Interprofessional practice in a hospital

Interprofessional practice in the hospital setting is a process that involves different professional groups- such as doctors, nurses, pharmacists, physiotherapists and occupational therapists, working together effectively. The degree to which different healthcare professionals " collaborate" can ultimately affect the quality of the health care that they provide.

Almost everyone who requires medical attention will interact with more than one health professional. The number of professionals involved, and the importance of their ability to work collaboratively increases with the complexity of the patient's health needs (1). For example, a chronic diabetic patient may require the expertise of the dietician, podiatrist, social workers and district nurses in addition to diabetic specialists as part of their medical care package. These professionals will need to work together in order to achieve maximum success on the management of the patient's condition, as well as being cost effective to the NHS as the government plan to cut NHS spending.

Why is interprofessional practice a good concept?

The interaction of the different professionals is crucial, giving rise to many potential positives:

It allows the development of an understanding and " respect of one's own and others' roles and responsibilities" (2).

It allows a more easier resolution of conflicts as a result of different approaches to patient care (2)

It allows a strong communication pathway to form between the medical team and the patient. If there is a strong collaboration, implementation of new initiatives to treatment and management can be easily fulfilled.

The establishment of a more satisfying working environment, where professionals can support one another.

What can prevent interprofessional practice?

Despite the attempts to have strong interprofessional collaboration, there are certain barriers to this; an intriguing barrier of which are “ professional cultures”. Baxter and colleagues stated that each health care profession has a different culture, which encompasses values, attitudes, behaviours, beliefs and customs. As the different professions developed separately, the cultures evolved; and combined with different training/educational experience, a form of “ tribalism” generated with “ deeply rooted boundaries” between professions (3). Increasing specialization (e. g. with obstetric medicine) has led to “ further immersion of the learners into the knowledge and culture of their own professional group” (4).

It is also strongly believed that inter-group stereotyping hampers effective working relationships. One negative stereotype is that “ doctors cure, nurses care”; doctors having a “ masculine”, objective view of their patients, whereas nurses, since the time of Florence Nightingale, having a more “ feminine”, nurturing and caring view. Working close to doctors improves the nurse’s status. This in itself has given unequal power favouring doctors (5).

Other barriers include differences in medical language and jargon; differences in the professions' schedule and routine; interprofessional rivalries; and differences in payment and reward structures (1).

Interprofessional practice in motion

Geriatric medicine is a field that requires a high level of professional collaboration in order to be successful in patient management. All of the patients not only require complex health care, but also need evaluation as to whether they are fit to be discharged back to their home, or to a nursing/residential home. It is an interesting area therefore, to hear the view points of various different professionals as well as observing the level of collaboration involved in geriatric medicine, and was subsequently chosen by myself. We interviewed and observed a physiotherapist, occupational therapist, a healthcare assistant, a ward nurse, the discharge coordinator, the pharmacist and the F2 doctor, as well as attending " white board" and multi-disciplinary meetings, on Caesar Hawkins ward.

A number of key points arose from interviewing the various professions. It was widely considered that the discharge coordinator, a highly experience nurse, was the most valuable professional to have in the team. They are important, as their role includes the allocation of patients to social workers; arranging check-list meetings and liaising with family; referrals to district nurses; TTOs; and foreseeing the best care package for the patient such that they don't " bounce back" into the hospital (thereby being costly to the NHS). As a medical student, I was previously unaware of the duties of the discharge coordinator, but I now felt that she was a crucial part of the team because the health care of the patients flowed with her input.

The “ Health Needs Assessment” was a valuable tool in bringing the team together. This is a 20+ paged form discussing the patient’s health issues- their needs, nutrition, behaviour, amongst other important management features. It requires written input from all professionals, and finally checked over by the discharge nurse. Filling this important document was deemed to be a very effective collaborative effort, as the professionals felt their expertise was valued and listened to.

The occupational therapist (OT) highly praised the team work on Caesar Hawkins. He felt that his input was considered important, and felt the team openly communicated with each other. He stated that there was a particular link between the physiotherapists and the social services. He stated that the physiotherapists got the patients “ up and ready to go” whilst the OT explored “ how the patient will manage in any environment” which then leads to liaison with social workers.

The physiotherapist felt the white board meeting was crucial to interprofessional working. In these meetings, the team discuss each patient, starting with a brief summary of the condition of the patient, followed by more detailed analysis on the patient’s progress in their rehabilitation, and their discharge plans. These meetings are, perhaps, more different than multi-disciplinary meetings (MDT), as the doctor has less of an input than the other different professionals. However, what was interesting was how the consultant slowed the meeting down, such that every opinion and expert advice was taken into consideration. I found this a very useful collaborative tool. The physiotherapist felt her input was well respected. She had a closer collaboration with the OT, but felt all levels of collaboration were equally

important. For example, with the doctor, the two different professions assess baseline and progress in mobility; with the nurses the two professions discuss the patient's ability to self-toilet and maintain personal hygiene. The physiotherapist works on one particular ward during each rotational block they are on, and she felt Caesar Hawkins had the best team and interprofessional collaboration.

