

Analyse principles  
underpinning  
collaborative working  
and its impact



As patients develop complicated long term illnesses, their care becomes disproportionately complex and it can be difficult for them and the health and social care practitioners to manage (DH 2010a). These patients suffer from diverse health and social care difficulties. Due to their vulnerability, simple problems can make their condition deteriorate rapidly, putting them at high risk of unplanned hospital admissions or long term institutionalisation (DH 2010a). This is especially true for the older adults. The Evercare model chiefly serves older adults with long term conditions categorising them according to the chronicity of their condition and depth of their health and support necessities. The third category involves those people who have very complex long term conditions. This high risk group of patients needs not only good management of their specific diseases, but also a holistic overview to be taken of their full health and social care needs. Their treatment and care should go beyond the clinical measures to encompass the full range of factors that affect them such as their ability to maintain personal interests and social contact (DH 2010a). In line with this, one possible solution to these complicated long term conditions will be adapting the concept of collaborative working.

This essay shall focus on exploring the principles behind the concept of collaborative practice and its effect in the management of patients with long term conditions. In line with this, we shall briefly cite a case study to better explore collaborative practice. In compliance with NMC (2008) code of standards for conduct, performance and ethics, which declare that need to respect people's confidentiality, the patient's identity is replaced with a

pseudonym. She shall simply be referred to as Mrs. Smith, a 70-year-old woman who has chronic obstructive airway disease.

This essay shall be divided into four outcomes; each of which discusses specific ideas highly related with collaboratively managing patient care.

## **Main Body**

### **Outcome 1**

According to the Department of Health (2004) under the NHS improvement plan, the government through its prime body, the National Health Service is now providing better and more effective health services to people with long term conditions. The NHS has definitely made big progress in providing faster and easier access to healthcare by creating innovations and changing the way things work (DH 2005). Furthermore, there now exists the right level of support to patients (DH 2004). Under this plan, patients are divided into 3 types to better match the kind of healthcare services that will be rendered. The first kind involves patients who are able to manage their own conditions but with the need to provide health advices and support from health care and social care professionals. The next category pertains to clientele who require more proactive support for their long term conditions with emphasis on preventing complications and slowing down the progression of the course of their illnesses. The third kind involves the concept of case management. At this level, patients suffer from highly complex long term conditions typically involving 3 or more health problems (DH 2004). It has been declared that personalised case management can significantly lessen emergency admissions and hospital stays; thus enabling them to return

home more quickly and ultimately, patient outcome is drastically improved. In fact, a series of studies done in United Kingdom has illuminated the reality that because of case management there has been a significant reduction in hospital admission at about 10 to 20% as well as hospital stays of approximately 20 to 30% (DH 2004). Indeed, case management is a positive innovation with how healthcare and social services are rendered but what exactly is case management? Cherry and Jacob (2005) relate that nursing case management as described by the American Nurses Association is an active and organised collaborative strategy in rendering and directing health care services to a defined population. It is a participative process in determining and facilitating options and services to meet the diverse health needs of health consumers with an enhanced quality of care and cost-effective clinical outcomes (Cherry and Jacob 2005). The principal component to meeting the needs of patients under case management is to have a new type of specialist clinician often a nurse who works with patients and social care providers and who has particular expertise in responding to patients' complex health related problems (DH 2004). Case management is also the initial step in formulating an effective delivery system (DH 2010a).

