Stroke Interprofessional Collaboration: Working Together for Better Patient Care

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Interprofessional Stroke Best Practices Workshop

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Have you ever heard something like this?

"I don't understand what to do...the RN tells me to do it one way, the OT something different and then I go to PT and she/he has another goal. I don't know how to do all these conflicting things. The only thing that matters is that I am able to go walk on my own to go home and look after my grandkids again."
Learning Objectives

By the end of this workshop, participants will be able to:

• Describe the stroke best practices that relate to IP teamwork
• Understand the literature and evidence for IP collaboration across health care teams;
• Explore effective communication and understanding the role communication plays to minimize silos in IP stroke teams;
• Consider models of care, tools and resources to coordinate safe, effective, patient-centred practice with IP stroke teams
What is Interprofessional Care/Collaboration (IPC)?

Occurs when multiple health workers from different professional backgrounds provide comprehensive health services by working with patients, their families, carers and communities to deliver the highest quality of care across settings.

World Health Organization

Framework for Action on Interprofessional Education & Collaborative Practice WHO, 2010
IPC and Stroke Care

An effective interprofessional team collaboration has members who cooperate rather than compete with one another, and put the interests of the patient first.

(Inter-professional Team Collaboration in Stroke Survivor Care: A Review of the Literature, Johnson, 2015)
What is IPC REALLY about?

• Not taking over each other’s jobs instead to be able to differentiate/appreciate the types of expertise that each profession brings.

• Recognize areas of overlap and tension to be able to work together for best practice.

• How to begin to negotiate who needs to be involved in which client’s care.

• Understand when need a referral to a specific discipline for specialized treatment.
When is a TEAM needed?

When one person is not enough – increasing complexity

**Multiprofessional Practice:** Uniprofessional-centric model

- Health Care Assessments
  - Individual Professional
  - Individual Professional
  - Patient / Client

**Care Plan**

**Interprofessional Practice:** Collaborative model

- Health Care Assessments
- Shared care plan
- Integrated Care Plan
- Patient / Client
Collaboration should occur within & across settings, following clients throughout their journeys.

**GOAL:**
Regular and frequent dialogue between all health caregivers, within and between settings as necessary.

All health caregivers see themselves as part of the patient’s care team.
Why?
IPC can decrease:
- total client complications
- length of hospital stay
- tension and conflict in caregivers
- staff turnover
- hospital admissions
- clinical error rates
- mortality rates
Evidence: Enhanced Organizational Efficiency and Provider Satisfaction

- More efficient resource utilization, better access to services, shorter wait times, better coordination of care, and more comprehensive care (Barrett & Curran et al. 2008)
- Improved Cost Efficiency (D’Amour, 2005)
- Improved Health Professional Satisfaction (Cohen & Bailey, 1997)
- Leads to a Healthy Workplace (Shamian & El-Jaradali, 2007)
Why is interprofessional teamwork important for Stroke Care?
Evidence in Stroke Care: IPC Positively Impacts Outcomes

• Improved **Patient Outcomes**:
  – “There is unequivocal evidence of improved outcomes when patients are treated in a stroke unit by multidisciplinary teams” (Clark, D., 2013)
  – “Reported benefits of effective multidisciplinary team working include more patient-centred decision making and a reduction in fragmentation of care” (Clark, D., 2013)
  – “There is strong evidence that specialized, interdisciplinary rehabilitation provided in the sub-acute phase of stroke is associated with reductions in mortality...” (Teasell, R., et al., 2015)
  – “Improved Stroke Functional Outcome” (Strasser et al., 2008)
Importance of Interprofessional Rehabilitation on Independence

• The 2015 update accentuates the positive impact of organized stroke units with interprofessional stroke teams on patient outcomes following stroke

• For every 100 patients receiving organized inpatient interprofessional rehabilitation, there is an extra five percent return home in an independent care state.

(Canadian Stroke Best Practice Recommendations, 2015)
Collaboration for Stroke Care

Rehabilitation should begin immediately after a stroke and involves interdisciplinary teams working together to maximize the individuals recovery.

(New national recommendations expand the concept of stroke rehabilitation. The Heart and Stroke Foundation., 2013).
How?
Goal: Interprofessional Collaboration

A partnership between a team of health providers and a client in a participatory, collaborative and coordinated approach to shared decision-making around health and social issues.
Six Competency Domains

• Role Clarification
• Team functioning
• Patient/Client/family/Community-Centred Care
• Collaborative leadership
• Interprofessional Communication
• Interprofessional Conflict resolution
Ontario Stroke Network: Stroke Rehabilitation Intensity

• We identified gaps with meeting QBP requirements and modified staffing ratios, treatment models, space and equipment resources in occupational therapy, physiotherapy, and speech-language pathology.

