RACGP
Royal Australian College *of* General Practitioners

RACGP aged care clinical guide (Silver Book)

5th edition

Part B. Collaboration and multidisciplinary team-based care

General principles

- Collaboration and multidisciplinary team-based care are essential for the optimal care of older people, particularly those in residential aged care facilities (RACFs) and in the community.
- Collaborative care has benefits for patients, the team and its members and the organisation.
- The team membership varies depending on the needs of the patient.
- Five principles that may help enhance team effectiveness include:
  - shared purpose and goals
  - clear roles and responsibility
  - mutual trust
  - effective communication
  - measuring process and outcomes of team function.

Introduction

Collaboration and multidisciplinary team-based care are essential for the optimal care of older people, particularly those in residential aged care facilities (RACFs) and in the community. These enhance the relational coordination and communication between medical, nursing and other health professionals.[1]

Collaboration and collaborative care occur when ‘multiple health workers from different professional backgrounds provide comprehensive services by working together with patients, their families, carers and communities to deliver

the highest quality of care across settings. Practice includes both clinical and non-clinical health-related work, such as diagnosis, treatment, surveillance, health communications, management …'.[2]

This definition of collaboration is not dissimilar to multidisciplinary care – when professionals from a range of disciplines work together to deliver comprehensive care that addresses as many of the patient's needs as possible.

This can be delivered by a range of professionals functioning as a team under one organisational umbrella or by professionals from a range of organisations, including private practice, brought together as a unique team. As a patient's condition changes over time, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient.[3] A team is formed when at least two healthcare providers work collaboratively with patients and their caregivers to accomplish shared goals within and across settings to achieve coordinated, high-quality care.[4]

Importance of collaboration and team-based care

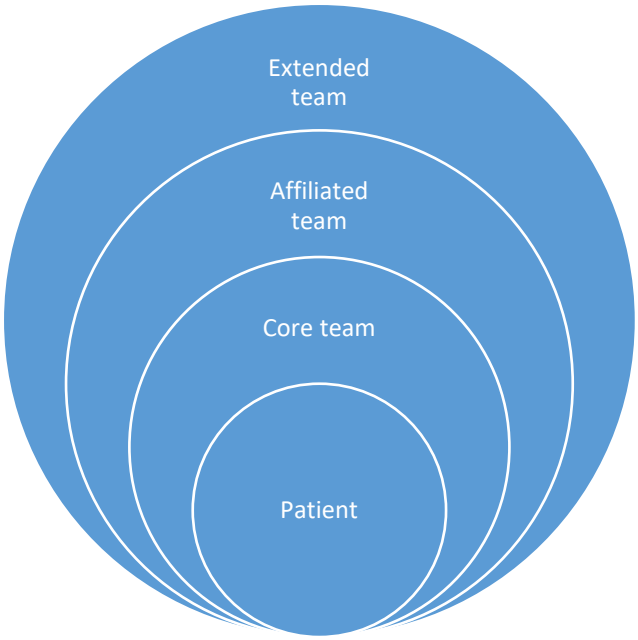
The increasing complexity of care needs for older people, particularly residents of RACFs who often have multimorbidity, requires a team-based approach. For example, there is an increasing number of people across all health systems who experience care gaps – almost a fifth of those with complex and chronic needs report experiencing gaps in the care they receive.[5] A review evaluating the effectiveness of healthcare teams found evidence for:[6]

- organisational benefits
  - fewer hospitalisations and reduced cost
  - fewer unanticipated admissions
  - better accessibility for patients
- team benefits
  - improved coordination of care
  - efficient use of healthcare services
  - enhanced communication
  - professional diversity
- individual benefits
  - patients
    - enhanced satisfaction
    - acceptance of treatment
    - improved health outcomes
  - team members
    - enhanced job satisfaction
    - greater role clarity
    - enhanced wellbeing.

Team structure

The team structure may be considered in three layers, in addition to the patient (Figure 1).[7]

Figure 1. Three layers of a team structure



The core team is typically the general practitioner (GP) who is supported by the general practice team, which may include a nurse practitioner, practice nurse, possibly a medical assistant or practice pharmacist, and the non-clinical practice support team (eg receptionists). These team members may be used to support a GP to deliver services in an RACF by either support call/recall and reminder functions or care delivery (eg comprehensive medical assessments, care plan contributions). Often members of the nursing team can support patients by providing a linking and coordinating function.

