture (1, 3)

- Geographical Separation (2)
- Different Employers (2)
- Professional Boundaries (2, 3)
- Hierarchical Role Boundaries (2)

1. Fewster-Thuente & Velsor-Friedrich (2008); 2. Griffiths et al (2004); 3. Hall (2005)

Potential inhibitors to collaboration:

1. **Interorganizational** - differences in power and resources available to groups may impact on collaboration.

2. **Interprofessional** - actual or perceived differences in status, training and skills may inhibit groups working together effectively to achieve commonly held aim.

3. **Interpersonal** - race, class and sex of participants may create barriers that prevent communication and collaboration.

Kenny (2002)

What team processes do they suggest?

- **Audit** (Xyrichis & Lowton, 2007)
- **Briefings/Debriefings** (Makary et al, 2006)
- **Coaching for managers and team leaders** (Whyte & Brooker (2001).
- **Daily interdisciplinary rounds** (Fewster-Thuente & Velsor-Friedrich, 2008)
- **Facilitators** (Xyrichis & Lowton 2007)
- **Individual Rewards** (Xyrichis & Lowton 2007)

- **Integrated documentation** (Atwal & Caldwell, 2002).
- **Meetings** (Xyrichis & Lowton (2007)
- **Setting common goals** (Atwal & Caldwell, 2002).
- **Single Assessment** (Cohen (2003)
- **Standardized care plans** (collaborative practice order sets for common diagnoses) (Fewster-Thuente & Velsor-Friedrich, 2008)

Try the "we" test!

- Observe your colleagues/co-workers use of "we" pronoun – what does it tell you about perceptions of "team"?

- E.g. Exclusive "we" – only our professional group - uniprofessional

- E.g. Qualified "we" as in "we nurses" – suggests – multiprofessional – separate roles

- E.g. Unqualified "we" – suggests interprofessional

- E.g. "One of us" – suggests transprofessional – any member of team

Developed from concept by Kvarnström & Cedersund (2006)

Includes **26 instruments/tools** for workforce change

(e.g.: CANDO; Christmas Trees - workforce planning tool; Drive for Change; How to change practice (NICE); Learning Needs Analysis; Measuring improvement from workforce change; NHS Workforce Scorecard; Nursing Workforce Planning Tool; Planning Now For Your Future Workforce Needs; Public Health Skills Assessment Tool)

Types of tools:

- Modelling tools
- Toolkits
- Resource Packs
- Tools adapted from other sectors

Tools aimed at

- Individuals

- Departments

- Trusts

- Professional Groups

- All staff

Tools aim to achieve:

- One or more of following:
  - Profiling the organisation's current workforce
  - Making an assessment of current and future demand and supply of particular skills/occupations
  - Identifying current and potential imbalances
  - Developing and implementing strategies to address future workforce needs
  - Monitoring and review

Useful Characteristics of our project tool might include:

1. Assessment tool to determine readiness for IPT working
2. Assessment tool to identify enablers and barriers to introducing IPT working
3. Workforce planning guide
4. Case studies/good practice
5. Community of practice to share experiences
6. Assessment tool to measure impact of IPT working on service

Results – Review 3 [Models-Outcomes]

- 94 papers (fewer studies as includes permuted authors)

- Primarily US, few UK studies

Conditions

- Stroke (19), Heart (7), Depression (11), Falls/Fractures (9), Discharge/Assessment (20), Frail Elderly (4)

Primary Roles of IDTs

- Geriatric Assessment
- Rehabilitation
- Medication/Coagulation/Glucose
- Complete path from assessment to discharge or beyond
- Coordination only – e.g. *"Hospital outreach stroke team based in stroke unit who made contact with patients in hospital, arranged discharge to home or rehabilitation unit, co-ordinated rehabilitation and support services and provided follow up. Variable duration of input. Team co-ordinated care largely delivered by other agencies"*

Composition of IDTs - 1

- Small group (e.g. three professionals) "GNP, geriatrician and nurse"

- Core group plus extended team

  - "E.g. Core members of PSC-Team included geriatrician (medical director of stroke unit IDT) , APN-CM, clinical nurse specialist from stroke unit, and extended team members (neurologist, pharmacist, dietitian, and social worker) available as-needed".

Composition of IDTs - 2

- Team excluding medical input
    - "Nursing, OT and physiotherapy and home health aides *under approval of* patients' physicians and also Medicare regulations"

- Specified as inputs rather than team members
    - (e.g. "Team comprising physiotherapy, occupational therapy, speech and language therapy and medical input.")

Composition of IDTs - 3

- Lead professional as case manager
    - "Case managers did initial assessment, reported to GEU which determined services that patients were eligible for, and designed and implemented individualised care plans in consultation with GPs. Case managers did assessments every 2 months and were constantly available to deal with problems, monitor provision of services, and to coordinate extra help as requested by patients and GPs. MDT discussed problems emerging from home visits during weekly meetings".

Patient & Service Outcomes

- Mortality! (32; usually NS); Activities of DL; functional status, independence, satisfaction

- Measurement period (6 weeks to 2 years)

- Scales (e.g. Barthel (16), SF36 (6), GHQ, HAD, Rankin, Frenchay)

- Some carer outcomes (e.g. SF36 or satisfaction; caregiver burden)

- Hospitalisation; Nursing home days; health facility days

- Admission/Readmission

- Length of Stay

- Place of Residence

- Medication Appropriateness

Team Activities

- Most common are Meetings
- Others include:
  - Case Conferences;
  - Protocols/Pathways;
  - Medication Reviews

- Smaller variety of activities compared with *Could Dos* from Review 1

What the literature doesn't tell us

Review 1 – Models

- How to diagnose whether at MPT, IPT, TPT stages?
- Interventions to move from MPT to IPT to TPT – what to use and when?
- Very weak (but widely promulgated!) evidence for impact of IPT on patient care
- Adverse effects of team working - we should not equate fully functioning team with better patient care
  - It can become self-serving
  - "Team commitment" (between organisational commitment and professional/job commitment)

Review 2 – Change Instruments

- Some tools/instruments have no evidence for use and effectiveness

- Some tools currently undergoing evaluation

- Evidence to support tools primarily from case studies

- Little about qualitative development of team processes

Review 3 – [Models-Outcomes]

- No staff views! – staff views for perception of intervention but not of team process. Focus on outcome of intervention

- No Outcomes/Instruments measuring staff perception/satisfaction

- Few studies include reception/admin staff

  - "Team of one doctor, five nurses, seven auxiliary nurses, three assistants, one *secretary*, one psychologist, OT, part-time social worker and two physios. Specialists consulted as needed"

- Focus on structural (who, how many), process (what they do and when) not on how team interacts

Overall Interim Conclusion

- Gap between qualitative research that informs Review 1 and quantitative outcomes that underpin Review 3

- Tools in Review 2 primarily designed to address numbers/skill mix/workforce requirements – little about qualitative development of team processes

- Need to synthesise across Reviews e.g. juxtaposing Review 1-Review 3 and Review 1-Review2 …and conduct our primary research!