Behind closed doors: rehabilitation team members' experiences of case conferences

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Research question:

How do rehabilitation team members collaborate with other members of their team?

Literature on teams & interprofessional practice:

- **tends to focus on education, task & organisation apsects**
- **less focus human experience**

Aims of presentation:

- **to highlight differences between case conferences in different teams**
- **to emphasise the potential for dialogue about preferred approaches to collaboration**

Background:

- **Rehabilitation teams:** medicine, nursing, PT, OT, SP, SW & Psych
- **Case conferences:** discuss, plan & coordinate patient care
- **Benefits of collaboration:** improved patient services and job satisfaction
- **Collaboration requires:** understanding of purposes and processes, and contextual and interprofessional challenges addressed
- **Contextual challenges:** work load, pressure to discharge, staff shortages
- **Interprofessional challenges to collaboration:** hierarchy, autonomy of health professional & different perspectives and language used by different disciplines
- **Case conferences:** phenomena of complex of human interactions

Literature examples highlighting complexity:

Nair & Wade (2003) – Team members reported congenial atmosphere, satisfaction with process, but would like more opportunities to participate

Pryor (2003) p. 345 – Recommended that priority be given to the:

‘*development of strategies to maximise effectiveness of the team as a synergistic whole as well as the effectiveness of the individual professions’*

Case conferences:

- team members' experiences not discussed

Interviewer: ***How does the team deal with changes to team membership?***

Team leader: ***I don't know. I can't answer that. I've got no idea. I don't know, I'm probably wrong but I don't perceive it to be a major issue. I don't know.***

- potential for dialogue, reflection and development of collaborative practice

Methods:

- qualitative methodology
- observation of case conferences of 9 rehabilitation teams were observed
- semi-structured interviews with 49 team members
- participants included medical, nursing and allied health staff
- interviews were transcribed
- NVivo software programme NVivo was used to manage data
- data were thematically analysed
- descriptive & interpretive differences identified

Descriptive differences:

- structure of team **processes**
- **timing** and length of meeting
- number of **patients** discussed
- **number** of team members
- **disciplines** at the case conference

Interpretive differences:

- what is **brought to** the meeting
- what is **shared at** the meeting
- what is **taken away** from the meeting

What is brought to the meeting:

- awareness of organisational constraints
    - pressure to discharge
    - team members' issues with time
    - department allocation of team members
    - co-location of team members
- discipline/professional qualities
- team stability
- personal qualities
- style of leadership
- team history
- focus of case conference

What is shared at the meeting:

- discipline and personal perspectives
- understandings of particular patient situations
- patient stories
- humour
- food

What is taken away from the meeting:

- developing understanding of rehabilitation
- understanding of team direction for particular patients
- understanding own direction for particular patients
- understanding of own role and others roles in rehab
- understanding of teams and teamwork

What is brought to the meeting:

- pressure to discharge patients, or flexibility with discharge

(RN) Alice: ***Sometimes I feel like I'm a baddie. I mean sometimes I'm sure that they look at me as though I'm a cold hearted person because I keep saying "discharge date".***

(PT) Erin: ***There really are no rehab goals at this point in time for that particular person. So, we'd be talking in that case about a process of disengaging and getting her to re-engage with more appropriate services.***

What is brought to the meeting:

- team members' time issues

(Dr) Vic : ***(We aim to) get it shorter, get it more precise, get a plan, cut the waffle.***

(Dr) Al: ***Sometimes it's really important to let therapists actually vent it. … I really think that you can't just say 'bang, bang, bang, bang' 'cause it's just not as comfortable for the team.***

(SP) Cindy: ***I guess a disadvantage of teams is that sometimes people can talk about their own discipline for an extensive period of time when we might not need that much information.***

(SP) Wendy: ***I think if someone needs to be talked about and ideas need to be floated then it's pretty typical that there's no hurry about making decisions. You just need to sort of throw everything in the pot, and mix it up a bit and then work out what best next step is.***

