Patient discharge process reflection

ASSIGN
BUSTER

This reflective commentary will focus on a patients discharge planning liaison drawn from my experience in attending a Multidisciplinary team Meeting (MDT) held at my Elective Placement (Cardiology Ward) in the context of the dimensions of Interprofesssional Working (IPW) I will preliminary define in the introduction IP working; recognize policies; introduce patient scenario, identify the Reflection Model which I will use to evaluate and analyse the Dimensions of IPW.

IPW refers to professionals with different training backgrounds (medical, surgical, counselling, psychotherapy, Occupational Therapist, physiotherapist) sharing common goals an objectives but who make a difference but complimentary contribution to the given client group in order to provide holistic care (Leathard, 2003).

IPW has been highlighted by the United Kingdom (UK) government in a series of policies which shaped and continue to shape the way services and professionals work interprofesssionally. In 1998 The Department of Health (DoH) (1998) encouraged joint working through integrated provision. In 1999 papers such as DoH (1999) re-enforced that the effective care is the product of interagency working, promoting NHS to move towards interagency collaborative working or IPW in a shift from institutional to community-based care. The DoH (2000) a ten year programme of redevelopment practice to design and promotes a patient centered service and promote IP and Holistic care. One of the areas the DOH (2000) considered needed improving was the older generation patient discharge. To combat this, standard two of The Single Assessment Process (SAP) and Intermediate care services (ICS) was introduced by the National Service Framework for Older People by DoH

(2001a) and this required services and professionals to work together in a co-ordinated assessment of needs for patients. From this, House of Commons Health Committee (2002) called for a number of key changes, one of them being a named Care Manager to coordinate all stages of the patient journey through hospital, up to and beyond discharge. And this coordination liaison could take the form of an MDT discharge planning meeting (DP).

New ways of working have to be found that cross professional boundaries, in order to allow a more flexible approach to care delivery (DoH, 2002). To achieve this, the Government introduced Interprofesssional Education (IPE) in pre-registered student's modules and their aim was to integrate IPE into their curriculum, enabling students to develop transferable skills that will facilitate communication and collaboration in the future (Barr, et al., 2005). Rattay and Mehanna (2008) suggest that as students should make an effort to attend MDT meetings to develop IP.

I have used pseudonyms throughout my reflective commentary, to protect confidentiality in accordance with the Data Protection Act (1998) and the Nursing and Midwifery Council (NMC) (2009). I will refer to the patient as Sam.

Sam is a 74 year old lady who lives alone in a ground floor flat. Sam has no family living locally however her neighbour visits regularly. Sam suffers from Chronic Heart Failure (CHF). Prior to admission Sam was fully independent at house cooping with her Activities of Daily living (ADLs) with slight difficulty due to breathing and poor balance (which Sam reported to suffering from for

years). Sam was originally brought into hospital via accident and emergency by her neighbour as her breathing became progressively worse.

There are many potential models of reflection. I will use Gibbs (1988) Model of Reflection (Appendix 1) as I find it more straightforward due to being depicted as a cycle, encouraging critical evaluation and analysis of the incident. Cyclical models are suggested by Ghaye (1998) to deepen awareness and increase knowledge and skilfulness from repeated movements around them.

Reflection will able me to learn from the experience and identify my learning needs in areas which solicit improvements (Allen, et al., 2008). As suggested by Price (2006) Reflection makes a connection between theory, policies and practice required to develop evidence-based practice, professional and academic growth throughout my career; important in the development of lifelong learning (NMC (2009).