Another definition declares that case management is a collaborative process that involves assessment, planning, implementation, coordination, monitoring, and evaluation of options and services required to meet an individual's health needs, using communication and available resources to promote quality and cost-effective outcomes (LBW 2010). From this second definition, we can deduce the key principles of case management. It is not a surprise that the main principles in a nursing process are also the key

principles in case management. In general, assessment, planning, implementation and evaluation are the key principles of case management that is being pointed out by the second definition. Of course, these key principles has to be accomplished not just by a single healthcare professional but by the entire team comprising of different professionals whereby each of them contributes according to their areas of expertise. The Department of Health (2010b) also emphasises key principles of case management. The first is enhancement of the general practice team role through a multi-disciplinary approach (DH 2010b). This implies the working together of different health professionals like a GP, community district nurse and intravenous therapy lead nurse as in the case of Mrs. Smith. The next is providing pro-active care to patients in the community with the highest burdens of disease (DH 2010b). This simply means empowering the patient to be actively involved in his or her own treatment and care. Third is working across boundaries and in partnership with secondary care clinicians and social services (DH 2010b). This is especially true in a community setting. Fourth is the professional and/or clinical case managers who develop a personalised care plan on the basis of the needs, preferences and choices of the patient (DH 2010b). This refers to the community matrons or case managers. Fifth is a care team that manages the patient journey proactively and seamlessly through all parts of the health and social care system (DH 2010b). This implies holistic care with emphasis on a positive interaction between health care professionals and non-health care professionals to ensure that every aspect of patient care is addressed thoroughly.

As previously indicated case management is the process of providing health and social care services in a particular manner. On the other hand, managed care simply refers to the idea that the health needs of a particular patient has been handled in a manner that coincides with the adhered form of case management. In effect, we can say that managed care is the positive result of sticking to a particular kind of case management.

## **Outcome 2**

Among the different kinds of assessment tools available, each has its own advantages and disadvantages. It basically depends on how the team will utilise it and what kind of scenario is in need of an assessment tool. The expertise in using such tool can also be considered as a determinant in predicting the kind of results it will yield.

According to Tanner and Harris (2007) the Single Assessment Process stresses on the utilisation of assessment tools. The use of such tools can supplement and enhance assessment information in particular providing frameworks for an assessment and enabling comparison between an individual's functioning in specific areas and general indicator of need and risk (Tanner and Harris 2007). A natural component of assessment is evaluating or making sense of the information obtained. Although it is true that the use of tools and scales can supplement and enhance assessment information, it cannot substitute for the understanding gained from running in to the service user's own perspective of their situation (Tanner and Harris 2007). Despite the big help which SAP provides, there seems to be some possible disadvantages. For example, social care dimensions may be

overshadowed by medical perspectives, some of the suggested tools for <https://assignbuster.com/analyse-principles-underpinning-collaborative-working-and-its-impact/>

collecting and recording information are more medical in their orientation and this is reflected in the assessment domains (Tanner and Harris 2007). Naturally, this may seem to be typical considering the fact that the problems which are sought to be solved are health related in nature; however, we cannot also deny that there are instances when the root cause of these complicated health problems are actually societal in nature. In the case of Mrs. Smith, although it was not mentioned, there could have been some social issues which could either help her overcome her illness or hamper her recovery. Unfortunately, SAP is more on the health care aspect rather than the social care side. Another possible disadvantage is the silent yet undeniable tension between social care workers and health care professionals. This tension can become a barrier to achieving the trust and confidence between the professions that is required for effective collaborative working. Aside from ideological differences, there are more practical obstacles such as organisational and technological barriers to cooperation (Tanner and Harris 2007). For instance, the sharing of information between agencies is fundamental to the SAP but shared systems for recording and accessing information are not well developed and would require a substantial investment of additional resources (Tanner and Harris 2007).

### **Outcome 3**

Sussex and Scourfield (2004) relate that joint working, cooperation, working in partnership, working together, inter-agency working, multi-disciplinary working, networking, coalition, integrated working and even consultation basically means one thing and that is collaborative working. Clouston and

