

Critical analysis on the context of multi- agency team work

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This essay will focus upon a critical incident analysis in the context of multi-agency team work and inter-professional working. The details of the incident will be drawn from the authors recent experience with the Community Housing Support Team, in particular from Care Programme Approach meetings. The names of both clients and staff, as well as details pertaining to their locale have been changed or omitted to comply with the UKCC" s Code of Professional Conduct, Clause 10, (UKCC, 1992).

The situation used within this assignment is based upon two clients who co-habit in a first floor maisonette as common law husband and wife. Mr Client has a diagnosis of paranoid schizophrenia which is controlled with xenobiotics and is the main carer for Mrs Client who has a diagnosis of chronic schizophrenia also controlled by xenobiotics that are administered by Mr Client. Mrs Client also has a prolapse of the uterus which causes her to suffer from double incontinence.

Arrangements have been made for Mrs Client to have the required operation to repair the problem, however prior to admission Mrs Client becomes very anxious and has twice refused to have the operation. Both clients have a poor dietary intake, poor personal hygiene, high caffeine intake, and a heavysmokinghabit. The conditions that the clients are now living in due to the above being ongoing for some time are now less than satisfactory, and to that end the present situation and what should be done about it, has become the primary focus of the various professionals and agencies involved in care of the clients.

Each client has their own keyworker representative from the agencies and professionals involved in their care, these are a community psychiatric nurse (CPN), social worker, and a member of the housing support team (HST). Both the clients have home care workers visiting as part of the social work input, and they also share the same general practitioner (GP), and psychiatric consultant. Housing support team input was on a daily basis with both clients and their role was to assist the clients with shopping and encourage the clients to use leisure facilities and local transport.

The housing support team although referred to separately within this essay are officially part of the social work team, as this is the source of their funding. The social work keyworkers roles were to visit the clients on a regular basis and to assist with benefits, finances etc, as well as assisting the clients in conjunction with the rest of the care team if a crisis arose. The social work department had also arranged for home help to visit on a regular basis to assist with housework and hygiene. The clients community psychiatric nurse" s role was to monitor medication and mental state.

These are the defined roles as the author understands them, however the care team as a whole interchanges, shares, or crosses over roles as a matter of course throughout the care deployment. In order to properly analyse the inter-professional working of the clients care team, it is important to collate the differing aims of each profession involved. Mr and Mrs Client" s keyworkers from the housing support team were of the opinion that the client" s accommodation had reached the stage where it was posing a healthrisk for both the clients and other residents in the building.

Because the housing support team had daily input with both clients they were also able to pick up on various other aspects of care that appeared to require reevaluation, such as medication and mental state, and had encountered such an issue with Mr Client giving Mrs Client the incorrect dosage of medication. Taking into account the issues raised the housing support team felt that they were maintaining a poor quality of life for the clients, and that alternative sheltered accommodation, and care approach should be discussed as this was unacceptable.

The social work keyworkers in addition to their normal visits had arrangements for further visits outside of the care plan agreement as there was a recognised need for more intense support at this time. It was felt that placement in a nursing home as a couple with continuing input from the housing support team and community psychiatric nurse, would improve the clients quality of life. The clients general practitioner and consultant had made a referral to residential services.

Both clients community psychiatric nurse felt that the clients mental state did not warrant an admission into hospital, however further arrangements should be made regarding medication and accommodation. These various agencies and professionals come together, in this case every six months, to partake in a care programme approach meeting (CPA). The care programme approach was first considered in nineteen eighty-nine then again in nineteen ninety in a Department of Health circular, before being implemented in nineteen ninety-one as an official guideline.

However inter-collaborative working has been an aim of government policy in mental health services since the nineteen seventies, (COUCHMAN, 1995). Its target group being psychiatric clients in hospital, community or other specialised mental health service. The aim of the guidelines were to encourage greater efficiency and co-operation between the various agencies and professionals involved in the care of a client or clients.

