

If you would like to contribute to the art and science section contact: Gwen Clarke, art and science editor, Nursing Standard, The Heights, 59-65 Lowlands Road, Harrow-on-the-Hill, Middlesex HA1 3AW. email: gwen.clarke@rcnpublishing.co.uk

Continuous care across teams: Principle of Nursing Practice G

Platt M *et al* (2011) Continuous care across teams: Principle of Nursing Practice G. *Nursing Standard*. 25, 34, 31-33. Date of acceptance: February 23 2011.

Summary

This is the eighth article in a nine-part series describing the Principles of Nursing Practice developed by the Royal College of Nursing (RCN) in collaboration with patient and service organisations, the Department of Health, the Nursing and Midwifery Council, nurses and other healthcare professionals. This article discusses Principle G, the need for nurses to work collaboratively with other healthcare professionals to improve patient outcomes.

Authors

Mark Platt, policy adviser, patient and public involvement, Lynn Young, primary healthcare adviser, and Amanda Cheesley, long-term conditions adviser, RCN, London.
Email: mark.platt@rcn.org.uk

Keywords

Care plans and care planning, interprofessional relations, nursing care, Principles of Nursing Practice

These keywords are based on subject headings from the British Nursing Index. For author and research article guidelines visit the Nursing Standard home page at www.nursing-standard.co.uk. For related articles visit our online archive and search using the keywords.

THE SEVENTH Principle of Nursing Practice, Principle G, reads:

‘Nurses and nursing staff work closely with their own team and with other professionals, making sure patients’ care and treatment is co-ordinated, is of a high standard and has the best possible outcome.’

Principle G focuses on the ability of nurses to work in an integrated way with colleagues across a care pathway to ensure that the patient is at the centre of each interaction and decision, and that their experience of care is as important as the desired outcome.

The rationale underpinning Principle G is to ensure that communication within, across and between teams is coherent, consistent and comprehensible, and that all interaction between those who provide care and those who receive it contributes to care being compassionate and holistic.

Care is being delivered increasingly by a number of different individuals, who may be employed by a variety of organisations, with different responsibilities and organisational cultures. For example, diagnostic tests may be carried out by one provider, while follow-up treatment may be provided by another, perhaps in a different location. Care might span acute and community services. Patients being cared for in their own homes often receive services from both health and social care organisations, and these may include public and private providers.

The introduction of personal health and social care budgets has added complexity, with people managing their own care arrangements and some employing their own care staff. This places greater demands on those providing care, requiring that a number of staff from different disciplines and often from a diverse range of organisations are committed to working collaboratively to ensure that Principle G is realised (Department of Health (DH) 2011, Social Care Institute for Excellence 2011).

Principle G requires that, from the outset, the trajectory of care should be planned with the patient and that where possible, without compromising outcomes and standards of care, interventions should be reduced to a minimum. A good illustration of this point is that care should be planned with the aim that a patient attends the fewest appointments at the fewest locations.

Each patient's care plan should be underpinned by the objective that his or her goals, aspirations and autonomy are respected. This is in line with the key principle of shared decision-making: 'no decisions about me without me' (DH 2010a, Elwyn *et al* 2010). Collaborative working requires accurate and up-to-date record-keeping. Where different care providers are involved, information technology systems should be inter-operable. This requires information-sharing agreements between all relevant staff, with issues of confidentiality being agreed by staff, patients and, where appropriate, carers.

Implementing Principle G in practice

Ensuring that Principle G becomes part of normal nursing practice requires the establishment of agreed shared areas of practice between healthcare professionals, which are underpinned by robust communication systems and processes. Shared and joint assessments, where care planning is performed with the full participation of patients and carers, are the start of the process. For most patients the identification of a named care co-ordinator who takes responsibility for overseeing the care plan is the best approach. The care co-ordinator, or named key worker, should be easily accessible and should ensure that patients, and families or carers where relevant, are at the centre of the process. All relevant members of the care team must be directly involved and key contacts should be identified in teams providing ancillary services.

One example is of an older patient receiving specific nursing care, but also receiving domiciliary care from the social services department of a local authority. All those concerned with delivering the patient's care should be aware of the details of the care plan, its timeframe and the desired and anticipated outcomes. Care provided should be reviewed regularly and adjusted, according to the patient's changing health and preferences. By listening to and encouraging feedback from patients and carers, nursing staff can ensure that those in their care feel included in the process.

Measuring outcomes

If performed collaboratively and effectively, care planning can be an excellent basis for outcomes measurement. Many clinical departments routinely establish outcome measures such as estimated length of stay or number of visits for specific conditions, episodes of care or

treatments. If this approach is used effectively it can deliver successful outcomes for both patients and providers. Costs and savings can also be measured using this methodology. Where there is an established care pathway for a specific diagnosis, for example stroke or fractured neck or femur, timescales and milestones can be built into the pathway and measured.

