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Citation for final published version:

Clouston, Teena J. , Whitcombe, Steven W. , Jenkins, Judyth and Mears, Julie 2018. Evaluation of interprofessional working on a therapist/nurse-led rehabilitation ward for older people in Wales. *International Journal of Therapy and Rehabilitation* 25 (4) , pp. 193-197. 10.12968/ijtr.2018.25.4.193

Publishers page: <https://doi.org/10.12968/ijtr.2018.25.4.193>

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International Journal of Therapy and Rehabilitation

An evaluation of interprofessional working, shared accountability and decision making on a therapist/nurse led rehabilitation ward.

--Manuscript Draft--

Manuscript Number:	ijtr.2017.0044R2
Full Title:	An evaluation of interprofessional working, shared accountability and decision making on a therapist/nurse led rehabilitation ward.
Article Type:	Critical review
Keywords:	Therapist/nurse led; integrated team; person centred culture; professional identity; timely discharge
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Abstract:	<p>The aim of this paper is to raise awareness of the issues that influenced the effective interprofessional working of a therapist/nurse led rehabilitation ward for older people in an acute hospital setting in Wales, UK. The ward was established to manage increased hospital admission rates over a four month winter period between January and April 2016.</p> <p>The opinions of a variety of staff from different professional backgrounds on the effectiveness of the service were gleaned. This comprised of two interviews with a consultant physician and senior registrar respectively and a focus group consisting of two occupational therapists, one clinician and one manager; three dieticians, two clinicians and one manager; one physiotherapist and one senior nurse (ward sister). Key elements which seemed crucial to the operational effectiveness and success of the service were as follows: First and fundamentally there was a philosophy of care that fashioned a culture of shared decision-making, responsibility and accountability. Alongside this, the ward utilised an experienced and skilled staff group who were confident in their professional identity and were ready and prepared to take on roles that were not traditionally associated with their professional scope of practice. Finally, the service was bolstered by a management structure that understood the ethos of the ward, supported the need for change, chose skilled and resilient staff and maintained an encouraging, caring and sustained leadership model. To support a balanced analysis the reported barriers to effective and timely discharge are also discussed. Final conclusions suggest that this is an effective model that could be implemented in periods of increased demands on hospital settings but also more widely across a range of rehabilitation services.</p>

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Abstract

The aim of this paper is to raise awareness of the issues that influenced the effective interprofessional working of a therapist/nurse led rehabilitation ward for older people in an acute hospital setting in Wales, UK. The ward was established to manage increased hospital admission rates over a four month winter period between January and April 2016.

The opinions of a variety of staff from different professional backgrounds on the effectiveness of the service were gleaned. This comprised of two interviews with a consultant physician and senior registrar respectively and a focus group consisting of two occupational therapists, one clinician and one manager; three dieticians, two clinicians and one manager; one physiotherapist and one senior nurse (ward sister). Key elements which seemed crucial to the operational effectiveness and success of the service were as follows: First and fundamentally there was a philosophy of care that fashioned a culture of shared decision-making, responsibility and accountability. Alongside this, the ward utilised an experienced and skilled staff group who were confident in their professional identity and were ready and prepared to take on roles that were not traditionally associated with their professional scope of practice. Finally, the service was bolstered by a management structure that understood the ethos of the ward, supported the need for change, chose skilled and resilient staff and maintained an encouraging, caring and sustained leadership model. To support a balanced analysis the reported barriers to effective and timely discharge are also discussed.

Final conclusions suggest that this is an effective model that could be implemented in periods of increased demands on hospital settings but also more widely across a range of rehabilitation services.

Key words

Therapist/nurse led; integrated team; person centred culture; professional identity; timely

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discharge

Word count 3653

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Introduction:

This article is a critical evaluation of a therapist/nurse led service in a rehabilitation ward for older people (aged 65+) in an acute hospital setting in Wales, UK. The service was initiated as a means to manage increased pressures on services during the winter period between January 2016 to April 2016. It was focused on delivering comprehensive rehabilitation and robust discharge planning in order to facilitate a safe and timely return into the community. In this context, rehabilitation refers to improving patients' personal skills of independence in order for them to be discharged function safely in their own home (Elbourne and le May, 2015). Through drawing on a range of perspectives including staff interviews and a focus group, the aim of this paper is to raise awareness of the issues that influenced the effective interprofessional working of a therapist/nurse led rehabilitation ward for older people in an acute hospital setting. These perspectives were gathered between June and July 2016 following the closure of the ward in order to assess the perceived effectiveness of the service.