(Rehab Ass) Carl: ***Time taken can be a bone of contention because we can talk about clients for too long, and it tends to go around and then it'll come right back to the start and start again.***

What is brought to the meeting:- -

- stability of team

'Incoming' team members

Team characteristics may influence the experience

(OT) Meg: ***It was a very friendly team to join and everyone was very welcoming, very friendly and seemed to be happy to have me.***

(SP) Mandy: ***Initially it was quite overwhelming because everyone was quite set in their ways in the team. Initially everyone was relatively welcoming, but it was the sort of team that you had to prove yourself.***

Individual characteristics of team members may influence the experience

(OT) Nell: ***I'm quite a shy person in a group situation. I'm a bit scared to open my mouth. It probably took me a few months actually to feel comfortable. I guess it still depends on the day what I'm feeling as to whether I feel like opening my mouth.***

What is brought to the meeting:

- stability of team

Remaining team members

(Dr) Lindy: ***You just adapt as it goes. Every person has a different personality and different approach and its just working out how to best work together.***

(Dr) Vic: ***My rule is very simple actually, if they're still there after 6 months I remember their name.***

What is shared at the meeting:

- focus of the case conference

- a forum for
  - sharing how the patient had progressed
  - sharing ‘where they are at’
  - piecing together information to build a ‘whole’ picture
- or a forum to
  - set discharge date
  - formalise discipline goals

What is shared at the meeting

- discipline and personal perspectives were shared

(OT) Debbie: ***I think if you're prepared and if you've done the work before you go into the case conference then if you're questioned you are able to provide the right foundations of your decision making to support what you're saying. Being prepared I think is really important.***

(SP) Penny: ***I don't have to prepare other than take a few minutes to think about what I've been doing with the patient that week. I guess I'm pretty old hand at it now.***

(RN) Diane: ***There are some people I would not allow in the meeting because they would just wreak havoc, but there are others that will work with the team, so I guess there are those that work with the team and those that work against it.***

What is shared at the meeting:

- humour

(PT) Erin: ***Little stories come out, we've got to have a laugh at them too because the rest of the week we tear our hair out about them. … I think this is a place where you can burn out very quickly if you don't allow yourself to laugh at some of what's going on.***

(RA) Carl: ***You need a little bit of humor as long as it's not taking away from the person you're talking about. Some people pay out on clients if you know what I mean. It sounds a bit iffy to me.***

What is shared at the meeting:

- food

(MD) Sam: ***The tea and coffee loosens up people, so it's like a nice interaction. They share, they cut pieces, they look at each other when you give it them and say thank you. So it's like a start of a friendly atmosphere.***

(SW) Jude: ***We're not saying that we can't have lunch. I think we've become a less relaxed team, I think we've become a bit more formal. When the lollies were around, there was this sense of food's OK kind of thing and sometimes (team members) used to bring lunch, whereas that doesn't happen as much now.***

What is taken away from the meeting:

- Understandings & affirmation

(OT) Leeanne: ***I get a lot of direction from the team. Like during the meeting today, I wanted to know whether the physio's goal was for this person to walk, because if it's not I then have to start looking at wheelchairs and access, so from the information given I can then work out well what's my next step.***

(SW) Josie: ***I remember when I was slowly working towards knowing what other team members did, its almost like you need a bloody manual, an orientation manual because you have no idea.***

(RN) Diane: ***I don't get warm fuzzies from these guys (laughing). We don't do group hugs here (laughing). The guys really aren't into that. But no you do get positive feedback particularly from the consultants about a job well done if we have done a job well.***

Conclusions:

- No ‘one size fits all’
- Balance the needs of organisation, team and members
- Engage in dialogue about:
  - What is brought to case conference
  - What is shared at case conference
  - What is taken from the case conference

Questions to guide reflection and dialogue:

- What are the features of the current team?
- What are the organisational constraints we are working within?
- What do we bring to the meeting?
- What do we share at the meeting?
- What do we take away from the meeting?
- How could it be otherwise?