Westcott (2005) declare that team working has always been an indispensable part in health and social care. In the nursing profession, no less than the NMC (2008) in its code affirms the need for nurses to work as part of a team. By definition, collaborative working is a multidimensional and complex activity which involves different professionals like health care practitioners and non-health care professionals all of whom work together in providing services for individual clientele, their families and the community in general (Cox and Hill 2010). Despite being difficult to achieve, collaborative working is necessary; government policy requires it (Leathard 2003). Most importantly, the people need, want and deserve access to a wide range of skills and flexible, flawless, high standard, holistic services that respond to their needs as whole individuals (Leathard 2003). From among these clarifications as to what collaborative working is, certainly it cannot be made clearer than what it truly is. In my own perception, collaborative working is and has always been known to us. The cliché no man is an island emphasises the nature of human beings as a social organism. We thrive in the company of others; moreover, we seek and benefit from the help of others as we also extend our help. Collaborative working is genuinely a positive action in accomplishing any goals or objectives set. It can be described as a give and take scenario. For example, a general practitioner will be the one to give medication prescriptions. After which, it will be the duty of the nurse to take that prescription and carry it out accordingly. It is a win-win situation whereby all the parties involved will be able to achieve what they desire by the fact that their inadequacies in accomplishing their task will be filled by the strengths of others whom they team up with. Going back to the case of Mrs. Smith, if the general practitioner, the different

<https://assignbuster.com/analyse-principles-underpinning-collaborative-working-and-its-impact/>



nurses, other health care professionals, social care professionals all work together effectively, it can be predicted that despite Mrs. Smith's complicated and long term condition, she will be able to survive it all.

Collaborative working is especially a beneficial strategy in rendering services to those who have long term conditions. It is because the limitation in the service of one type of professional will be compensated with the service of another kind of professional. Community nurses may share some responsibilities with that of a social worker but of course, there are professional limitations as to what the former can provide and so those which need to be done which are beyond the scope of community nursing will be satisfied by a social worker.

Based on my experience with the different health, social and voluntary agencies I have worked with, collaborative practice was always in the minds of each and every professional. It was just a matter of how it will be adhered to. We all knew that we had to work together but the problem was that we do not know how to work together. Translating the idea of collaborative working into actual practice is not as easy as it sounds especially if it will transcend to other non-health care professionals. Collaborating with doctors, midwives, pharmacists, nutritionists, etc is more burdensome than working with fellow nurses only. It is even more difficult to work hand in hand with social workers, community volunteers and other members or staff.

Fortunately, in my own experience, after overcoming timidity, hesitation and confusion, we were able to work effectively as part of a team and our set goals were satisfactorily met at a desired time frame.

If there is one indispensable thing that must never be left out in promoting the concept of collaborative working, it has to be the mode or method by which collaboration will be initiated and maintained. This is where team and/or organisation policies and protocols come in. Guidelines have to be in place and everyone involved must learn it for them to know how they will work together. All the professionals, staff, personnel and other people involved must be trained by undergoing formal or informal instruction for them to be familiarised with if not master the ways and means of effectively collaborating at each stage of service provision. For instance, in the case of Mrs. Smith, the community district nurse must follow a certain policy or protocol in communicating his or her nursing assessment and evaluation to other members of the team attending to Mrs. Smith. It cannot be just in any manner he or she wishes. There has to be uniformity in communicating pertinent patient information. Communicating among each other is already a part of collaborating with one another. If every member of a team and organisation possesses the knowhow in efficiently working together, then successful collaboration will be most expected.

In contrast, lack of knowledge and skills on how to initiate collaborative practice is a clear barrier to collaborative working. Absence of smooth inflow and outflow of communication is another barrier which can hinder the desire to want to work together effectively. Third potential barrier already mentioned in outcome 2 of this essay is the reality that there exists tension between different kinds of professionals and often times even with colleagues of the same profession. Nurses may realise the need to work collaboratively but they might feel intimidated or subordinated by a doctor.

In the same light, a doctor may know that he or she cannot work flawlessly without the help of nurses but he or she might hesitate because of the desire to avoid being too dominant or superior.