This was to be done by systematically assessing all the clients needs and the agency or profession that could best meet those needs, the appointment of a keyworker from one of the agencies or professions involved, to reach agreement between the carers involved and the client, and then to implement, monitor and set regular review dates, (COWART & SEROW, 1992), In addition to the care plan approach meetings there is almost daily interaction between the agencies and professions involved.

In addition to this there are meetings within each individual agency or profession, usually on a weekly basis, concerning the most appropriate delivery of care within the role of the individual agency or profession. The diagram in Appendix A shows the ways that clients enter the psychiatric services, and where inter-professional collaboration happens, it also shows that this care team is a hybrid parallel pathway team. Efficient inter-professional collaboration exists only where there is good group dynamics and working relationships, both within the care team and within the government who" s laws and guidelines that care team follows.

However when reviewing the history of British social policy it is easy to become pessimistic, Webb, (1991) points out, " exhortations to organisations, professionals and other producer interests to work together more closely and effectively litter the policy landscape, yet the reality is all too often a jumble of services fractionalised by professional, cultural and organisational boundaries and by tiers of governance". In order to overcome these problems they must first be identified and then strategies devised to overcome them.

Whilst in the community with the housing support team the author observed that the main problem or cause of problems was communication, whilst ironically, most if not all of the problems encountered could have been avoided or solved more efficiently with effective communication. However the author feels this may be viewed by many as an over-generalisation, and so will break this down further into some of the 'sub" problems. A key difficulty is that working together appears to be the logical way forward, yet it is the authors experience that little consideration is given to the effects of such an activity, (CARLING, 1995).

From an agencies or professions point of view collaborative activity raises two main difficulties first it loses its freedom to act independently when it would prefer to maintain control over its domain and affairs. Second, it must invest scarce resources and energy in developing and maintaining relationships with other organisations, when the potential returns on its investment are often unclear or intangible, (HUDSON, 1987). The main

sources of conflict within an organisation and inter-professional collaboration are communication, power, goals, values, resources, roles and personalities.

As mentioned previous a major source of conflict is the misunderstanding or breakdown of communication. However communication can also be used as a tool for clarifying opposing views. It is the authors observation that most values within an organisation are internalised and are therefore difficult to change, but they can be clarified through communication so as not to become a barrier. This kind of logic is a skill that can only be learnt through the application of common sense and the wisdom of experience, (BILLIS & HARRIS, 1996).

Conflict situations often arise suddenly, the author has observed that the more people that attend a meeting or that are involved in a decision regarding care organisation the more potential there is for conflict to occur. Power causes conflict when there are relationships within organisations between individuals of unequal power, the classic example being the doctor/patient relationship, or the nurse and the consultant. This can cause additional conflict where there are differently structured organisations working together as the power differences between individuals then become unclear.

For example the power relationship between the community psychiatric nurse and the social worker. Another common cause of conflict is different goals, different methods of reaching those goals, different values, unclear or overlapping designation of responsibilities, lack of information

and personality conflicts. It is acknowledged within health care that some conflicts can not be resolved, Mallory, (1981) states that unresolved conflicts need to be managed carefully within any work group in order to balance the level of conflict.

Banton, (1985) remarks that the essential point is that conflicts of interest are of fundamental importance in all major areas of life in our society and therefore full consensus is only possible when people are prepared to restrict themselves to the trivial. Conflict in an open environment can be beneficial to the work environment as when handled in a mature and professional manner conflict can lead to creativity, innovation or growth, however if too much energy is expended in non productive activity then conflict becomes destructive.

It is the author's opinion that conflict is an inherent part of the nursing and general health care culture, and that psychiatric nurses in the community are prime candidates for this because of the need to work collaboratively with people both professional and non professional of varying social, ethnic and educational backgrounds. Collaboration suggests that the combined power of the agencies or professions is distributed evenly, yet nurses are employed in a hierarchical system.