• From April 2010 to March 2015, therapy time has increased by 54%.

St. John’s Rehab, Sunnybrook Health Sciences Centre, Toronto, ON (2016.)
(With thanks to Jennifer Shaffer and Siobhan Donaghy)
Communication and Role Understanding in Interprofessional Stroke Teams
National Interprofessional Competency Framework

Goal: Interprofessional Collaboration

A partnership between a team of health providers and a client in a participatory, collaborative and coordinated approach to shared decision-making around health and social issues.

Role Clarification

Learners/practitioners understand their own role and the roles of those in other professions, and use this knowledge appropriately to establish and meet patient/client/family and community goals.

Interprofessional Conflict Resolution

Learners/practitioners actively engage self and others, including the patient/client/family, in dealing effectively with interprofessional conflict.

Team Functioning

Learners/practitioners understand the principles of team dynamics and group processes to enable effective interprofessional team collaboration.

Collaborative Leadership

Learners and practitioners work together with all participants, including patients/clients/families, to formulate, implement and evaluate care/services to enhance health outcomes.

Contextual Issues

Simple

Interprofessional Communication

Learners/practitioners from varying professions communicate with each other in a collaborative, responsive and responsible manner.

Quality Improvement

Complex

www.cihc.ca
Importance of Role Understanding

• Without knowledge of what each other’s role and consider what others CAN DO, it is difficult for health care team members to develop respect, tolerance, and a willingness to work together.
Role clarity leads to better utilization of individual health care workers, improved communication, reduced error, and enhanced delivery of patient care.

(Meuser et al. 2006)
Diverse Interprofessional Team

• “Stroke unit care is characterized by an experienced interprofessional stroke team, including physicians, nurses, physiotherapists, occupational therapists, speech language pathologists, among others…”

• “Outpatient and/or community-based rehabilitation services should include the same elements as coordinated inpatient rehabilitation services: An interprofessional stroke rehabilitation team (Evidence level A)” page 11

• “Specialized stroke care, provided by an interdisciplinary team in a unique stroke unit, continues to be strongly supported”

(Canadian Stroke Best Practice Recommendations, 2015)
ROLES VS SCOPE OF PRACTICES

ROLES:
• Can be defined as a shared set of expectations, values, attitudes, norms and beliefs governing one’s behavior in a particular position in society (Scott 1970, Linton 1945).

SCOPE OF PRACTICE:
• May be shaped by educational preparation and legislation (Oelke et al. 2008)
If >1 Health Professional is competent – does practice support and HCP trust to share?

Who is **competent** at the time?

Who has legislated **SCOPE**?

**ROLE** of health care professionals

Providing education about positioning
Physical Therapist

What my friends think I do

What my patients think I do

What society thinks I do

What my co-workers think I do

What I think I do

What I really do

[ Generate image at www.whatireally.com ]

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## Activity Inventory Analysis

### Table 1: AIR Team Activity Inventory Analysis

<table>
<thead>
<tr>
<th>Competency</th>
<th>Care Delivery Activities</th>
<th>Registered Respiratory Therapist</th>
<th>Registered Nurse</th>
<th>Registered Pharmacist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Assessment</td>
<td>Head to Toe Assessment</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Physical Assessment</td>
<td>Chest Assessments</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td>Neurological Assessment</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td>Vital Signs (Blood Pressure, Heart Rate, Respiratory Rate, Temperature, Oxygen Saturation, Pain Scale)</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td>Braden Scale/Skin Assessment</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Patient History</td>
<td>History of Present Illness, Past Medication History, allergies, etc.</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td>Obtain Best Possible Medication History</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Performing &amp; Interpreting Diagnostic Tests/Results</td>
<td>Obtain Peak Flows</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td></td>
<td>Bedside Spirometry</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td></td>
<td>Sputum Collection</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td>Obtain Electrocardiogram</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td>Cardiac Monitor Lead Placement</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td>Cardiac Monitoring and Interpretation (Lethal Rhythms Only)</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td>*Arterial Blood Gas Procurement</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td>*Arterial Blood Gas Interpretation</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td>*Venipuncture</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td>*Capillary Blood Sampling and Glucometer Testing</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td>Obtaining Blood from a Peripheral or Central Line</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td>Interpreting Lab Values</td>
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<td>✔️</td>
<td>✔️</td>
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<tr>
<td></td>
<td>Obtain Urine Specimens</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td>*Swabs for Infection Control Screening</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td></td>
<td>Assist with Lumbar Puncture</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>
Shadowing Activity

• How did you decide to enter your profession/role?
• On this team, what does your assessment & intervention usually involve?
• Who do you collaborate most closely with on this team? Why? Can you provide a specific example/story to illustrate?
• How do you work to establish and maintain relationships on this team?
Collaborative Practice

Health care professionals need to:
✓ take the time to clarify roles and responsibilities
✓ be able to express their ideas and feelings freely

This will:
✓ build respect and value for different roles and their capabilities and
✓ promote sharing of knowledge to enhance joint decision making
... NO... IT'S YOUR JOB TO CLOSE THE DOORS...

