

Changing to a client-focused quality service through more effective team work

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ABSTRACT

The Mary Marlborough Disability Service, a specialist NHS unit providing non-acute support which enables people with physical disabilities to lead independent lives, established an inter-disciplinary team which addresses any problem of relevance to individuals which might affect their daily existence, social life, work, education or leisure pursuits. Three areas of change were identified: 1. the style of service, 2. its effectiveness, and 3. its efficiency. It was found that, although the unit perceived itself to be working as team, there were major operational difficulties which led to lack of cohesion and communication. As the unit was resistant to change, a clinical coordinator experienced in the field of disability was seconded to the unit to guide the necessary changes, and a number of lessons were learned.

FULL TEXT

Introduction

The majority of health services for people with physical disabilities are focused on recovery from an acute episode of illness or trauma. For people who have long-standing or congenital disabilities this rehabilitation model is not always appropriate. What is needed is specialist support to enable people to live with their disabilities. This support needs to come from a number of agencies of which the health service is one. The Mary Marlborough Disability Service, formerly known as Mary Marlborough Lodge, has provided such a specialist enablement service within the NHS for the last 30 years. Its original purpose was as a half-way house for people recovering from poliomyelitis. Over the years, as local services for disabled people have developed, the unit has expanded its service to cater for people of any age and any diagnosis which results in severe and complex physical disability. The unit's inter-disciplinary team collaborates to address any problem of relevance to the client from getting out of bed to going fishing. Its special facilities include a large rehabilitation engineering department which can modify or manufacture customized equipment to assist or replace weak, paralysed or missing limbs. It deals with approximately 1,500 people per annum and as their needs are complex often two, three or four staff at any one time may be committed to an assessment which could take a full day to complete. In 1992 the unit found itself in major difficulties.

Background

The unit had no line management as such and, although the medical consultant acted as director, he had no designated budget or clear management responsibility or accountability for the staff working within the service (40 whole-time equivalents). It had remained relatively unchanged since its opening. The unit's reputation was good within the field of rehabilitation. However, there were concerns as practice was beginning to be out of step with changing attitudes about disability and there were some reservations about the quality of the service. Added to this, facilities and equipment were out of date and the skill-mix needed review. As a small, highly specialized supra-regional service the unit suffered greatly as a result of the NHS reforms when it entered the internal market as part of a first wave trust in 1991. The trust board was under pressure to make radical changes as by the end of the first

year the unit was running at a loss of approximately L400,000. Its total running costs were L1.3 million. In order to determine the most appropriate means of managing this very specialized unit which was fairly autonomous within the Trust and where many of the staff had over 20 years' service and were quite understandably resistant to change, a project was established. A senior clinician (the hospital's head occupational therapist with experience in the field of physical disability) was seconded for a period of 12 months to guide the service through internal review and change. The position was entitled Clinical Operations Co-ordinator, the term "manager" being deliberately avoided.

Operation of the service

At the beginning of the work described below, the unit functioned mainly on a residential basis and the majority of clients were admitted for a period of approximately two to three weeks. There were 18 beds and admissions could be on any day of the week although it was usually Sunday or Monday. Assessments took place during the first week of admission by each member of the inter-disciplinary team individually. Each professional used their own assessment forms and identified their own goals. Up to five individual assessments could identify as many as 25 different goals. A team meeting was held on a weekly basis in an attempt to co-ordinate the treatment plan. It was possible for clients to be in the unit for up to a week before a clear plan of treatment had been formulated. After the treatment plan had been agreed any of the following could take place, all of which were aimed at minimizing disability:

- * investigations and treatment;
- * teaching of techniques of lifting and handling to carers, etc.;
- * trying out equipment;
- * manufacture of customized equipment;
- * training and practice in the use of new equipment or techniques.

Problems

There was no way of knowing in advance of the clients' level of dependence and at times some members of staff were very heavily overstretched. This led to tensions within the team and frustration for the clients. Following discharge a comprehensive report was sent to the GP, the client and others involved in their care.

Although the unit had perceived itself to be working as a team, it became obvious that there was a lack of cohesion and communication. The issues involved were complex and a number of operational and attitudinal changes were needed. To help implement some of the procedural changes, the clinical co-ordinator worked with the local NHS Clinical Audit Service. Using an external facilitator in this way proved to be very successful as many of the ideas which were implemented had been attempted previously within the service but had met with scepticism and rejection.

Methods

In 1986, prior to the health service reforms, an audit was undertaken which highlighted deficiencies in the service, but no action was taken. Early in 1992 a small retrospective medical audit pilot project was undertaken looking at the outcomes of treatment. Respondents highlighted the following problems (as shown in Table I): (Table I omitted)

- * clients were bored and frustrated – they were waiting for long periods of time during the standard two-week stay and they did not understand why;
 - * the equipment supplied by the unit was not always suitable for the home environment;
 - * the recommendations for equipment to be provided by local social services were not always implemented.
- Consultations took place with staff, patients' carers, three major disability groups and local purchasers. These discussions identified that there was:
- * an unco-ordinated approach to clients;
 - * poor workload planning;
 - * poor communication between staff;
 - * lack of information about the home environment and community resources;

* concern about the medical model of service delivery currently in use.

