Interprofessional working as central to healthcare management nursing essay

Fast-Track Discharge is a service available to in-patients who wish to leave hospital at the end of their lives and to die in a place of their choosing (REF). In practice, this requires the use of Fast-Track Pathway Tool for NHS Continuing Healthcare (July 2009) which aids healthcare practioners in ensuring support for individuals with a rapidly deteriorating condition entering the terminal phase in their preferred place of care (REF). This process is designed to bypass potential delays associated with the completion of the full NHS continuing healthcare eligibility process; meaning responsibility for care packages lies with the PCT in order to move the individual to their preferred place in a timely fashion (REF).

This innovation has been introduced to combat the issue that the majority of people who would choose to die at home ultimately end their lives in hospital (Gomes & Higginson, 2006) despite the UK having one of the world's most developed palliative care systems (Economist Intelligence Unit, 2010). The Fast-Track Discharge aims to reduce the incidence of hospital deaths by speeding up the discharge process, facilitated by the Department of Health (DoH) End-of-Life strategy that includes ten markers to measure implementation and effectiveness (REF); for example, ensuring that individuals end-of-life care preferences and choices are well documented, communicated and where possible, achieved (DoH 2010). Furthermore, the strategy makes recommendations to better meet patient needs by improving community services, improved cross-agency communication, and improved communication skills of the healthcare worker to better enable delivery of end-of-life through collaborative efforts by PCTs and specialist NHS providers (RCN/Royal College of General Practitioners 2011).

Partnership working and quality of care has become a central focus for the NHS following the NHS Next Stage Review – High Quality Care for All (Darzi, Date?), that has identified the need to personalise services for individuals through the provisions of information and choice. However, the current economic climate of austerity has seen the NHS identify £15-20bn of efficiency savings that must be achieved by year end 2013/2014 as a result of increased pressure on the NHS budget from the growing healthcare demands of an ageing population with higher patient expectations (DoH, 2010). This is being achieved through four themes shaping healthcare policy in an environment of austerity; quality, innovation, productivity, and prevention – QIPP; a regional and national programme supporting clinical teams and NHS organisations to improve quality care whilst making efficiency savings that can be reinvested into NHS services (REF). QIPP is engaging large numbers of NHS staff to help address quality and productivity challenges at local and regional levels through tools and programmes developed by national QIPP workstreams, to ensure success implementation (REF). The dynamic nature of the healthcare environment and the need to successfully deliver efficiency savings whilst enhancing patient care, particularly in relation to the Fast-Track Discharge, has highlighted the importance of effective communication and successful motivation by those in management and leadership roles to achieving this (REF).

Leadership and management are by no means two distinct and separate roles, and in fact the level of overlap between the two means they often form part of the same role, with many leadership or management roles involving a combination of both – i. e. there is continual adjustment of the

direction (leadership) and controlling resources that pursue that direction (management) (REF). Essentially, leadership articulates a new vision or direction for a group whilst management facilitates the realisation of this vision through effective control of people/resources according to established values or principles (REF). Scouller (2011) quantifies this by suggesting that management involves the effective utilisation of resources to achieve goals that have been formulated by the change, inspiration and enthusiasm necessary for leadership.

However Marquis and Huston (2012) warn against viewing these as two separate functions performed in two distinct roles, asserting instead that leadership is a function of management. Nonetheless Finkleman (2006) contends in healthcare settings it is possible to observe many nurses who fill roles of leadership without being in formal management positions, and arguably there exists managers who are not effective leaders; suggesting then that the harmonisation of management and leadership falls to individuals to be able to successfully integrate the need for change and inspiration with the ability to control and utilise.