- Description

The MDT meeting was held at the sister’s office. The MDT consisted of a Ward Nurse (who was there intermittently due to staff levels), a Heart Failure Nurse Specialist (HFNS). Care Manager (Social Worker), Physiotherapist, Occupational Therapist, Doctor (Cardiologist Register) and myself. The meeting was led by the Doctor who gave an introductory overview of the Sam’s social situation and medical condition. The Doctor recommended that Sam was medically fit for discharge with a referral for HFNS community visits, as further health education was necessary. The physiotherapist suggested Sam was regaining confidence in her mobility but recommended

further input to improve Sam’s balance and posture. The ward Nurse suggested Sam’s Nursing needs were stable and no input was required on discharged, upon this, I respectively argued that Sam discussed with myself earlier in the shift that she felt she was not coping at home and would feel more confident if she had minimal assistance with her ADL’s at home. The Doctor re-directed the question to the HFNS, who re-directed the question to the Ward Nurse, both dismissing my input. At this point I respectfully assured the MDT that what I was advocating, it was also documented in Sam care plan. Subsequently, The HFNS requested Sam’s discharge planning to be discussed in a second meeting.. Following to this, The Occupational Therapist recommended she would liaise with Sam regarding any house equipment that would facilitate Sam’s ADLs. The social worker (Care manager) who would be coordinating all stages of Sam’s journey through hospital, up to and beyond discharge, organise possible (i) care (ii) meals on wheels. The Doctor summarised the MDT plan and rescheduled the meeting for 2 days to allow professionals to liaise with Sam in order to evaluate the discharge planning in partnership with Sam. Doctor was reluctant to reschedule and to change Sam’s expected day of discharge (EDD), it seemed. In the follow up MDT meeting, Sam was medically fit for discharge, her it seemed, had improved, as had her slightly her confidence but she could still benefit from further rehabilitation; therefore, Sam was referred to Intermediate Care Services (ICS) (Appendix 2) for further rehabilitation in the community, with out-patient medical follow up and HFNS home visits.

- Feelings

When I asked my Mentor to attend the MDT meeting, I was excited as I was going to be able to see how the IPW provides a positive outcome for the patients. Slightly anxious but ready to be a Patient advocate. Soon it dawned on me when I was introduced to other professionals and given opportunities to work with them and I felt slightly insecure at the thought of having to expose myself to the criticisms of others. When Discussing Sam's DP I commented on her behalf the feeling of slight insecurity was soon overpowered by a feeling of achievement as I was in a position to be her advocate appropriately and contribute in ' making a difference' to her life for better. This feeling overpowered the shuttled frustration I felt when the Doctors dismissed initially my input but understandable due to my still pre-reg position, he needed reassurance as this input was going to change Sam EDD. As the meeting was lead by the Doctor I had inadvertently imposed a sense of hierarchy upon the group. I soon felt that the hierarchy, even after the incident above, was not actually evident once a patient DP was being discussed as every professional was having a say and all professional seemed to understand each others responsibilities, roles and the documentation used involved all MDT input. I felt that through the discussions each professional's identify was gain and respect was given accordingly, although, I considered there was possibility of gaining a professional ' personality' stereotypes and therefore ultimately a hierarchy may develop in future group meetings. By the end of it, I still felt slightly daunted to be in a MDT meeting working with professionals who knew so much (i) HFNS who developed their careers to a point of extreme knowledge, it overwhelmed me, that I am still just in the beginning of an extraordinary journey.

- Evaluation

In accordance to Holland, et al. (2005) and Gonseth, et al. (2004) Heart Failure Nurse Specialist (HFNS) input was fundamental as HF patients as Sam require close clinical management and encouragement to manage their symptoms in order to remain in the community (James and Sarah, 2008). Furthermore, Blue, at al. (2001) randomised controlled trial suggested that HFN have the ability to focus not only on the clinical needs of the patient, but the educational and supportive needs as well as establishing effective liaison between health and social care. Although HFNS is important in the provision of Sam's Good Health in the community, without front line staff (i) ward nurse to document appropriately and report to the appropriate professional and act as an advocate for patients in meeting such this, the provision of IP working and Safe Discharge Planning would be compromised (Atwal and Caldwel (2006).