In some general practices, there may be an affiliated team. This is a team that is not directly employed by the general practice, but forms part of the healthcare team through formal links and established networks. For example, this might include community pharmacists, optometrists, psychologists and other members of the allied health team. It may also include community nursing, and home and personal care providers. The staff at an RACF may certainly be considered to be part of the affiliated team when considered from the practice's perspective, and part of the core team when considered from the patient's perspective. This would include the registered nurses and carers at the facility, but also allied health providers (eg physiotherapist, speech pathologists, dietitians) who may be employed by the facility or have contracted services.

As a patient's needs increase, the extended care team may become more involved in their health. The extended care team includes services and resources that are shared by the core and affiliated teams; for example, it may include medical specialists, palliative care services or wound care services.

Effective team

There are five principles of effective teamwork and collaboration in healthcare:[8]

- Shared goals
- Clear roles
- Mutual trust
- Effective communication
- Measurable processes and outcomes

These five principles are codependent and support each other; for example, effective communication helps build mutual trust.

Shared goals

A shared purpose is a critical step in working together as an effective team. Members of the team create a common purpose and goal/s that include their collective interests and demonstrate shared ownership. The shared team goals in many teams are not explicit, in particular for affiliated teams and extended teams. The implied goal is usually around the care of a specific patient and often to deliver person-centred care.

Practice tip: In communication with team members, it can be helpful for GPs to clarify the shared goal for the patient (eg use phrases such as 'Let's confirm the goals of care for this patient and how we can help to best achieve them').

Clear roles

Every member of the team brings a unique perspective given their different backgrounds and specific skill sets respective to their disciplines. While there may be some overlaps in roles, for effective and efficient teamwork it is important to have clear expectations of functions and responsibilities. Given the patient and their family are key members of the team, it is important that their roles and responsibilities are also clear.

The role of each member of the multidisciplinary team needs to be outlined and properly communicated to the patient and their family and carers. Good teamwork within the multidisciplinary team also requires resolution of problems that may arise because of factors within the team. Factors may include:

- personality differences
- perceptions of one person's role in the team being more important than others
- a lack of confidence in expressing one's views
- ignoring the wishes or concerns of the patients and/or families.

External factors such as scarcity of resources or difficult organisational changes can also have an effect within the team.

Multidisciplinary team leader

The multidisciplinary team leader or coordinator has an important role in any multidisciplinary team care.[9]

For residents in an RACF, the role of the multidisciplinary team leader is usually carried out by the senior nursing staff; however, social workers or case managers have also taken on this role in the community setting. It is increasingly likely that GPs will be involved in leading aged care teams, as is the case in countries like the Netherlands.[10]

Whoever takes on the role as the multidisciplinary team leader needs to coach their staff and fellow team members in the principles of teamwork, and inspire them to perform their best in their role. They need to ensure the team is achieving its objectives, and adjudicate between team members when there are problems within the function of the team. At the heart of all this, the patient should be at the forefront of every decision made.

Practice tip: Reinforce the roles and responsibilities by being clear in your documentation who is responsible for action (eg record notes from a case conference or care plan contributions).

Trust

Mutual trust is a critical element for effective teamwork. Findings from a review on interprofessional collaborative teams identified that the effectiveness of shared care models was primarily limited as a result of role ambiguity and lack of trust between providers.[11] Collaboration is a by-product of trust. Trust needs to be present at both an individual level and also at the organisational level. Trust needs to be established between patients and their care teams, as well as between the members of the care team/s and the organisations in which they work.

A core mechanism to establishing trust among team members is ensuring all voices on the team are heard equally. There are three elements within trust:[12]

- Relational trust – how one member of a team treats another member.
- Functional trust – trust built through achieving and getting things done together.
- Flow-of-value trust – this is complex, but involves a combination of reciprocity, competition and exploitation.

Practice tip: You can contribute to improving trust in your team by working on how you treat other team members and by ensuring you follow through on areas you have agreed to do (this could be as simple as ensuring you have the prescriptions done if you promised you would send them later).

Communication

Communication is a critical component of effective teamwork. Patient safety research demonstrates communication failures between team members contribute to adverse events. In medico-legal claims, communication failures were responsible for about 30% of the claims.[13] An effective team prioritises communication, and continuously monitors and works to improve communication. High-quality communication should be a guiding principle for the team's operation, rather than an attribute of individual team members.

Team meetings

Multidisciplinary team meetings and case conferencing should take place regularly, where a number of cases can be discussed at the same session. These can take place face to face or by teleconference or videoconference. Each member of the multidisciplinary team should have input during the team meetings and use their expertise to advocate for the benefit of their patient.

Each team member should be responsible for providing a snapshot of the patient's health to the team, which may include:

- medical issues
- mobility
- activities of daily living functions
- care issues (eg transfers, continence, pain control, wound care)
- speech and communication
- cognition
- eating and swallowing
- social and family
- behaviour and mood.