The qualities and abilities required for managers/leaders to effectively implement the necessary vision and drive with organisations have been the focus of models and styles of leadership that have their foundation in theoretical approaches to leadership and have impacted the management and delivery of healthcare (Finkleman, 2006). Perhaps the most prescriptive of theories pertaining to management/leadership is the trait-based leadership model that emerged from Carlyle’s (DATE) “ Great Man Theory”; it is based on the integrated patterns of personal characteristics, following the

assumption that individuals possessing certain qualities and traits are better disposed to leadership roles (Zaccaro, Kemp & Bader, 2004). There is a strong emphasis on values and beliefs, personality, confidence, the need for acceptance or achievement and emotional, mental and physical attributes and the theory contends that people are born with specific traits, some of which are strongly aligned with good leadership (Eysenck, 1992). However Tulsian & Pandey (2006) have reiterated the argument raised by Spencer (1680) regarding this assumption; that the belief that people demonstrate successful leadership abilities independently of their environmental situations and influences is flawed.

However this approach to identifying what makes a good leader is inherently appealing in so much as it fits with the notion that leaders are gifted individuals that can do extraordinary things; which individuals can use as a measure of their own personal leadership attributes (Jung & Sosik, 2006). That notwithstanding critiques of the theory express concern about the over-simplified approach to leadership (Conger & Kanugo, 1998), contending that traits are a poor predictor of behaviour, primarily because a high score on an assessment of a particular trait does not necessarily equate to consistent displays of that trait in varying situations (Boeree, 2006). This contention is particularly applicable when considering leadership in nursing environments; the dynamic nature of said environment is largely unpredictable, potentially leading to individuals integral to these environments to react to this capriciousness and behave in ways that are strongly indicative of consistent traits (REF). However from these traits, it may be possible to patterns of behaviour in individual leaders.

The behavioural view of leadership, whilst acknowledging the traits of leaders, places emphasis on the learned patterns behaviour that leaders acquire (REF); Weber (1905) identified two types of leaders – bureaucratic and charismatic. The highly structured and procedural approach of the bureaucratic leader contrasts with the energy-enthusing enthusiasm of the charismatic leader approach. From this developed the democratic leadership style, which assumes that individuals are motivated by internal drives and impulses with a proactive desire to undertake and complete tasks (Sullivan & Garland, 2010). Arguably, such an approach to leadership is suited to the automony and individual management required for extended periods of group working (Marquis & Huston, 2009). However, critiques of theory propound that without clearly defined roles or in a time-constrained environment this approach to leadership has the potential to lead to communication failures and incompletion of projects (REF), highlighting the integral role that communication and motivation play in the context of the effectively delivery of the Fast-Track Discharge innovation.

Communication, defined by Boddy (2008) as the reaching of a common understanding through the exchange of information in the form of written or spoken words, symbols or actions, impacts all levels of management activities and incorporates all key stakeholders including; clients, colleagues, superiors and subordinates (Marquis and Huston, 2012).

The process of communication is a complex two-way complementary process used to convey a message between two or more individuals, with sender and receiver roles that should be used in such a way that benefits patient care and reaches identified outcomes (Finkleman, 2006). Considering the

potential implications of ineffective or inadequate communication on patient care and the implementation of initiatives, an understanding of the communication process for healthcare providers is of paramount importance (Marquis and Huston, 2012).

This process, at its most basic level, involves the initiation of communication from the sender by trying to transfer ideas, facts or information to the party who receives the message, the receiver; the message is coded by the sender using words, actions or expressions which represent a tangible expression of the sender's ideas through a chosen communication channel (face-to-face, electronic communication, written words). This message is then decoded by the receiver and reconstructed to resemble the original message (Boddy, 2008). However, Finkleman (2006) asserts that perception of a message is fundamental to the communication process and effective communication dictates that the receiver must be capable of perceiving the senders message correctly; failure to do so will result in ineffectual communication or messages being misconstrued (University of Rhode Island, 2010).