The Department of Health has identified that nurse and therapist led initiatives in particular can be productive in enhancing proficiencies and improving patient flow by using the skill mix innovatively to provide a focused discharge plan (DH, 2010). These initiatives work by first delegating the responsibility for discharge to skilled therapists or nurses as opposed to relying specifically on the medical profession as the ultimate decision maker and second, by ensuring there are clear protocols in place that are in line with specific criteria and an agreed plan.

Much of the research to date supports this position. Nurse led wards have been effective in terms of improving discharge across diverse settings such as acute hospitals (Bowen et al, 2014), day surgery (Graham et al, 2012) and high dependency to general care (Knight, 2003). Similarly, whilst the effectiveness of therapist led initiatives may not specifically be associated with the ward based setting, there is a range of research highlighting the benefits of therapists leading on discharge from acute hospitals settings (Smith et al, 2010) and for

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older adults (Wales et al, 2012). In general terms research has shown therapist led services can greatly improve hospital flow and efficiencies (College of Occupational Therapists, 2016) thus illustrating that therapist led discharge at ward level would be effective.

In the context of this particular service, the leadership of the ward was equitably shared with a dietitian, occupational therapist and a nurse. The wider interprofessional team comprised of a range of skilled staff from different professional backgrounds including dietetics, medicine, nursing, occupational therapy and physiotherapy. All members of the team were experienced in rehabilitation and were brought together to complement the required skill mix to meet the identified client/patient needs.

The ward comprised a 24 bedded unit and ran for a 4 month period between January and April 2016. Criteria for admission to the ward was clearly defined to address timely discharge of patients transferred from existing acute hospital services within the Local Health Board. This required patients to be medically stable/fit, to be in need of active, ongoing multidisciplinary rehabilitation and to be cognitively and functionally able to participate in rehabilitation. They were also required to be likely to have a short length of stay of on this ward of approximately 10 days or less, have a place of residence identified as suitable to discharge and to be waiting for a referral to be actioned by the community rehabilitation team (CRT). Out of a total of 139 patients over the four month period, the discharge outcome in terms of goals being met or exceeded was achieved for 76% or 105 patients, whilst 1% or 2 patients achieved partial goal attainment. As 14% or 20 patients were inappropriate referrals and 9 % or 12 patients had documented reasons for not meeting expected outcomes, this was considered an effective outcome.

In setting up the service the staff were aware of the fundamental principles of the Francis (2013) and Andrews (2014) reports regarding patient focused care underpinned by the principles of dignity, respect, compassion and patient involvement. Thus the service was, from the onset, both pragmatic in terms of managing discharge efficiently and mindful of the principles of care and compassion. Both Francis and Andrews have noted the oppositional

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juxtaposition of target driven and person centred care in hospital settings. Therefore a notable feature of the ward was a philosophy of care that created a culture focused toward meeting the individual patient's needs, as well as meeting targets and/or organisational priorities rather than being driven only by the latter. This cultural context proved to be a key factor in the success of the ward and was underpinned by four key elements. Whilst acknowledging that this analysis focuses on one rehabilitation ward, these elements i.e. the shared philosophy, the approach and attitude to teamwork, the skill mix and finally the management support are not limited to this setting and are pertinent to other health and social care contexts. To support a balanced analysis the reported barriers to effective and timely discharge will also be discussed.

The culture of the therapist/nurse led ward

For the purpose of this article, 'culture' is understood to be the shared values, beliefs and ways of doing things that shaped the everyday context of the ward environment. Moreover, the concept of culture is regarded as a dynamic rather than a static entity (Eagleton, 2006), thus not only to be a product of the people and setting, but something that is organic and evolving in nature.

