Accountability in the multidisciplinary team

Much has been written on the benefits of using multidisciplinary teams to achieve positive outcomes in health care. Both the prevention and healing of wounds also requires multiple disciplines (e.g. medicine, nursing, dietary) working in concert to benefit the patient. A multidisciplinary team cannot work successfully if its members do not have good basic team skills. The need for all members of the team to be accountable not only to themselves but to the team is less understood. Hence, we will explore the importance of accountability in multidisciplinary teams in order to achieve optimal wound care.

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1. Describe the members and disciplines that create your multidisciplinary wound care team?

DL: I have worked in several wound care teams during my career, principally in the North East (when Professor of Surgery at the University of Newcastle upon Tyne), and currently in South Wales (as Visiting Professor at Cardiff University). In the first of these two groups the wound care team was formed in response to local needs and was mostly involved with referred surgical wounds, chronic wounds (the majority being leg and pressure ulcers) and those needing a diagnosis (which often involved an occult cancer). The vast majority of the work was through a weekly clinic and many of the patients seen were entered into local and multicentre research trials. For every 10 patients seen only one was usually eligible. It has been a privilege to work with Keith Harding in his Department of Wound Healing in Cardiff because the referral pattern is virtually national and involves every known cause of wound healing complication and presentation.

These two types of team represent different responsibilities. In a small wound care team there ought to be a doctor (a general or vascular surgeon with an interest perhaps) and a nurse, either of whom could manage a clinic alone. Both offer special skills — for example a surgeon can biopsy an ulcer of suspicious aetiology (although this is a skill easily learnt) and a nurse can initiate compression bandaging (I have yet to meet a surgeon who is competent in this skill). The larger wound care team can also offer advice for inpatients and 24-hour management, and because of the wider aetiology of wounds seen, needs a larger team which can include more specialist skills within it. The commitment is larger and ought to involve full-time staff who have been trained in wound care. Nevertheless both types of teams must depend on external specialist skills depending on the population of patients being catered for. This can extend to microbiologists, immunologists, geneticists, endocrinologists and interested surgical groups such as orthopaedic and plastic surgeons; podiatrists, rehabilitation experts, orthotists, infection control and tissue viability nurse specialists. This list is by no means exhaustive but all these groups need to have been approached and have agreed to support the concept of a wound management team. Few truly multidisciplinary wound teams exist as they must depend on this wide-reaching referral pattern, which is an important missing link in the NHS, bearing in mind that the cost of this care is now thought to be more than £3bn annually.

CMI: I am fortunate enough to work in two different locations and my experiences across both of these locations are very different. I primarily work at the University of Huddersfield where we have an outpatients podiatry service. The working of this clinic is largely uniprofessional, however, we regularly refer patients with foot ulcers to the district nurse/practice nurse for re-dressing appointments. Previously we would have referred

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patients requiring antibiotics to their GP for assessment and treatment; however, since the recent changes in medicines legislation, suitably qualified podiatrists can access and dispense broad-spectrum antibiotics. Additionally, we are able to refer patients directly to radiology should we require an X-ray. Furthermore the university clinic is equipped with the latest technology and diagnostic kit to predict a prognosis for wound healing, for instance the vascular assist, transcutaneous oxygen monitors and diagnostic ultrasound so patients can undergo a comprehensive assessment at the clinic. So while referrals are made to other disciplines we largely work in isolation at the podiatry clinic. In contrast, I also maintain an honorary contract with an NHS trust in North Yorkshire where I work in a diabetic foot ulcer clinic. This outpatient clinic is led by the consultant diabetologist, and his team of registrars, and specialist podiatrists. We also have access to the appliance department, radiology, diabetes specialist nurses, tissue viability nurses, orthopaedic and vascular surgeons and we regularly refer to practice or district nurses for wound care in the community. So we tend to work together as a team to optimise the management of our patients.

VAH: The membership of the multidisciplinary wound care team within my trust is dependant on the wound care needs the patient has at the point of assessment. This will include several or all of the following disciplines:

- The patient
- Tissue viability
- Nursing
- Podiatry
- Surgeon/physician
- Dietetics
- Dermatology
- Vascular
- Psychologist
- Palliative care
- Pharmacology
- Pathology
- Spinal injuries outreach.