Furthermore, Marquis & Huston (2012) have suggested that directions of communication (upwards, downwards, diagonal, lateral) also impacts of the way the message is decoded by the receiver; contributing to directives, facilitation of tasks, negotiation, problem-solving and discussion according to which direction of communication is used (Sullivan & Garland, 2010). In the context of the Fast-Track Discharge initiative, downward and diagonal communication are likely to be most salient, owing to the need for senior management to effectively impart the initiative throughout the organisation and the requirement for nursing practictioners to communicate with external

agencies in order to effectively deliver said policy (Nursing & Midwifery Council, 2010).

However, these are not the only consideration for the effective implementation of the Fast-Track Discharge initiative; the choice of communication model has the potential to impact on the sending and receiving, and integrity of information. Models of communication are “ visual, simplified representations of complex relationships in the communication process” (West & Turner, 2010).

The earliest of these models, the linear model developed by Shannon and Weaver (1949), frames communication as a one-way process of transmitting a message to a destination, from the sender to the receiver through a channel (see appendix 1) and gives consideration to the potential for message distortion in the process – communication noise (University of Rhode Island, 2010). Critics of this model suggest that the definable beginning and end of communication presumed by the theory is incorrect and does not take account of interuptions (Anderson & Ross, 2002). Furthermore, there is an assumption of the passivity of listeners and that communication can only occur when speaking that has not been borne out in reality (West & Turner, 2010).

These issues are addressed in the interactional model (Schramm, 1954), that highlights the bi-directional nature of communication; from sender to receiver and receiver to sender; suggesting an ongoing rather than linear process that is characterised primarily by feedback or response to the message in the form of assessment of the communication. However although

this model addresses some of the shortcoming of the linear approach, critics have suggested that the interactional model still neglects to consider the impact of non-verbal messages sent with verbal messages and maintains the one-dimensional view of senders and receivers propounded by the linear model (West & Turner).

Conversely, the transactional model highlights the notion that sending and receiving messages is simultaneous and mutual and both senders and receivers are responsible for the effect of and effectiveness of communication, building a shared perception of the message being communicated and acknowledging the necessity of both verbal and non-verbal behaviours as an inherent element in the communication process (West & Turner, 2010)

Clearly then, effective communication is of paramount importance in the conveying, delivering and receiving of messages and is therefore central to the effective implementation of the Fast-Track Discharge initiative. The most appropriate model of communication to ensure the successful delivery of the initiative is the transactional model, allowing for the building of shared perceptions regarding the initiative that have the potential to converge to form a shared vision (Torrington et al, 2005). Such a model does not fall prey to the overly-simplified approaches to communication propounded by the linear and interactional models such as neglecting to consider the symbiotic nature of human communication and the issues caused by not giving due to consideration to the influence of external distortions; whilst giving appropriate weight to the impact of non-verbal communication on

sender/receiver perception of the message and how noise levels alter this message (West & Turner, 2010).

Semantic noise is a particularly pertinent issue; the highly technical nature of frontline healthcare, in this case delivered by nurses to terminally ill patients, invariably results in the use of jargon and technical language to communicate with colleagues (Devlin, 2009). The British Medical Association contends that the use of jargon and technical language when dealing with wider stakeholders, as is central to this initiative, has the potential to cause confusion for both staff and patients and feedback collated from patients surveys by the BMA has revealed a significant negative emotional impact on patients and their families as a result of ineffectual communication methods (Triggle, 2009). The interdependent, cross-agency relationships that are necessary for the effective delivery of the initiative means that frontline care providers have to communicate information to individuals in a diverse range of agencies that are not familiar with the use of department or speciality-specific language (REF). The use of unfamiliar or technical language has the potential to alter the receiver’s perception of the message, which may lead to mistakes or delays in the delivery of the initiative for a particular patient (Triggle, 2009)

Whilst styles of leadership and the qualities and skills of leaders is of paramount importance in the effective implenatation of the fast-track discharge programme, the issue of interproffessional working and team building needs to be considered in conjunction with these skills (sounds clumsy!).