ROLE CLARITY
Quality care = quality communication

- Multiple hand-offs across teams, sectors and orgs
- Different language/jargon/acronyms
- Hierarchy and interprofessional interactions
- Common goal/vision
Stroke QBP
Focus on improving time to inpatient rehab for moderate/severe strokes
(includes decreasing wait time for admission and time to therapy)

Example

REHAB UNIT
Intake Screen Admission Assessment Treatment

Handoffs/inputs into the process
Acute Care Discharge Planner

Rehab Team:
- Physician
- Charge Nurse
- Intake Coordinator
- Admission Clerk
- Physio/OT

Handoffs from the process

If the aim was to improve flow through inpatient rehab, then adding a team member from Home Care or an SPC might be appropriate
How is this possible!

2.3 Is Communication Important in Healthcare?

Root causes of sentinel events (all categories; 1995-2005)

Communication
Orientation/training
Patient assessment
Staffing
Availability of info
Competency/credentialling
Procedural compliance
Environment safety/security
Leadership
Continuum of care
Care planning
Organization culture

The evidence is clear that communication failures lead to adverse events. Sentinel events are preventable adverse events that result in serious injury or death.

Communication failures were:
- The largest contributor to wrong site surgery and delays in treatment
- The second-most-common cause for medication errors, patient falls, and adverse events during and after an operation
- The third-largest contributor to restraint deaths and adverse events involving ventilated patients
Communication Tools: SBAR

**Situation** (What is going on with the patient)

**Background** (Give brief history, relevant context)

**Assessment** (What do you think the problem is?)

**Recommendations** (What do you need & in what time frame? What would you do to correct the problem)
Team Video: Ineffective Communication

https://www.youtube.com/watch?v=NBNrYOBFWDs

• What did you see?
• What were some barriers to collaborative discussion?
• What could have been some enablers?
Team Video: Effective Communication

https://www.youtube.com/watch?v=1r31pL1aZDQ
Not just the TOOLS but…..

- HOW the team is working together
- Process > tasks of communication
- Exchanging information ABOUT the communication itself
- Reflective > reactive
- Align intent and impact of communication
- All team educated and reinforced with follow-ups
IP Models of Care

• *Mutual* respect
• *Role understanding* versus scope of practice
• Shared leadership
• Interprofessional staffing mix
  – Variety of professions to meet patient needs, including new roles
• Common goals & integrated care plan
• Some co-location
IP Models of Care

• Care co-ordination (e.g. multiple appointments with various team members)
• Specialized roles for care coordination (e.g. navigator, service co-ordinator)
• Team “meetings”
• Blend of face-to-face and technology
IP Models of Care

- Case reviews for complex patients
- Rounds/huddles (e.g. attendance should vary according to patient need and consider including other roles such as the administrator/receptionist)
- Reflection, reflection, reflection (e.g. business meetings, rounds etc.)
- Debriefing
- Socialization
IP Meetings

“Stroke unit teams should conduct at least one formal interprofessional meeting per week to discuss the progress and problems, rehabilitation goals…”

Canadian Stroke Best Practice Recommendations, 2015
Shared decision making

“It is recommended that rehabilitation plans be patient–centered based on shared decision making, culturally appropriate, and incorporate the agreed upon goals and preferences of the patient, family, caregivers and the healthcare team (Evidence Level C)”

(Canadian Stroke Best Practice Recommendations, 2015)
Team Norms

• Team norms are a set of rules/guidelines that a team establishes to shape the interaction of team members with each other and with employees who are external to the team.

• Once developed, team norms are used to guide team member behavior. Team norms are used to assess how well team members are interacting.
I’m sure glad the hole isn’t in our end...

We are all in the same boat.
Additional Resources

- Creating the Health Care Team of the Future: The Toronto Model of Interprofessional Education and Practice, Book
- http://www.cihc.ca/
- www.ipe.utoronto.ca
Thank you to the Centre of IPE at the University of Toronto for their contributions in the development of this presentation.

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