Record keeping was to be commended as the Discharge planning Form (DPF) (Appendix 3) was filled in from admission and updated regularly by Sam's Multidisciplinary team regarding assessment, planning, and implementation and evaluation goals specific to each professional to establish safe discharge. Effective record keeping is the key factor to effective care and continuation of care of Patient; and a Code of Conduct requirement for excellence practice and care (NMC, 2009).

The Community Rehabilitation/Intermediate Care Services (ICS) Appendix 3. Referral was suggested appropriately in order to meet Sam's needs, in accordance with the DoH (2001a, 2001b) agrees that ICS establishes IP working and avoids duplication, enhances communication and allows each

team member to view and check the patient notes at all times. Furthermore Godfrey, et al, (2005) suggests that it enhances Holistic care. According to Leathard and Cook (2009) Sam's care could be considered Holistic as her physical, psychological, sociological, spiritual needs were addressed, and Sam's views were considered alongside any recommendations offered by all the different multi-disciplinary teams in a mutual participation in a shared decision-making partnership. With changes in Nhs such as patient-centred care (DoH, 1998), and the establishment of sophisticated holistic approach to health and social care, one of the key features of Sam's patient centred care is the development and implementation of integrated care pathways (ii) collaborative care plans such ICS, providing Sam with a continuity of care.

MDT meeting structure seemed to reflect The DoH (1998) in its drive for a ' first class service' as staff seemed to clear understands of how their own roles fit with others in both the health and social care professions. Although, Role Clarity was predominant and significant, the Status caused distress within the MDT; it made some members feel their opinions are not as important as others (Robinson, et al., 2005). Furthermore, at certain points of the discussion the blurring of the boundaries of one's discipline Ward Nurse and (HFSN) (i) Doctor redirected the question about Sam to the HFSN first instead of the ward Nurse. I agree with Molyneux (2001) is a factor that may create a competitive atmosphere rather than a collaborative one. In addition to the group dynamics, the situation of Sam needing care set up also highlighted the tension between professionals and in a sense organizational aims and resources.

- Analysis

The DoH (2000, 2006) stressed the need for team working to helping rove the quality of care to patients and encourage role development to meet the demands of IP working. (i) Registered nurse specialists are expanding their roles and skills in numerous clinical areas (DoH 1999, 2006) due to patient's diversity of needs in today's society (Furlong and Smith, 2005). According to DoH (2000, 2003) and the National Institute of Clinical Excellence (NICE) (2003) Heart failure care and management is one of this areas which had an increase in nurse specialists (HFNS) in a broad evaluation by Patterden, et al., (2008) which showed that HFNS reduced (i) all-cause admissions by an average of 35 per cent an average saving of £1, 826 per patient is gained after the costs of the nurse have been deducted. Furthermore, a systematic review by Holland, et al., (2005) argues that HFNS management of HF associated with (reducing readmissions, improving patient's quality of life, Like Sam and reducing financial costs is more efficient compared with medical management. In outcome, Hewison (2004) and Abbot, et al., (2005) agreed that although the development of roles and increased flexibility is usually a benefit to many professions, it can be seen as a threat for their own interest and power status, generating a resistance to IP collaborations. Moreover according to Molyneux (2001) a tribalism sense. This is normally the professional at the top of the hierarchy (i) as when the doctor was resistant to move the EED. Furthermore, as far back as 1998 when (DoH, 1998) was published, Stapleton (1998) suggested that Collaborative working emphasis that demarcations and hierarchical relations between professions are neither sustainable nor appropriate. Although, in Sam's MDT it was apparent in agreement with Hean (2006) my preliminary feelings of hierarchy are common and traditionally hierarchies place more power to the

medical profession. The tension seemed in a way to be overcome through the structured but open discussion regarding Sam's needs which according to Freeth (2001) open discussion helps develop the team and recognise the benefits and the diversity and development of skills. Martin and Roger (2004) highlight that it is important to premise a clear understanding and appreciation not just for the roles but also for the pressures of other professionals (i) performance targets to meet.