AKF: Mental health services have largely forged ahead with holistic care and multidisciplinary working continues to develop. Our wound care team is fluid with core members who cover the trust and those that become part of it for specific patient's needs. The central members are myself as the full time TVN, three part-time dieticians, one of whom has a particular interest in tissue viability, inpatient services link nurses, physiotherapists and porters. Consultant psychiatrists and junior doctors contribute according to the treatment needs of their own patients. The continence nurse specialist and infection control nurse also feed in as requested. Nursing staff have more every-day input, as they are responsible for the ongoing care of their patients. Link nurses are identified for each clinical area, however, there is no-one to cover their work when they are on training days and support for education is variable due to changing clinical needs and priorities.

2. What were the precipitating factors that led to the creation of your multidisciplinary wound care team and how long has the team been functioning?

DL: The precipitating factors for me were first a personal interest in wounds and wound infection, second a perceived unmet need for multidisciplinary wound care, and third the belief that to move forward patients needed to be entered into clinical trials. In addition to this there is a national need for education for these patients and their carers as well as for the undergraduates in medicine, nursing and paraclinical specialties. Wound teams are often seen by management as an expensive luxury. Certainly in the North-East, the clinic, once established, was effective and over the 10 years I was there I supported many doctors and nurses. Many of the staff at the clinic went on to produce higher degrees and research related to wound care, but few have retained the interest. I am sad that there was no successor after I left.

CMI: The multidisciplinary diabetes foot care team has been established for about 15 years. Many similar teams were established in the early 1990s following the successes of Mike Edmonds and his team at Kings College London, whereby they demonstrated a team approach to the management of diabetic foot ulcers reduced amputation rates (Edmonds et al, 1986).

VAH: My trust does not have a dedicated multidisciplinary wound care team, however, we do recognise that each discipline has knowledge and expertise in different aspects of wound care prevention and management that can enhance the patient's wound care experience.

We have built up a respect for each other's knowledge and recognise our own limitations and therefore have developed effective communication links, which ensure that we can contact each other in a timely manner to deliver effective wound management. Formal multidisciplinary team meetings are regularly held for patients with complex wounds on wards and in primary care.

AKF: The creation of a full time post in mental health for a tissue viability nurse is unusual and arose from the recognition of changing patient vulnerabilities. Mental health services in Leicestershire were traditionally isolated from the general hospital. The move in the 1990s to community care saw the closure of old hospitals and development of services that enabled new provision in purpose-built units on acute hospitals sites. The result of this, however, has been that patients who previously were transferred to acute hospitals (for various physical complaints) are now nursed within mainstream psychiatry. Increasing longevity, in dementia care particularly, has seen an upsurge in physical ill health and frailty among those with mental health problems which increases the risk of pressure ulcer formation. In addition to this was poor diabetic foot care due to lack of knowledge as well as suturing and dressing wounds in A&E for wounds caused by patients who self-harm. These factors together demonstrated the need for a responsive wound care team that was on site and able to provide tailored training as well as clinical visits and advice.

Dementia care services have had a part-time TVN since 1999 and this became full time for the whole trust in 2005. The team continues to develop and we are fortunate that our counterparts at University Hospitals Leicester contribute their expertise when needed.

3. Which clinician(s) is (are) most often responsible for the coordination of the team?

DL: Throughout the UK there are many wound teams that function effectively in primary as well as secondary care. They do need tertiary referral centres, which are patchy in their distribution. In these tertiary centres any trained discipline could act as team leader but the ultimate responsibility usually rests on a medically qualified member, probably related to trust and defence union legal liabilities.

CMI: The diabetic foot care team in the NHS setting is largely coordinated by a joint initiative between the consultant diabetologist and the lead diabetes podiatrist.

VAH: In most cases it is the discipline to which the patient with a wound is referred to, unless after initial assessment and diagnosis by that professional it was deemed more appropriate for another discipline to coordinate care. Or it could be after initial assessment it is evident that the patient has been under the care of a particular discipline in the past and therefore it is more appropriate for that discipline to re-establish care for the patient.

Often a plan of care will include the need to call in a member of the multidisciplinary team as the patient's wound improves or deteriorates. In the case of a palliative care patient with a fungating wound, the coordinator of the team may be the nursing staff as they will be managing the day-to-day care of the patient and will call in appropriate disciplines as and when they require assistance with specific aspects of wound care.