Despite the clarity of the benefits of collaborative working, one cannot speak for everyone else. People have different perceptions of things. Views, opinions may differ and sometimes conflict even if only one thing is being talked about. It is plausible to believe that some people may not want to work in a team. They might prefer to work independently or to limit the amount of collaborative working. To some extent, this is acceptable. It may be true that some things are done best independently. For instance, the intravenous therapy lead nurse will be able to perform his or her functions even without the help of a GP or community district nurse. The intravenous therapy lead nurse has mastery over his or her roles with regards to caring for Mrs. Smith. The doctor or district nurse need not involve themselves with how the intravenous therapy nurse performs his or her specific independent nursing actions. This proves the notion why some people prefer to work alone rather than in a team.

The implementation of SAP has definitely enhanced collaborative working. Innately included in SAP is better and more comprehensive assessment of pertinent client data. This thorough extraction of patient data allows every member of the team to be able to fully understand the condition of the patient thereby, enabling each one of them to formulate their best professional judgment, action or intervention to help the patient.

## Outcome 4

What is often left out in the concept of collaborative working is that it also involves the patients themselves and their families. In the case of Mrs. Smith, she and her primary carer must also take an active role in cooperating with the professionals who are helping her. After all, the type of care that is often utilised is patient-centred care. The patient; therefore, must also focus her attention in helping those who are helping her. Under the concept of Expert Patients by the Department of Health (2001) a patient who receives proper support can take a lead role in managing his or her own long term condition. It can be said that many patients are experts in their own right considering the fact that they have gained the necessary knowledge and skills in coping with their long term condition for years (DH 2001). The primary carer also performs several important functions which need to be recognised by the health team (Doyle et al 2005). The carer serves as the immediate extension of the professionals. Certainly, health and social practitioners cannot be with the patient all the time. During their absence, the carer becomes the link between the professionals and the patient in ensuring that what the professionals has provided will continuously be given to the patient. Educational programmes and even informal health teachings equip the patients and their carers in becoming more knowledgeable and skilful in the treatment and care. Educational programmes serves as the support mechanism by which the professionals share to the patients and carers simple ways for them to take a role in the actual provision of services. This support mechanism is a sure way to empower and harmonise the patients and their carers to become part of the

team in trying to achieve the goal of overcoming or surviving the long term health and social related conditions of the patients.

In implementing educational programmes or even informal patient and carer education scenarios, it is a must to first perform motivational interviewing. The purpose of which is to determine what amount and kind of information is needed by the patient and his or her carer. Motivational interviewing is also in itself an informal manner of educating the patient and carer. An effective motivational interview can help the patient realise the need for him or her to not lose hope and to take a proactive part in being well again. Motivational interviewing can be seen as a manner of promoting behavioural changes (Miller and Rollnick 2002). It is a kind of therapeutic way of communicating with patients (Dart 2010). By utilising motivational interviewing tactics, we can become a tool for the patient's health behaviour change (Dart 2010). Motivational interviewing gives us the ability to unlock the doors of resistance, balance the scale of ambivalence and mobilise change talk to action (Dart 2010).

The approach of motivational interviewing definitely seems a great way of further helping the patient but it cannot be easily incorporated in one's practice. It requires practice. The more practice one has on this kind of approach, the better one becomes in truly motivating patients by mere interview. Clearly, its strengths revolve around the idea of changing patient behaviours for the better. Another is the thorough patient data one can get out of motivational interviewing. On the other hand, it is limited by the fact that it has to be done at the right time, place and condition which heavily depends of the patient.

<https://assignbuster.com/analyse-principles-underpinning-collaborative-working-and-its-impact/>

The study of sociology, social policy and psychology can truly help to understand the health experiences of people living with long term conditions. It is through these topics that we become aware of the social aspect of having to bear a difficult and chronic condition. Through studying these concepts, we may be able to discover the underlying social causes, consequences and solutions to such problems. In the end, if we have substantial knowledge and skills coupled with adaptation of collaborative approaches and strategies that have been proven effective, then we will be able to genuinely help patients with long term conditions.