The Qualitative methodology questionnaire led interviews and focus group (18 cases studiers across Europe) by Coxon (2005) suggestion that IP working promotes job satisfaction, improved team working, good communication and enhance co-operation with other agencies, and identifies IP difficulties to be due to organizational boundaries and financial limits. Additionally, Hubbard and Themessi-Huber (2005) used the same method as Coxon (2005) although he identified that a main difficulty to IP is managers focusing on policies and changes of services: arranging MDT meeting whilst front line staff, as ward nurses need to adapt to practicalities of the IP. Atwal, and Caldwell (2006) argues the importance of staff ratios as a barrier to nurses developing IP practices, furthermore a study carried by both with nineteen nurses in acute health care ward, it is spotted that in MDT meetings not all the professionals involved in the care of a patient are invited and that nurses did not regularly attend the meetings due to staff ratios. Another conclusion of this study is that nurses not always express their opinion for fear of being made a scapegoat, the result from the research show as well, that consultants and medical staff usually speak first and with more confidence on all issues. In divergence, Barrett and Keeping (2005) argues

that collaborative working should minimise staff pressures from a ward level to

community (primary and secondary setting) but research done within this Era of IPW still shows that at a nursing level in a 2005 survey by RCN (2006) found that 49% of nurses left the NHS due to stress/workload problems. Horder (2004) and Pullon and Fry (2005) goes further to suggest to overcome the work pressure, shared decision making is the ultimate hallmark of partnership and this requires distribution of power or the empowerment of all involved within the multidisciplinary professionals in a manner that would equalize the hierarchy through (i) through IPE. It is essential that health and social care professionals realise the important of IPW as it has now been recognised that a single profession can no longer deliver the complex patient care that is demanded nowadays, a holistic approach is required (CAIPE, 2007). Rattay and Mehanna, (2008) suggest in summary that structured MDT meeting provides the discharge process with a structure that is organised professionally and timely, allowing patients to return home earlier safely, consequently reducing the NHS cost, minimising the risk of hospital acquired infections, promoting independence and enabling patients to return back to their homes and community, like Sam. Lack of co-operation between agencies has led to a failure of service (Glasby, et al., 2004).

Communication within the team is also an important issue to good collaborative working, developing ways to communicate and to work together is the key for successful IP working (Abbott, et al., 2005). The NMC (2004) advises that at the point of registration students should have the

necessary skills to communicate effectively with colleagues and other departments to improve patient care. Cook, et al., (2004) identify that communication and decision making are very important for teams. Larking and Callaghan (2005) argue that teams who do not regularly hold meetings for policy making and resolutions of differences, should not be considered a team, these findings are also emphasized by Molyneux (2001) who states that communication is supported with weekly MDT meetings in order to evaluate and plan patient centred care delivery.

- Conclusion

This reflective commentary allows me to connect policies, NMC requirements, theory and practice. It provided me with the assurance that the dimensions of IPW is complex but possible in practice IPE exists. It highlighted that different professionals have to deal with their own perceptions and adapt to changes. There is no doubt that IPW promotes a better and more holistic care and the documentation in place promotes further patient-centered care. The MDT gave me the opportunity to work closely with other professionals and understanding further their roles. This will help me to effectively work together in the future.

- Action Plan

I will allocate the Action Plans in my professional portfolio to demonstrate achievement in clinical practice linked with theoretical knowledge. All my Action Plan are made SMART Specific, Measurable, Achievable, Realistic and Time (Drew and Bingham, 2004)

1. Inter-Professional To develop an awareness of the roles and services provided in the inter-professional team and identify examples of how this is appropriate in delivering appropriate patient/client focused care. 2. Enhance my knowledge about decision-making processes within care management 3. Continue to reflect in and on Practice therefore to participate in further process of reflection to establish my own learning needs (Appendix 4).