Outcome measures are successful only if all staff use them effectively and consistently, baselines are established and review mechanisms exist so that progress can be measured. Everyone involved in the care process, not least the patient, must agree the desired outcomes from the start, and regular reviews should be conducted throughout the care trajectory to ensure that problems are identified and managed quickly.

There is a range of well-established outcome measures that are linked to improved function, mobility, mood and quality of life. These include the Barthel Activities of Daily Living Index (Mahoney and Barthel 1965), Canadian Occupational Performance Measure (Law *et al* 2005) and Therapy Outcome Measures (Enderby and John 1997). Nurses should be comfortable with using patient reported outcome measure systems (Royal College of Nursing 2011) and with listening to what patients say about their care.

Case study

The practical application of Principle G is best illustrated by the Somerset Primary Link service, part of NHS Somerset, a nurse-led referral management service for urgent hospital referrals made by GPs. The service works by assessing at referral whether a patient needs hospital care or can be better supported with a package of care provided in the home.

If a patient is assessed as needing hospital care, the nurse making the assessment will select the best location for the individual, either a community or a district hospital for which the referral service has bed availability information. The referring nurse will also make the admission arrangements, including transport. If home care is needed, the Somerset Primary Link clinician will liaise with community nursing, general practice or the local authority to arrange it.

The service has reduced hospital admissions and freed-up time for GPs and district nurses. The referring nurse communicates directly with the patient, thus ensuring clarity about what is being planned and generating high levels of patient satisfaction. Additionally, and to support the promulgation of good practice, the service offers an information service for organisations keen to find out more about its successful approach.

Taking Principle G forward

If care services are to be of a consistently exemplary standard they must be regularly and rigorously evaluated, with feedback from patients at the centre of the evaluation. This will be crucial as the NHS and social care services become more diffuse in their structures, where more services are likely to be delivered by different and numerous providers, and be commissioned by public authorities rather than directly provided or managed. The numbers of organisations providing care is likely to increase, and clear and understandable communication will be vital to ensure that patient outcomes, now identified as the key measurement of health and social care practice, are met and improved (DH 2010a, 2010b, 2010c).

The involvement of patients in the development and provision of their care is essential to promote

optimum patient outcomes and to improve the quality of care provided by the NHS (DH 2010a, Elwyn *et al* 2010). This will necessitate clear and effective communication both with patients and between the professionals and teams providing their care, regardless of how many different organisations are involved.

Conclusion

While recognising that multidisciplinary and cross-organisational working is not easy or simple, Principle G sets out for nurses and other care staff the core elements that should be addressed. Ensuring that everyone knows what is being sought, who is responsible and, fundamentally, that the patient is at the centre of care planning, will ensure better outcomes for all concerned **NS**

References

Department of Health (2010a) *Equity and Excellence: Liberating the NHS*. DH, London.

Department of Health (2010b) *Transparency in Outcomes – a Framework for the NHS*. DH, London.

Department of Health (2010c) *A Consultation on Proposals – Transparency in Outcomes: a Framework for Adult Social Care*. DH, London.

Department of Health (2011) *Personal Health Budgets*. www.dh.gov.uk/en/Healthcare/Personalhealthbudgets/index.htm (Last accessed: April 7 2011.)

Elwyn G, Laitner S, Coulter A, Walker E, Watson P, Thomson R

(2010) Implementing shared decision making in the NHS. *British Medical Journal*. 341, c5146.

Enderby PM, John A (1997) *Therapy Outcome Measures: Speech and Language Therapy*. Singular Publishing, San Diego CA.

Law M, Baptiste S, Carswell A, McColl MA, Polatajko H, Pollock N (2005) *Canadian Occupational Performance Measure*. <http://www.caot.ca/copm/index.htm> (Last accessed: April 7 2011.)

Mahoney FI, Barthel D (1965) Functional evaluation: the Barthel Index. *Maryland State Medical Journal*. 14, 56-61.

Royal College of Nursing (2011) *PROMS: Patient Reported Outcome Measures – The Role, Use & Impact of PROMs on Nursing in the English NHS*. www.rcn.org.uk/__data/assets/pdf_file/0009/355248/PROMs_Briefing_-_Revision_2_2.pdf (Last accessed: April 7 2011.)

Social Care Institute for Excellence (2011) *Think Local, Act Personal: A Sector-wide Commitment to Moving Forward With Personalisation and Community-based Support*. <http://tiny.cc/puttingpeoplefirst> (Last accessed: April 7 2011.)