Interviewing a nurse again portrayed good collaborative practice on Caesar Hawkins Ward. The nurse stated that he spends the majority of the time with the patients, and therefore has an important role in updating doctors on the patient's condition. He felt the doctors relied on his input to a significant degree, thereby creating a need of good communication and interprofessional working. On observation of the level of communication between doctor and nurse, the nurse was able to explain his view and concerns on a particular patient, and action was taken quickly by the doctor, thereby providing the best health care. In MDT meetings, the nurse's input and expertise was clearly valued- if there was a patient a doctor felt could be discharged, but the nurse disagreed upon, it was often the nurse's opinion which had the final say. The nurse felt his expertise meant he was able to determine which environment a patient would best flourish in.

There were a few areas of concern- sometimes the nurse felt there was poor communication between nurses and administrative personnel, leading to the nurses being short-staffed. This leads to the nurses having too many patients to take care of, leading to less individual patient attention and less constructive feedback to the rest of the team. Additionally, the nurse felt there should be twice daily ward meetings for nurses alone, in order to

discuss any patient that requires more focus on, or to mention any improvements or decline in a patient's condition. Just recently St George's have introduced a " productive ward scheme" allowing nurses from different wards to get together and discuss any issues they have in their working environment. The effect it has on interprofessional working is still too early to tell.

A health assistant to the nurses was interviewed, and her views were supportive of the high level of interprofessional working in this ward. She felt, to a fair degree, well recognised and respected for her expertise in health care; she felt she had strong collaboration with the nurses and physiotherapists; however, there were various doctors who had a negative stereotype of her role, often ignoring her valuable input to the patient's care, and ignoring her presence even at the patient's bedside. She feels the best way to have professionals working together is to be highly appreciative of what each different profession has to offer.

The most important member of the team is the patient, so it was crucial to have a patient's view on their experience of interprofessional practice. The patient interviewed had a mild form of dementia, but was still aware of his health care, and felt the different professionals not only worked well together but helped each other synchronously. This was shown when he described his physiotherapy sessions, which were often entwined with occupational therapy input. The team communicated well with him, and he was always informed of the next steps in his management.

Conclusion

The quality of modern day health care received is largely reliant on how effective different professionals can work together. This is because it is not feasible for one professional to have all the skills and the knowledge to deal with the degree of complexity of the patient's illness.

I found that Caesar Hawkins geriatrics ward shows an excellent example of interprofessional practice being implemented in patient health care. The feedback received was excellent, there is strong communication between all professionals, as viewed through the MDT and white board meetings; the different professionals respect one another; the environment is satisfying and supportive. There is a strong aura that the professionals acknowledge the value of sharing knowledge and their expertise. The team governing this ward are able to integrate their resources to nullify the complexity of health care in geriatric medicine.

I believe that the value of interprofessional working can be brought into the education of students in each profession right from an early stage. For example, in medicine, we are taught the fundamentals of diagnosing and treating patients; we can combine this by learning and experiencing what input the physiotherapist would provide in the given situation, or the occupational therapist, thereby learning and strengthening communicative skills and developing the concept of working as a team to fulfil health goals.

I felt that the discharge coordinator can be seen as a professional advisor, through which all the professional expertise is channelled through, helping to remove boundaries between different professionals.

Reflecting from what I was told by the health assistant, I realised that collaboration starts from the simple acknowledgement of the people that are around you. They should be considered as your day and night support team, and we should make the effort to appreciate their input in the health care of the patients. It should be a moral obligation to work interprofessionally to provide the best service and fulfil the interests of our patients; much like for " clients" in the business world.

I appreciated the value of the MDT and white board meetings. I saw them as an essential form of verbal communication. The NHS has largely relied on communication through written means such as case notes, care plans, referral letters and forms. Although this " inactive" form of communication is essential, it leads to a rigid approach from each profession for patient care. However, having regular interactive meetings removes a rather static collaboration and allows knowledge to be shared and learnt and effectively spread.

It is often stated that there is a hierarchy of power which threatens interprofessional practice. For example, it is thought that a senior, who is more experienced, has more power in the delivery of health care given, than a junior who lacks experience. I did not notice this, and from interviewing the F2 doctor, she felt she was treated with respect; her relatively lack of experience did not impact her input in the health care of patients.

There is a fear that interprofessional practice is a concept that the NHS are using in order to reduce costs. This is because one of the advantages of this practice is that medical staff are more efficiently used, and that if

professionals gather knowledge from others, a particular profession may not be needed (6). I think this fear is irrational, because the knowledge of each profession is so deep that it will be impossible to exclude a particular profession. For me, I think the more different professionals working together effectively, the better the health care the NHS will provide. Other professionals that were not interviewed are dieticians and social workers, both of which being valuable resources to the NHS.