From the early stages of analysis it was evident that this service was underpinned by a culture that was created by the collective belief that everyday practice was patient focused and where accountability and decision-making were equitably shared amongst healthcare professionals. The occupational therapist (OT) for example remarked:

I think that's a benefit of working on this ward - the culture. It's a lovely ward to work on and you get it, the shared culture and responsibility, as soon as you come on here.

This shared and collaborative sense of culture was reported as impacting not only on staff satisfaction, but also on the patients on the ward and their families:

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Patient feedback has been exceptional. Overwhelmingly they've said they've loved it and that everybody is happy and willing to help no matter who they are. And they [patients] have just been appreciative of everything...Also relatives of the patients have been very appreciative and very positive (Head Dietitian (HDT)).

This positive feedback would suggest that a shared approach to promoting person centredness and genuine care for patients does enhance both staff and patient satisfaction and facilitate carer and/or family involvement.

The shared philosophy

The members of the interdisciplinary team clearly identified that the shared philosophy of the service was central to the success of the ward. It was also clear that they had co-created this shared approach from the inception of the ward. In practice, this meant a model of working with clear lines of communication, shared decision making and shared accountability that created an integrated model of working:

I think we've been an integrated ward from the beginning. It's something we all took on...We soon gelled and became a really good integrated team...Communication between all of us has been really good; we have always stopped and talked to each other about what we found out...We all knew what each other was doing (physiotherapist (PT)).

This integrated approach to communication and shared sense of knowing was also linked to a sense of collaborative solution focused care and shared accountability and responsibility across the team for decisions made. This was reported as not only effective but satisfying:

Well last year as an OT felt I that that patients having to wait for visits delayed discharge and you felt part of the problem. Whereas now, in this team, you feel part of the solution. It all seems to automatically flow and when you identify that something needs to be done you are in a good position to do those things really

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quickly. You've got the joy of doing joint visits with physios, which solves a lot of problems very quickly, and we haven't had to wait for various things (OT).

In terms of discharge planning this approach addressed potential barriers by empowering the staff to take a shared approach, use each other as resources and make decisions to resolve the problem. This approach was also reported as enabling staff to look at discharge from a person centred and needs led perspective by focusing on the patient's specific requirements:

I think we have looked at looked at it [discharge planning] in a completely different way. People should be relatively stable [before they come to the ward] so then it's looking at what that person needs to go home (Dietitian (DT)).

The culture of ward was marked by the preparedness of individual team members to demonstrate shared responsibility and the ability to make decisions as a team as well as utilising a needs led, person centred approach. This emphasis on shared responsibility, accountability and a consistent focus on the needs of the patient led to an environment that was acknowledged by the patients on the ward as effective and caring:

From their [patients'] stories they all said how welcoming the ward is. If you ask for something you actually get it. And they all refer back to the wards they've come from and say that it wouldn't have happened there...It was seeing what was possible really (Nurse).

Working as an integrated team then i.e. one that provides an integrated service and works in a more synergic and collaborative way than a multidisciplinary team (Mitchell et al, 2010) was a critical success factor in making the ward work effectively. The success of this integrated service was due in no small part to the decision to use staff experienced in rehabilitation and who were confident in their own professional identity. The impact of these factors on the integrated approach will be discussed further as we progress through the paper.

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Approach and attitude to teamwork

As experienced staff, each professional was confident in their professional role and understood their unique contribution to patient care. Such confidence, coupled with sound systems of communication mirrors an interprofessional approach, which is marked by a deeper level of cooperation, innovation and a genuine sharing of skills and resources than the more competitive or 'silo' approach frequently reflective of multidisciplinary team working (Mitchell et al, 2010). It was also the professionals' attitude to teamwork and their willingness to work flexibly, and in some respects 'generically' that supported a person centred, needs led service:

I think...it has been beneficial in terms of making an interdisciplinary model work that everyone has been really flexible with their roles and you do a bit of everything. In a multidisciplinary team everyone has their role. But here, everyone has meshed in and done a bit of everything. And that's been very beneficial in sharing the load but also appreciating how much about something you didn't know before (PT).