AKF: Responsibility is very much shared. For non-complex referrals I may make recommendations for different team members to be contacted and involved in the patient's care but it is the ward team that make the relevant calls, the named nurse being accountable if this does not happen. This would be for simple interventions i.e. checking footwear fit. For more complex patients I would coordinate the team, discuss the patient's needs, suggest interventions and complications and follow up to evaluate effectiveness of care. I would assume responsibility for this, and be accountable for the prescribed treatment plan. Implementation, however, would be the responsibility of individual practitioners on the wards.

One of the difficulties with multidisciplinary teams is the lack of 'team liability' as a concept in law; all practitioners are accountable for their own practice, not just to themselves and their patient but also their colleagues. While other professionals decide their priorities, good communication with clear clinical rationales ensures a harmonised approach.

CMI: *There is a definite disparity between working in a university and the NHS. While CPD is encouraged at the university, I am aware that colleagues in the NHS have limited time and funds to update their skills...*

AKF: *Experience has shown that medical colleagues, while interested in their own patients, do not have a specialist interest in wound care, viewing it very much as a nursing arena.*

4. What activities are taken by members of your multidisciplinary wound care team to increase their knowledge in the management of wounds?

DL: All members of the wound care teams are involved both in the receiving and giving of education in the field. In addition, they virtually all contribute to research in the field. At last we are well blessed with societies and publications in this area of clinical medicine: for clinicians we have the European Wound Management Association, and European Pressure Ulcer Advisory Panel; for scientists we have the European Tissue Repair Society. There are many local and some national societies, that embrace sub-specialty interests, notably the Tissue Viability Society. Attendance of meetings, submission of higher research degrees by thesis and publication in specialist journals has raised the extent and quality of knowledge. All members of wound care teams are encouraged and supported to contribute. All this is well supported by industry which also produces vast amounts of clinical material. The Cochrane Collaboration has focused on evidence-based practice in this field and the National Institute for Health and Clinical Excellence (NICE) is producing guidelines of care with which trusts have to comply. The general knowledge of wound care in nursing is at its most developed, but in medicine in general this expertise is lagging.

CMI: Again, this is an area where there is a definite disparity between working in a university setting and working in the NHS. I am extremely fortunate to have access to an excellent staff development programme and I am regularly funded to attend national and international wound care conferences and continually update my wound care knowledge with formal training. However, while continuous professional development is encouraged I am aware that colleagues in the NHS have limited time and funds allocated to update their skills and knowledge. Indeed we recently held a lower extremity wounds study day at the university and I know of colleagues who had to take annual leave in order to attend. As part of this day we surveyed the 102 attendees and the majority (52%) of nurses and podiatrists who responded maintain their wound care knowledge and skills via CPD activities and conversing with colleagues (28%). Very few held a formal qualification in wound care.

VAH: Each discipline has access to training specific to their professional group and access to any tissue viability training available within the trust — regionally or nationally. In-house training is usually organised by either podiatry or tissue viability.

AKF: This is a difficult area and there are many competing mandatory study days for staff. This in turn leads to greater autonomy in the TVN role. This is not necessarily a positive thing as isolated working can be complex and there are many conflicting priorities in such a multifaceted and diverse organisation, particularly when it is a resource issue when there is only one TVN for the whole trust. In reality it is the nursing staff who are targeted to increase the knowledge base. Experience has shown that medical colleagues, while interested in their own patients, do not have a specialist interest in wound care, viewing it very much as a nursing arena. I feel strongly that all team members have a personal and professional responsibility to remain updated in this area of practice and where possible facilitate learning opportunities.

For nursing staff there is good provision of tailored study days and a new pressure ulcer prevention competency for both nurses and healthcare assistants. I also circulate relevant literature, information from websites, newsletter, link nurse updates and ad hoc training on site. Input from other professionals is relevant to their own specialist area and as such they maintain their own professional competency.

It would be useful to have regular time to discuss cases and evaluate team input and success but workloads prevent this and closer examination only occurs when something 'goes wrong'.

5. How does your multidisciplinary wound care team reach consensus on wound treatment?

DL: Continuous audit and up-to-date governance guidelines ensure that disagreements are minimised. At meetings, which are ideally multidisciplinary, such disagreements

can be resolved and the whole wound team has the opportunity to contribute. This has to take in new concepts found in local research and those learnt at meetings and in publications; the introduction of a journal club to governance sessions can be valuable. Ultimately responsibility has to be taken by a team leader who is also the coordinator but to ignore the opinions of the team would be foolhardy.