The patient's goals and management plan can then be formulated based on all the issues identified.

Individual case conferences or family meetings are held in a similar manner, where the patient and/or their family members also have a chance to express their views, needs and wishes.

Care records and management plans

All healthcare professionals are required to keep contemperous accurate records (refer to Part B. Medical records at residential aged care facilities); however, those records are often not shared or accessible by different care team members, especially across care boundaries. Documentation of each case discussed should be kept with the patient's medical records in general practice, the RACF, and with any other agency involved (eg with case managers providing home-based care). Technology can also be a lever; My Health Record can be used to create shared summaries and event records, and remote access can be set up to the practice computer or via a cloud-based clinical system.

Once goals and management plans have been drafted for a patient, it is important to note that these are living documents that can be modified and adjusted after discussion with the rest of the multidisciplinary team (eg individually or in subsequent team meetings).

Management plans should generally cover all the patient's relevant clinical, social and functional domains. The most relevant information to include in the management plans of older people include:

- long-term and short-term medical conditions
- medication management (refer to Part A. Medication management and Part B. Principles of medication management)
- chronic pain (refer to Part A. Pain)

- cognitive impairment (refer to Part A. Dementia)
- spiritual and mental health (refer to Part A. Mental health)
- continence (refer to Part A. Urinary incontinence and Part A. Faecal incontinence)
- mobility
- functional goals
- nutrition
- medical and financial decision-making powers
- advanced care directives (refer to Part B. Advance care planning)
- limitation of treatment (eg resuscitation) plans.

GPs can be remunerated under the Medicare Benefits Schedule (MBS) for participating in case conferences (refer to Part B. Medicare Benefits Schedule item numbers); importantly, GPs can contribute detailed information concerning symptoms, medical issues and progression along the illness trajectory. The team's goals and management plan can inform GP clinical care plans.

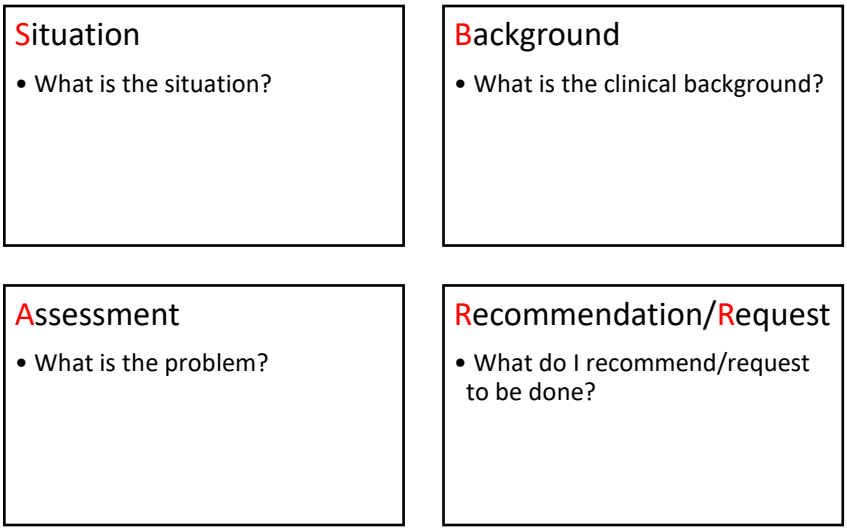
The patient and/or their family can be given a summary report of such meetings, especially after those designated as 'family meetings'. Some organisations and aged care providers will routinely provide patients and/or their families and carers with copies of the team case meeting reports. This is especially important where family members are scattered and cannot always be present at meetings or spend time with senior staff during weekdays.

The overarching outcome of this kind of teamwork should focus on ensuring the aged care patient's needs, goals and wishes are dealt with to the satisfaction of all concerned (ie person-centered care).[14]

Standardised communication tool

Standardised communication tools can assist in facilitating information exchange in a more structured and systematic way to ensure the necessary information requirements are communicated. Standardised communication tools (eg SBAR; Figure 2) can be used for both verbal and written communication. The SBAR tool requires training to be used and is described with other similar tools in the Australian Commission for Safety and Quality in Health Care's (ACSQHC's) *OSSIE guide to clinical handover improvement*.[15]

Figure 2. The SBAR tool



The SBAR tool is a structured communication tool often used to escalate care, but may be used in a range of settings and may be very helpful for conveying information between team members.

Practice tip: Consider using a structured communication tool such as SBAR when you hand over to other members of the team.