It is crucial that intergrated models of health and social care are effectively implemented in a timely manner that is cost efficient, innovative whilst using resources wisely (CIPW DATE). Team working enables the professions to solve ‘ complex health problems that cannot be adequately dealt with by one profession alone’. (WHO 1999: 135). A team can be described as “ a group of people with complementary skills who are committed to a

common purpose, performance goals, and approach, for which they

hold themselves mutually accountable.” (Carrier & Kendall 1995), implying a willingness to share ideas and knowledge for a common goal.

Various models of team working exist to allow recognition of basic concepts. Identifying team roles may be useful in identify people’s strengths and weaknesses in the workplace. This information can be used to: Build productive working relationships Select and develop high-performing teams Raise self-awareness and personal effectivenessBuild mutual trust and understanding(REF). Belbin identifies 9 roles (Appendix) within a team and suggests that balance is the key to an effective team that requires at least one of each role to ensure a strong team. Allowable weaknesses of each role are also recognised allowing for management of these perceived weaknesses (Belbin 1981). However it can be argued that not all teams will be made of 9 people each carrying an identified role and that some people may have one or more strength in a preferred role (Brooks, 2009).

B. Tuckman (1965) proposed an alternative view to addressing group dynamics, suggesting that groups move through 5 stages of development. Firstly, leader-led information and resource gathering (Forming). Conflicts

may develop with tasks being resisted (Storming), and then conflicts settled with a developing team group cooperation with new standards set (Norming). At this point teamwork is achieved and solutions are found and implemented (Performing). On completion of task the group disperses (Adjourning) (Cole, 2004). This suggests then that effectiveness as an outcome is achieved over a period of time as the group develops an understanding of the task, what is required to complete the task and an awareness of the skills and knowledge of the individuals making up the group (REF).

These models focus on the behaviour within groups, however inter-professional working requires intergroup working and collaboration between these groups is vital in the delivery of good quality healthcare. Following a three year study of multi-professional working Miller et al (2001) suggested three main types of interprofessional working; Integrated team working whereby the teams served the same population of patients leading to a joint approach to care planning and evaluation of care. However it was noted that this approach worked most well when caring for a group of patients who were medically stable (Hewison 2004). Fragmented working describes a group of professionals making decisions within their own profession groups but with sharing of information often resulting in a superficial understanding of roles and boundaries and a lack of consensus around decision making. A type of interproffessional working incorporating both of these models has been described as core and periphery working whereby a predominantly integrated core group works alongside a more peripheral fragmented group. Glendinning et al (2002) argue that whilst integrated style of working has

benefitis for the patient the circumstances to achieve this in its purest form are not often in place and as a result this disclocation of the core group from the periphery can result in a lack of communication and a poor understanding of the role of others.

These various approaches to interprofessional working can enable practitioners to plan and design the best type of care and to clarify how they are organised. The fast-track discharge programme involves health care professionals from both health and social care sectors and is supported by a Fast-track Discharge End of Life Pathway (DoH 2008). An integrated style of interprofessional working is required to co-ordinate all elements of the care pathway. With nurses being the key provider and co-ordinator for patients in hospital reaching the end of theirs the responsibility falls to them to link and communicate across the health and social care teams (RCN 2011) whilst working in partnership with and as an advocate for the patient and their family/carers. This requires the nurse to ensure that all team members contribute to the care planning process and, with consent (NMC 2008), circulate relevant information to key co-ordinators. A MDT meeting with the key nurse, consultant/Registrar, OT’s/Pt’s, Discharge Liaison Nurse, Palliative Care Nurse, Pharmacist, and Social Services representative is appropriate to share information, ensure that all team members are aware of the patients wishes and the plan to discharge. It may be most appropriate for the Palliative Care Nurse to liaise with the patients GP and this needs to be decided upon. All decisions need to be clearly documented and regularly updated and shared with relevant professionals.

Poor communicaton and fragmented working across professions is the main barrier to this innovation being successful.

Organisational cultures refers to the values and behaviours that contribute to the social and psychological environment of an organsition, including the expectations, experiences and philosphosies and is based on shared attitudes and beliefs. (Schein 210).