Goal setting

At the outset of the project the clinical coordinator held an away-day with the whole team which agreed the aim of the service, its values and its vision for the future. These then acted as guiding principles for the duration of the work detailed in this article.

Three main steering groups were established with a mixture of disciplines and grades. The groups met regularly and established goals which covered: workload planning, facilities and future developments.

Workload planning

Aims:

* To produce a multidisciplinary assessment form with common, client-centred goals to improve the effectiveness of the team. A steering group was set up comprising an occupational therapist, the clinical co-ordinator, a physiotherapist, a doctor, a nurse and the audit adviser - this group drafted a form. Each discipline brought with them a copy of their own assessment form and after discussion the minimum essential areas of common interest were agreed. Three members of the steering group (OT, nurse and clinical audit adviser) then met to produce a first draft of a multidisciplinary form. Ownership of the form was achieved by encouraging all the staff to take part in the evaluation process, and then redesigning the form in response to the comments received. Over a period of four months the form was systematically refined, after which time all members of staff were using it, including the medical staff.

* To produce a self-assessment pre-admission form which would help both with workload planning and also with gathering information about the home and local community. The staff knew exactly what information was required and the first evaluation showed the form to be working very well. It has been in constant use ever since with regular updating, to take account of changing circumstances. The form enables information to be collected on: key workers in the local community; the individual's care needs and levels of dependence.

Facilities

Aim. To de-institutionalize present accommodation, particularly improving accessibility, decor and function. The steering group looking at facilities knew what was needed and worked with an interior designer to plan the unit's refurbishment. It also identified equipment to the value of £200,000 which was needed to upgrade the demonstration equipment. The trust board supported the refurbishment plans using trust fund moneys although the future of the unit was still unclear. This tangible demonstration of commitment was a major boost to staff morale and did much to allay the fears of visiting clients who over the years had come to depend on the service. A case of need was successfully submitted to the Regional Health Authority and new equipment was ordered.

Future developments

Aim. To determine the future direction of the service and to produce a strategy for its implementation. This group produced an imaginative plan which reduced the need for unnecessary hospitalization of clients by offering an outreach service which would operate within a 60-mile radius. Acceptance of this plan led to the closure of 14 of the unit's 18 beds, but no compulsory redundancies. The impact of this proposal was a reduction in staffing levels of 20 posts, the majority being nurses. As the unit formed part of a large orthopaedic hospital, staff who did not opt for early retirement were all redeployed elsewhere in the hospital. Although the bed closures were the most painful part of the whole restructuring exercise, there is unanimous agreement that this is the direction the unit should have taken long ago and it was its failure to recognize this need that was symptomatic of its myopic stance at the outset.

By the end of the steering groups' work, where the outreach service was not appropriate clients were only admitted on Sunday or Monday. One major assessment is then carried out by the whole team prior to the team meeting on Tuesday morning. Sensitive information and discipline-specific information are taken separately. The problems identified are client-focused and the aims of admission are agreed with the client. The team meeting coordinates the plan of care and agrees the discharge arrangements.

Results

The original medical audit was not repeated as the pilot showed that patients had been upset by what they perceived as insensitivity in some of the medical questions. Instead a simple patient satisfaction questionnaire was developed to be filled in at the end of the admission. This is used to monitor quality after the introduction of the new forms and shows that the internal organizational issues had been addressed (see Table II). (Table II omitted)

To assess the external issues a post-discharge questionnaire has been developed.

A pilot showed that problems are being addressed satisfactorily, the report is useful to the client, the suggestions made are helpful and the general experience of being an inpatient is better than before. There has been a significant reduction in the length of the average in-patient stay from 11 days to six days.

Conclusions

The following conclusions were revealed:

- * The use of the multidisciplinary assessment form has improved communication within the team and been instrumental in increasing the effectiveness of the service which has led to a significant reduction in the average length of stay (from 11 to six days) (see Figure 1). (Figure 1 omitted)
- * Satisfaction surveys of those admitted to the unit have shown clients to be very happy with the service, and boredom no longer to be an issue.
- * The pre-assessment form provides contact names in the community which enables information on the home environment to be gathered. This is backed up by changes in the service delivery which has resulted in home visits being provided within a 60-mile radius of Oxford.
- * Work-load planning is now possible so that a balance can be achieved between heavily dependent and less dependent clients.
- * Report writing has been facilitated and is now more focused and concise.
- * Referrals to the restructured service are increasing.
- * The service is financially viable.
- * A new model of disability has been developed which introduces the concept of enablement into traditional rehabilitation models. This has helped in a skill-mix review.
- * Staff satisfaction and retention are high and the service is attractive for recruitment.

Further reading

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