Measurable processes and outcomes

Teamwork is a process. When teamwork is impactful and effective, it leads to improved outcomes of care. Measurement of the effectiveness of teamwork therefore requires a measurement of the outcomes of care and the process of teamwork and/or level of team functioning. The measurement of the process of teamwork and functioning is more specific to address the effectiveness of teamwork itself. Measuring processes and outcomes may be challenging and requires everyone to be on board.

Increasingly, patient-reported measures (PRMs), which can include patient-reported experience measures (PREMs) and patient-reported outcome measures (PROMs), are being used in healthcare. PRMs can inform teams on how patients experience the care they receive and if that care is having an effect on the outcome as it matters to the patient.

Practice tip: Sometimes focusing on things that have gone well can be supportive and encouraging. For example, if the care of a patient has gone well then acknowledge and thank the members of the team and perhaps ask what we can learn from this to see if we can make it happen more often.

Conclusion

Healthcare is increasingly becoming a team sport, and, like any team sport, a winning team requires everyone to actively participate and contribute. GPs are often seen as leaders in a team and it is therefore important for GPs to understand not only the need and importance of collaboration and teamwork but also how effective collaboration can be achieved.

References

1. Hartgerink JM, Cramm JM, Bakker AM, van Eijsden, Mackenbach JP, Nieboer AP. The importance of multi-disciplinary teamwork and team climate for relational co-ordination among teams delivering care to older patients. J Adv Nurs 2014;70(4):791–99.
2. World Health Organization (WHO). Framework for action on inter-professional education and collaborative practice. Geneva: WHO, 2010. Available at http://apps.who.int/iris/bitstream/10665/70185/1/WHO_HRH_HPN_10.3_eng.pdf?ua=1[cited 8 July 2016].
3. Mitchell GK, Tieman JJ, Shelby-James TM. Multidisciplinary care planning and teamwork in primary care. Med J Aust 2008;188(S8):61–64.
4. Naylor MD, Coburn KD, Kurtzman ET, et al. Inter-professional team-based primary care for chronically ill adults: State of the science. Unpublished white paper presented at the ABIM Foundation meeting to advance team-based care for the chronically ill in ambulatory settings. Philadelphia, PA, 2010.
5. Penm J, MacKinnon NJ, Strakowski SM, Ying J, Doty MM. Minding the gap: Factors associated with primary care coordination of adults in 11 countries. Ann Fam Med 2017;15(2):113–19.
6. Mickan S. Evaluating the effectiveness of health care teams. Aust Health Rev 2005;29(2):211–17.
7. Hupke C. Team-based care: Moving from ideas to action. Tokyo: IHI Corporation, 2016. Available at www.ihi.org/communities/blogs/_layouts/15/ihi/community/blog/itemview.aspx?List=7d1126ec-8f63-4a3b-9926-c44ea3036813&ID=192 [Accessed 6 November 2019].
8. Mitchell P, Wynia M, Golden R, et al. Core principles and values of effective team-based health care. Washington, DC: Institute of Medicine, 2012. Available at www.iom.edu/tbc [Accessed 6 November 2019].
9. Gaitz C. The co-ordinator: An essential member of a multidisciplinary team delivering health services to aged persons. Gerontologist 1970;10(3):217–20.
10. Grol SM, Molleman GRM, Kuipers A, et al. The role of the general practitioner in multidisciplinary teams: A qualitative study in elderly care. BMC Family Practice 2018;19:40.
11. Virani T. Interprofessional collaborative teams. Ottawa: Canadian Health Services Research Foundation, 2012. Available at www.cfhi-fcass.ca/Libraries/Commissioned_Research_Reports/Virani-Interprofessional-EN.sflb.ashx [Accessed 6 November 2019].
12. Capra C. Types of trust in high-trust networks. Greater than the sum, 2016. Available at http://greaterthanthesum.com/types-trust-networks [Accessed 15 August 2019].
13. The Joint Commission. Sentinel alert event – Issue 58. Oakbrook Terrace, IL: The Joint Commission, 2017. Available at www.jointcommission.org/assets/1/18/SEA_58_Hand_off_Comms_9_6_17_FINAL_(1).pdf [Accessed 6 November 2019].
14. Brownie S, Nancarrow S. Effects of person-centered care on residents and staff in aged-care facilities: A systematic review. Clin Interv Aging 2013;8:1–10.
15. Australian Commission on Safety and Quality in Health Care. OSSIE guide to clinical handover improvement. Sydney: ACSQHC, 2010. Available at www.safetyandquality.gov.au/wp-content/uploads/2012/01/ossie.pdf [Accessed 6 November 2019].