This openness to learn and adapt roles to meet needs was essential to effective interprofessional working because there was a sharing of traditional roles. Everyday activities associated with self-care, for example, washing and dressing patients, assisting patients with their toileting needs or even making patients a hot drink, were done by all staff and not seen as the responsibility of one professional or caring discipline. As Clouston and Whitcombe (2008) maintain, a strong professional identity is not necessarily characterised by rigidly defined roles, but by an awareness of what specialised services a profession can offer, coupled with an acknowledgement of the values, knowledge and skills they share with others.

This willingness to share such roles was only made possible by a model of working that incorporated a seven-day shift pattern, inclusive of evening hours. For the therapists, this meant they sometimes had to work over the weekend and/or extended hours, which traditionally, was outside of their normal practice routine. However, the importance of this in

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upholding the mutual ethos of the service cannot be understated. As the dietitian described:

I think the shift working 7 till 7 as a therapist, and the fact that therapists have been available in the mornings to help with washing, dressing, getting patients out of bed. I guess on a normal healthcare ward it would be the nurses and the healthcare assistants who would do that. I think that's beneficial because it's been done in a therapeutic way; but also for me it grabs your appreciation of how much work everything takes in the morning to get patients up and ready (DT).

Integrated patterns of working were also crucial in supporting a holistic service that took account of families and/or carers' concerns and enriched the communication between the staff and the patients' loved ones/ significant others:

Because they [therapists] are 7 to 7, they are able meet up with the families on the ward. Rather than you are just reliant upon ringing them because by the time the family come up for visiting times they [the therapists] have left the ward. If they are there until 7, they have a greater opportunity of meeting the family (OT).

Engaging family members and carers directly at visiting times was reported as effective in delivering greater levels of connectivity and support. This involvement of carers, by the extension of service provision, clearly supports the directives found in the carers' strategy to increase carer involvement in decision-making (Yeandle and Wigfield, 2011). It also supports the notion that extending therapists' working hours over a 7 day, 12 hour work pattern is more effective in terms of patient satisfaction and effective discharge planning (NHS, 2013).

Skill mix

The integration of appropriate professional groups together with the use of experienced rehabilitation staff with a defined skills set and a knowledge base around working with frail elderly to meet patient needs was an important factor in respect of the success of the ward. The ability of the individual to embrace change and to engage with a new model of

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working also emerged as an essential theme in terms of the ability to work in an integrated way. Essential to this was the presence of a strong sense of professional identity; the confidence and competence in terms of roles and skills accompanied by good professional reasoning and the readiness to be flexible to be able to provide person-centred, needs-led care. As one of the doctor's remarked with regards to the leadership model:

It wouldn't work with junior therapists. I think it was because it was all quite senior therapists, well established in their roles. There was pretty much a Registrar in term of experience and six staff who were bands 6 and 7. So I think it was coordinated [because] you had a fairly confident team there (Consultant).

Furthermore, members of the team were specifically chosen by the managers to assure they were prepared to take on a leadership role in the management of a busy rehabilitation ward:

We targeted people who we thought would do a good job...Because you've got all those years of experience and I know that you will be able to do it.... It was just about making sure that we had the right people. I think that's absolutely fundamental to the success of the ward (HDT).

This strength of professional identity and experience was clearly valued because it underpinned a strong sense of identity and self-assurance in decision-making. It was also about the readiness to work differently and to adapt to the needs of the patients and staff as required. An interesting point raised by the team was that they felt the overall success of this shared culture required team members who were prepared to work in this integrated way:

And I think that is something you would probably have to think about if we were rolling it out. We would have to recruit people who would actually want to work in this way (OT).

Van Dijk-de Vries et al, (2016) discuss the importance of teamwork effectiveness, team processes and psychosocial traits as critical components for effective working in interprofessional teams, whilst Kelly and Coons (2012) suggest that individual readiness to work differently is essential to the effectiveness of integrated care. Thus the correct skill mix,

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team dynamics, level of experience and expertise, readiness to work differently and personal traits, as well as the team dynamics, are all essential to effective interprofessional working.