CMI: Patients' care plans are usually implemented after a comprehensive assessment on their first visit to the clinic or after a review, for example if the wound is not responding to treatment. Assessments are undertaken by podiatrists and therefore the patient care plan is largely developed by the specialist podiatrist in conjunction with the patient and their carers in the diabetic foot clinic. Often consensus is reached following discussion with other specialist podiatrists and the patient, or in cases whereby revascularisation is required or infection is present the diabetologist or his team are involved in the decision-making process.

VAH: Consensus on wound treatment is reached by regular joint assessment and reassessment of the patient and the wound and is reached using local, regional and national standards of care and formularies.

AKF: This is difficult for mental health staff as they are not routinely taught wound care as part of their training. Many ward nurses are therefore passive in the wound care decision-making process following the lead given by the link nurse or myself. Ownership of the treatment plan needs to be gained through explanation of clinical rationales and outcome measures as well as ensuring staff are clear about their role. Ultimately they are accountable for the treatment plan being followed through and alerting me to any problems, although I remain involved for more problematic cases.

Medical input in wound treatment decisions is less obvious. As a nurse prescriber I take responsibility for prescribing my own treatment, though conversely I am unable to prescribe maggots as they are not in the *British National Formulary* and we do not have a patient group direction for them. With prescriptions comes further professional accountability, not just from a treatment perspective but also financial. When making a decision about wound care that involves a more expensive option fiscal accountability combined with clinical-effectiveness are the drivers adhered to by myself and the team I work with.

Achieving consensus is either via the ward round or ad hoc personal review where a patient's care is discussed directly with the consultant and treatment options are considered.

6. How is conflict resolved by your multidisciplinary wound care team when there are different opinions on the optimal treatment of a wound?

DL: For the reasons given above any conflict should be unusual, but the final responsibility may have to be taken by consensus through the team leader, maybe after a 'vote'. When this occurs it probably involves, as examples, an aspect of social management such as the need for hospital admission when carers can no longer cope, or an unusual wound which needs the opinion of expertise outside of the group, such as the need to involve a psychiatric or a genetics opinion to look for a rare cause of delayed healing.

CMI: I think this largely depends on individual personalities within the team. It is important to remember that we all have a shared goal — to offer optimum patient care and where possible facilitate wound healing. Effective communication is vital to prevent conflict. Regular discussion between team members, especially before altering a patient's treatment regimen, is essential to avoid differences of opinion. Equally, if conflict has arisen, effective communication can help to resolve any issues. It is important to offer a rationale for your opinion, listen to the opinion of other members of the team and try to work with the patient and other professionals to offer unified care. If conflict goes unresolved it is the patient who will ultimately suffer.

VAH: Where there are different opinions on the optimum treatment of a wound, this is resolved through professional mutual agreement following a joint assessment or reassessment.

VAH: *Consensus on wound treatment is reached by regular joint assessment and reassessment of the patient and the wound and is reached using local, regional and national standards of care and formularies.*

CMI: *It is important to remember that we all have a shared goal — to offer optimum patient care and where possible facilitate wound healing.*

AKF: Conflict is not something I have yet experienced within wound care, probably due to my knowledge base being up to date when compared with our medics who are focused on psychiatric needs. I am, however, receptive to challenge and feel it is important as an accountable practitioner to have a clear evidence base and rationale for any clinical decisions. I also refer to more experienced colleagues who are specialists within their own field; any difference of opinion is discussed with the best interests of the patient being the primary concern. Within mental health we do not have the luxury of having more than one TVN, related fields such as infection control and continence sit well within the larger context and their advice forms part of the overall treatment plans where relevant. What we often find is each will refer patients to the other thereby promoting a more seamless communication and care package.

It is also important to view the role as providing transformational leadership. Empowering staff to make wound care decisions and implement successful treatment plans is a cornerstone of practice when striving to achieve multidisciplinary accountability.

7. Describe the benefits and potential liabilities for having a multidisciplinary wound care team.

DL: The benefits hardly need stating, as such large proportions of patients have wound care problems which are often suboptimally managed, incurring a huge cost to the NHS. Even if there is a willing multidisciplinary group it may be difficult to persuade management to pay for it and multidisciplinary groups are expensive. Nevertheless multidisciplinary teams are now mandatory in many clinical service frameworks; cancer management being the obvious example which has raised national care standards to the highest levels. So why not in wound care? A truly multidisciplinary team is probably not possible to achieve but a group of interested, experienced and dedicated doctors, nurses, and paramedical specialties can run a service but only when they are supported by appropriate interest from others, for example specialist surgeons, infection control and microbiologists.

