The whole team is greater than the sum of the parts: Partnerships in wound healing!

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Objectives

• Review the need for interprofessional teams
• Discuss the recommendation from the SCI BPG and on interprofessional teams (IPT) in pressure ulcer prevention and treatment
• Review the concept of patient centered care and IPT in the Canadian context
• Discuss concepts of self-management
WHO: Interprofessional Collaboration Strategy

• The World Health Organization (WHO) partners recognize interprofessional collaboration in practice as an innovative strategy that will assisting with the global health workforce crisis

• Collaborative practice can decrease:
  – total patient complications
  – length of hospital stay
  – tension and conflict among caregivers
  – staff turnover
  – hospital admissions
  – clinical error rates
  – mortality rates ¹⁻⁹
What do we recommend in SCI BPG on Pressure Ulcers
Interprofessional Teams

• The patient/family is the most critical aspect of the team
• Our role as team members is to ensure patients/families have been empowered with knowledge to make their own health care decisions
Interprofessional Teams

• We can no longer pay lip service to patient centered care
• Reflect on a patient who was labelled as non-compliant???
• Think about your own wished and reflect
Pressure ulcer prevention and the interprofessional team

• *Spinal cord injury interprofessional team*
  – Develop an interprofessional spinal cord injury team that includes, at a minimum, a physiatrist (or physician with spinal cord injury training), occupational therapist, physiotherapist, wound care clinician, nurse, psychologist, social worker, and dietitian
  – Include additional members as local resources allow
  – Ensure that all team members have knowledge of spinal cord injury and pressure ulcer prevention and care
    • Recommendation level III
Pressure ulcer prevention and the interprofessional team

• *Promote self-management*
  
  – Promote self-management for people with spinal cord injury.
  
  – Help them learn, consistently apply, and incorporate into their daily lives effective and appropriate pressure ulcer prevention strategies.

• Recommendation level IV
IPT assessment after development of a pressure ulcer

• Ensure that the interprofessional spinal cord injury team performs a prompt, comprehensive evaluation including the following:
  – Investigate underlying medical conditions
  – Identify recent changes in physical or mental status
  – Evaluate nutritional status
  – Evaluate microclimate management
  – Assess all support surfaces, lifts, and transfers
  – Review pressure redistribution strategies, repositioning schedules, and skin checks
  – Review posture and positioning in sitting and recumbency to identify changes and needs
  – Review current preventive strategies
    • Recommendation level Ib
CBS New York

• https://www.youtube.com/watch?v=7lWJfaxmA-k
Canadian Competencies in Patient Centred Care

• Practitioners seek out, integrate and value, as a partner, the input, and the engagement of the patient, client, family, community in designing and implementing care/services.
Canadian Competencies in Patient Centred Care\textsuperscript{10}

• To support inter-professional collaborative practice that is patient/client/family-centred, learners/practitioners need to:
  – support the participation of patients/clients, their families, and/or community representatives as integral partners alongside with healthcare personnel
  – share information with patients/clients (or family and community) in a respectful manner and in such a way that it is understandable, encourages discussion, and enhances participation in decision-making
Canadian Competencies in Patient Centred Care\textsuperscript{10}

- To support inter-professional collaborative practice that is patient/client/family-centred, learners/practitioners need to:
  - ensure that appropriate education and support is provided to patients/clients, family members and others involved with care or service
  - listen respectfully to the expressed needs of all parties in shaping and delivering care or services
Persistent isolationist or collaborator?  
The Nurses Role\textsuperscript{11} 

• My personal experience was my education was very uni-professional 
• That is not true of all nursing education many examples of interprofessional education 
• My experience with nurses in the MCIScWH program many come from the isolationist type of education 
• Many nurses are socialized in the uni-professional manner
Persistent isolationist or collaborator?
The Nurses Role\textsuperscript{11}

• Findings interprofessional collaborative practice research emphasize the importance of health providers to clarify roles to effective collaborative practice.

• How well can we articulate our roles to others?

• Personally I have seen that nurses have a greater difficulty articulating their roles to others
Persistent isolationist or collaborator?
The Nurses Role\textsuperscript{11}

• This what I had to do to convert myself to a collaborator nurse:
  – re-socialize myself to be part of collaborative teams;
  – understand and be able to articulate myr own role, knowledge and skills to others;
  – gain an understanding of roles, knowledge and skills of other health providers;
  – gain an understanding of where there are shared roles, knowledge and skills across their own and other health providers;
  – learn how to work in collaborative teams
Persistent isolationist or collaborator? The Nurses Role

- Nurses tend to perceive themselves at the lower end of a power hierarchy within the health system.
- Nursing is seen as quite a powerful juxtaposition to other professionals, and this includes physicians, from the perspective of non-nurses.
RNAO Best Practice Guidelines