Huber, (1996) suggests that nurses find that working in groups creates a situation in which there are a number of different colleagues and a variety of client types and different personalities to work with, these are complex interrelationships, and added to that complexity is the fact that there are

multiple providers requiring co-ordination and communication to manage the care for any client. Within healthcare as a whole there is an interdependence between its members.

The multi-disciplinary team breaks down into multiple care providers each relying on the other to carry out a portion of the work. For example a member of the housing support team can not monitor a clients medication if the clients community nurse has not organised the Dose box from the pharmacy. The source of conflict can be organisational, interpersonal or a combination of both. Personal and organisational goals and values may also be in conflict with or over general policies, a general policy being the course of action taken by an institution, department or unit.

Policies in the main are meant to soothe conflicts over specific issues, they are designed to give about standard ways to make decisions in recurring situations. However different people within the care team may approach situations with differing viewpoints on how to best deal with certain issues, differences may occur over such things as clerical or managerial routines, or over record keeping and information sharing.

Clashes may result at the intersection of a nurses professional judgement as an autonomous professional with standardised policies developed by the institution and designed to produce uniform behaviour, (AJN, 1987).

Resource allocation comes under organisation issues and is especially important in the case of Mr and Mrs Client as the general consensus is that sheltered accommodation of some description is required, which inevitably

will require funding. Budgeting has caused conflict over scarce resources within organisations.

In the case of Mr and Mrs Client the funding for the accommodation should come from the social services department. Power conflicts can be both organisational and interpersonal and result in role conflicts. Role conflicts have been identified as being of two types, role overload and role ambiguity. Role overload is when a carer is expected to perform the work of other employees or disciplines in addition to providing their normal care tasks. Whereas role ambiguity is when the role and responsibilities of the carer expands faster than is officially recognised, (JOHNSON, 1994).

To assist in making interprofessional collaboration joint working recommendations such as those stated in Building Bridges, (1996) have been suggested these include commitment on all levels of care approach and delivery, to maintain a primary focus on the service users, jointly owned or shared strategies for care of people with severe mental health problems, agreed procedures for access to services, agreed procedure for information exchange, clarification of roles and responsibilities and regular reviewing of interprofessional dynamics. vretveit, (1997) states that UK policy in the nineteen nineties has asked the question, what is wrong with the service? Rather than what problems need tackling in the outside world. In future it should re-focus on how partnerships between the users of the service, professional workers and managers can be achieved, in other words how can we make an integrated service truly democratic? The solutions to nearly all

the crisis encountered by the care team can be or could have been solved or at least minimised through the effective use of communication.

It is felt that it would also be important in interprofessional collaboration to have shared values and cultures, while a mismatch along these lines between health and social services has been well documented. (SMITH, 1993). Collaboration is the basis for team building and with the changes to healthcare, work redesign, restructuring and reengineering depend on effective collaboration, co-operation and group accomplishment.

Proactive conflict resolution in work groups is the essence of building successful teams which are flexible and adaptable, and have a high degree of trust and communication. Therefore the ingredients for successful interprofessional collaboration may be a common goal, interdependence, co-operation, co-ordination of activities, task specialisation and therefore role clarity, equal division of effort and mutual respect.

Team building is defined as being the deliberate process of creating and unifying a group into an effective functioning work unit to accomplish specific goals, (FARLEY & STONER, 1989). In conclusion, collaboration has been called the most effective strategy for managing conflict to achieve long term benefits. However a wide differential in power (both felt and actual), exists between nurses, social workers, and consultants, and this hinders effective collaboration.

Therefore with wide differences in power the most commonly used techniques seem to be compromise and accommodation. There are

indications however that this is changing as the health service as a whole is and has undergone some major changes with the implementation of the care plan approach, care management and the formation of community teams such as housing support and community support teams, and as a result effective interprofessional collaboration could soon become more commonplace. (BALDOCK, 1974).