CMI: Wound care is an area of clinical practice that is truly multi-professional. It is imperative therefore that medics, nurses and allied health professionals work in collaboration to optimise patient care. Unified care provided by a multidisciplinary team has many benefits: improved continuity of care, increased patient satisfaction, greater potential for education and training across disciplines, and improved possibilities for clinical research in wound healing (Gottrup, 2004). However, there are many barriers and potential liabilities to multidisciplinary wound care. Xyrichis and Lowton (2007) identified several barriers to multi-professional working in primary and community care including: separate bases or buildings which can limit team function, a lack of understanding as to who leads the multi-professional team can cause frustration and poor decision-making. Lack of organisational support has been attributed to feelings of concern and disappointment which can impact negatively on team-working, lack of time can hinder regular team meetings, poor communication, for instance change to regimens without discussion, could prove detrimental to patient care. Furthermore misunderstanding of each other's roles and professional stereotyping can promote conflict among team members.

Identification of potential barriers to effective team-working can instigate change to overcome such barriers and enhance and maintain teamwork, which can in turn optimise wound care provision.

VAH: The benefit of a multidisciplinary team is the joint knowledge from each professional enabling the optimum healing of a wound.

AKF: I feel the benefits to the patient are huge. Instead of an isolated practitioner with a limited sphere of knowledge they have access to a wide range of staff each of whom has a different area of expertise and can approach the presenting problem from a different viewpoint. The advantage of this would be the overall holistic view taken of the patient as opposed to the wound being considered in isolation.

As with anything, there is a downside. Communication needs to

be strong as does documentation. Elements of the team need to respect each other's contribution and all team members need to have a good understanding of their own accountability. The sheer volume of patients contributes to contact being made in stages and at different points in the treatment plan. This has the potential to delay patient care and mixing priorities if communication is not clear.

8. Do you have a multidisciplinary patient record and, if so, how successful is this and, if not, why not?

DL: Weekly audit and monthly governance sessions are mandatory for wound care teams. It need not be all-encompassing at every session and certain types of wound can be revisited on a 'rolling' basis. All patients in clinical trials are subject to intensive independent monitoring and with the advent of NHS IT systems and the picture archiving and communications system (PACS) this should be enhanced for all. Archived but easily accessible photographic records from the clinic are invaluable but expensive.

CMI: Currently we do not use a multidisciplinary patient record card at the university and we maintain our own podiatry records. Within the NHS we use the patients' hospital records, so in a sense they can be considered multidisciplinary but they are only accessible to healthcare professionals working in secondary care. Often we refer to our nursing or podiatry colleagues in primary care and therefore they do not have access to the patients' medical records. I have in the past worked closely with the district nursing team when caring for individuals with foot or leg ulcers and I have duplicated my notes within the podiatry record card and the district nursing notes. While this has meant extra work it certainly improved our communication and allowed us to coordinate patient care. Effective communication is imperative in the quest to offer optimum patient care. Members of the multidisciplinary team are often unable to physically meet to discuss patient care therefore access to a multidisciplinary patient record card could overcome many barriers in terms of poor communication across the wound care team.

VAH: We do not have a specific multidisciplinary wound care patient record, however, we have multidisciplinary care pathways, which are disease specific, and the medical notes or electronic multidisciplinary medical records in primary care. The disadvantage of medical notes is that the nursing staff in some areas have care plans that are specific to nursing care that are held separately to the medical notes. The advantages of multidisciplinary records are that the goals and treatment plans are visible to all disciplines.

AKF: We do have multidisciplinary records and overall I would consider them to be successful. The current documentation is a single assessment process whereby admission and assessment paperwork follows the patient from hospital to community thereby negating the need to repeat work previously done. It has the facility to be updated and record new treatment areas as they occur, as well as identifying risk factors that are medical, social or psychiatric.

From a nursing perspective it is useful to have all the relevant documentation, i.e. blood and X-ray results in one folder instead of having to hand search multiples. On the downside not everyone is subject to the NMC standards of record-keeping! **WUK**

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