Strategies to Support Self-Management in Chronic Conditions: Collaboration with Clients
Guiding Principles\textsuperscript{12}

- Self-management follow the principle that care is a client-led, nurse facilitated processes
- Client and family participation is paramount
- Care strategies tailored to the attitudes, beliefs, culture and preferences of client are needed
- Shift of power must occur from health care provider to client
Guiding Principles

- Establishment of a therapeutic relationship is paramount
- Focus on client-centred care
- Therapeutic relationship is an interpersonal process that occurs between the IPT and the client/family
- Purposeful, goal-directed relationship that is focused on advancing the best interest and outcome of the client is needed
- Therapeutic relationships begin on assessment as the practitioner establishes a rapport and obtains accurate information about the client’s context
Key assumptions: RNAO\textsuperscript{12}

1. Clients may need information and support for self-management about their health state, they are in control of these self-management decisions

2. Client’s need for support with decision making specific to their self-management is variable and should be individually tailored

3. Information and support for clients related to their self-management should promote care consistent with scientific evidence and client preferences
Key assumptions: RNAO\textsuperscript{12}

4. Collaborative relationships with clients and their families are critical to the success of self-management support

5. Self-management options depend on individual client’s circumstances, and availability of resources

6. This BPG is intended to promote the provision of evidenced based care of the highest quality related to decision and self-management support for adults with chronic disease

7. IPT member are one of several health care provider groups that are involved in providing self-management support
Recommendations

- IPT utilize the “5 A’s” of behavioural change approach of assess, advise, agree, assist and arrange, to incorporate multiple self-management strategies when supporting clients with a chronic illness to assist in improved outcomes

- LOE Ia
Assess

• IPT establishes rapport with clients and families. LOE III
• IPT screens for depression on initial assessment, at regular intervals and advocate for follow-up treatment of depression. LOE Ib
Assess

- IPT establishes a written agenda for appointments in collaboration with the client and family, including:
  - Reviewing clinical data
  - Discussing client’s experiences with self-management
  - Medication administration
  - Barriers/stressors
  - Creating action plans
  - Client education

- LOE IIb
Assess^{12}

- IPT consistently assesses client’s readiness for change to help determine strategies to assist client’s readiness for change with specific behaviours. LOE III
- IPT encourages clients to use health risk appraisal instruments; model use of such tools, and discuss the results of the risk assessment with them at regular follow up. LOE Ib
Advise

- IPT combines effective behavioural, psychosocial strategies and self-management education processes as part of delivering self-management support. LOE Ia
- IPT utilize the “ask-tell-ask” (also known as "Elicit- Provide-Elicit") communication technique to ensure the client receives the information required or requested. LOE III
Advise₁²

- IPT uses the communication technique “Closing the Loop” (also known as “teach back”) to assess a client’s understanding of information. LOE III

- IPT assist clients in using information from self-monitoring techniques (e.g., glucose monitoring, home blood pressure monitoring) to manage their condition. LOE Ib
Advise\textsuperscript{12}

- IPT encourages clients to use monitoring methods (e.g., diaries, logs, personal health records) to monitor and track their health condition. LOE III
Agree\textsuperscript{12}

- IPT collaborates with clients to:
  - Establish goals;
  - Develop action plans that enable achievement of goals; and
  - Monitor progress towards goals.

- LOE Ia
IPT members who are appropriately trained use motivational interviewing with their clients to allow clients to fully participate in identifying their desired behavioural changes. LOE Ia

- IPT teaches and assist clients to use problem-solving techniques. LOE Ia
IPT members are aware of community self-management programs in a variety of settings, and link clients to these programs through the provision of accurate information and relevant resources. LOE Ib
Arrange

- IPT members arrange regular and sustained follow-up for clients based on the client’s preference and availability (e.g., telephone, email, regular appointments). IPT and clients discuss and agree on the data/information that will be reviewed at each appointment.

LOE Ia
Recommendations

INNOVATIVE DELIVERY MODELS

IPT use a variety of innovative, creative, and flexible modalities with clients when providing self management support such as:

– Electronic support systems
– Printed materials
– Telephone contact
– Face-to-face interaction
– New and emerging modalities

• LOE IIb
Recommendations¹²

INNOVATIVE DELIVERY MODELS

- IPT tailor the delivery of self-management support strategies to clients’ culture, social and economic context across settings. LOE Ila
- IPT facilitate a collaborative practice team approach for effective self-management support. LOE Ib
MCISC Wound Healing

• Distance Education, 1 year program
• Interprofessional clinical masters
• Western University, London, ON
• Email me if you are interested
• kcampbel@uwo.ca
• Spots available for September 2013
• Come to London if you love wound healing!!
Questions?
References


References