Management support

Finally, the team also identified the values of senior leadership and their support in terms of engendering the cultural context through a three-fold approach. First the professional leads supported the ward's development as a tool to manage service pressures; second they provided professional and team supervision and leadership which was recognised and appreciated by the team; third, they provided practical support in terms of facilitating the development of effective systems and processes that underpinned this new way of working and took on a trouble shooting role for this 'new' service at a time of winter pressures. The actions of the managers in and dealing with challenges e.g. inappropriate referrals was significant in terms of promoting the philosophy of the ward:

We've had very good support from our managers. In the beginning it was hard because we set up a ward and we were having patients admitted that were not meeting our criteria. We knew we had to be strict about it because we only had two nurses and two auxiliaries on each shift. And at the beginning staffing levels were not right at all; and it was very difficult. And whenever we had patients that didn't meet the criteria our managers supported us all the way. And I suppose we made a pain of ourselves by getting people moved off the ward very quickly. And once that all settled and...we had a system going....it was fine. We got our list on line and everyone could track how many beds we had (OT).

Barriers to Effectiveness

Francis (2013) has clearly shown that service improvement should be measured in terms of patient experience and outcome not performance measures. This service seems to achieve this aim, as well as discharging people successfully and offering a rehabilitation setting that

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could provide an opportunity to transfer patients from acute wards. This would suggest that this therapist/nurse led model of working could be an effective tool to assist in not only managing discharge effectively but also improving the quality of care and fundamentally, patient satisfaction. However, the team did raise a notable barrier in the process that did detract from the overall success of the service and this was the lack of community based resources:

That ward-based culture has empowered everybody to take it on... but it would be nice if you were taking it forward to think about having some kind of bridge to community services. And I think we noticed that a lot given the culture here was so strong (OT).

This absence resulted in some patients staying on the ward longer than necessary because the required community based care packages could not be implemented in a timely way.

Thus, as pointed out elsewhere (Ashton, 2015; Macadam, 2015), a micro-social approach does not resolve the wider socio-cultural challenges of interagency working that require co-produced, systemic context change if integrated services are to be achieved. As the OT manager remarked:

It's the social care aspect again isn't it where we require the investment.

As with the wider UK, Wales does have an awareness of the ongoing issues in terms of inter-agency working between the health and social care sectors. The recent Social Services and Wellbeing (Wales) Act (2014) is designed to address just these issues by ensuring a common approach is taken to the delivery of health and social care in Wales. The experiences shared in this paper suggest that the implementation of this policy needs further consideration.

Conclusions

To summarise, this paper has identified how a therapist/nurse led model is an effective method of implementing not only the efficient management of safe discharge that can assist

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in patient flow, but critically, through working as an integrated team, provide and sustain a person centred approach to care, where the service responds to individual patient need rather than being driven by performance targets. Through the process of service evaluation several key strands emerged that were integral to the operational effectiveness and success of the therapist/nurse led ward. First and fundamentally, there was a philosophy of care that fashioned a culture of shared decision-making, responsibility and accountability. Alongside this, the ward utilised an experienced and skilled staff group who were confident in their professional identity and were ready and prepared to take on roles that were not traditionally associated with their professional scope of practice. Finally, the service was bolstered by a management structure that understood the ethos of the ward, supported the change process, chose skilled and resilient staff and maintained an encouraging, caring and sustained leadership model. Notably future evaluations would benefit from the direct analysis of patients' experiences and accounts of the therapist/nurse ward.

Challenges to this model of working included the inter-agency partnerships between health and social care, which could be addressed at the simplest level by the inclusion of a social worker integrated into the ward team and/or more effective working with social care organisations.

In terms of the implications for practice, this analysis suggests that a therapist/nurse led service can increase effectiveness in terms of discharge through implementing a model and philosophy of shared decision-making, accountability and responsibility supported by sound leadership. Notably the appropriate skill mix, experience, readiness and preparedness to work differently were crucial factors in individual members to promote effective team dynamics. These qualities are a significant factor to consider in the development of future therapist/nurse led initiatives and the success of integrated teams.

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