CHAPTER 5

Interdisciplinary Rehabilitation Team

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LEARNING OBJECTIVES

At the end of this chapter, the reader will be able to

- Define the term ***interdisciplinary team***.
- Recognize the benefits of team collaboration.
- Discuss the roles of each member of the interdisciplinary team.
- Contrast various team models used in rehabilitation.
- Describe characteristics of an effective interdisciplinary team.
- Recognize benefits and challenges of working within interdisciplinary teams.

KEY CONCEPTS AND TERMS

Advanced practice nurses
Case manager
Collaboration
Collaborative discussion
Dieticians
Emotional intelligence
Group dynamics
Interdisciplinary model
Interdisciplinary teams (IDTs)
Medical model
Multidisciplinary model
Nurses
Occupational therapists
Physiatrists
Physical Medicine and Rehabilitation
Physical therapists
Psychologists
Speech-language pathologist
Social workers
Team competence

BACKGROUND AND HISTORY

Rehabilitation involves the successful and productive interaction of many stakeholders. The patient and family, physician, nurses, psychologists, therapists, social workers and case managers, dieticians, chaplains, payers, and, at times, even lawyers and employers are all collaborators in a process of joint decision making with a goal of achieving a sustainable outcome: return to the highest level of productivity possible for the patient. Central to contemporary rehabilitation philosophy, well-functioning **interdisciplinary teams (IDTs)** are critical for service integration and successful outcomes (Strasser, Uomoto, & Smits, 2008). The ever-increasing complexity of healthcare interventions and the myriad challenges that impede patients in their quest to return to productivity demand an interface between all healthcare professionals.

> *The interdisciplinary team continues to provide more combined knowledge and skill, clinical expertise, sensitivity, compassion, and understanding for individuals with disabilities than can be found in any other area of health care. . ..The individual team members each bring a unique perspective and expertise to the collective planning of the group. But the team shares similar goals for the patient.*
>
> *Easton, 1999, p. 31*

Ample evidence in multiprofessional, peer-reviewed literature supports collaborative practice as a strategy to produce optimal patient outcomes, and the IDT is one vehicle to implement that strategy. As early as 1900, interdisciplinary healthcare teams were active in the mission hospitals of India. In the United States the concept of teamwork was advanced by nursing theorist, Dorothy

Rogers (1932), as a means of achieving professional acceptance for nursing and allied health professionals. The IDT, as it is known today, emerged after World War II in response to the complex needs of wounded soldiers who survived injuries due to advances in medical care, such as antibiotics. The mandate to provide comprehensive treatment for service men and women with severe injuries and disabilities that could not be managed by a single-discipline medical model gave rise to the notion that multiple healthcare professionals could effectively and efficiently meet the needs of this population. From that point, the IDT (composed of all members of the treatment team as well as the patient and family) became the gold standard for the care coordination process. Eventually, the IDT became the cornerstone of a new field of medicine, **Physical Medicine and Rehabilitation** (Strasser et al., 2008), which focused on the restoration of patient capabilities.

Concurrently, in the 1950s social and behavioral scientists made substantial contributions to the structure, function, and process of small groups. Social psychologist, Kurt Lewin (1951), led the field of pioneers in **group dynamics** by proposing that a group is more than the sum of individuals in it. Lewin offered a context whereby well-functioning groups could be evaluated and proposed that effective group process could be taught and developed. This heralded the recognition that team leaders must possess particular skills. Today, it is accepted that interpersonal skills, including communication and negotiation skills, a willingness to compromise, and an ability to value and accept individual differences, are vital to the IDT process. Also understood is that effective team membership requires an awareness of one's own talents, limitations, and biases as well as an appreciation of the talents, limitations, and biases of other team members (Rossen, Bartlett, & Herrick, 2008).

Interest in interdisciplinary **collaboration** has exploded in the past two decades due to the increasing complexity of patient care and efforts to manage escalating healthcare costs. Research studies indicate that IDT collaboration enhances patient compliance, improves patient satisfaction, reduces costs, lowers mortality, reduces length of stay, and increases team member job satisfaction (Rubenfeld and Scheffer, 2010). That kind of efficiency is necessary in today's healthcare climate because consumers expect healthcare teams that are not only technically and emotionally competent, but that also are capable of blending professional boundaries when it is in the patient's best interest. Regulatory and accreditation bodies, such as the Joint Commission, Commission on Accreditation of Rehabilitation Facilities, state departments of health, and the Centers for Medicare & Medicaid (Box 5.1) have identified IDTs as necessary for patient safety and quality care, and each organization has specific criteria to demonstrate compliance related to IDT function.

BOX 5.1 Web Resources

The Joint Commission: http://www.jointcommission.org

The Commission for Accreditation of Rehabilitation Facilities (CARF): http://www.carf.org

Institute of Medicine (IOM): http://www.iom.edu

The IDT is widely accepted in healthcare today, particularly in the areas of mental health and rehabilitation. The goal of the IDT is to provide well-coordinated care by marshaling the talents of multiple professionals in concert with the patient (Bokhour, 2006). Healthcare consumers expect high-quality, transparent care with optimal outcomes. Because of a variety of available World Wide Web databases, consumers are able to "shop" for care that meets the necessary criteria. All payers, whether managed care organizations or government entities, challenge healthcare organizations to demonstrate efficacy and value. Maintenance of provider–payer contracts hinges on providing metrics that support the "value-added" benefit of IDT-based treatment programs. Ultimately, in an unpredictable economy it is imperative that multisystem interventions by an IDT use combined skills to meet the rehabilitative needs of patients with complex injuries to ensure optimal outcomes at the lowest cost in the shortest possible lengths of stay.

In the final analysis, the value of the IDT can be attributed to one basic fact: Decisions made synergistically produce higher quality solutions than those made independently (Gage, 1998). To become an effective member of an IDT, it is important to understand not only the origins of the concept, but the variety of team models, members, and their roles and how to achieve IDT competence and success.

BOX 5.2 Web Exploration

Visit this interesting website that offers articles, games, activities, and books about team building at http://teambuildingportal.com

TEAM MODELS

The healthcare field, like the corporate world, has identified that working together toward a common goal or project is cost effective and more productive than working individually. Looking for ways to improve quality and decrease the cost of health care has been an ongoing goal, and in pursuit of that goal four main models of professional teams have been developed and practiced over the years: medical, multidisciplinary, interdisciplinary, and transdisciplinary models.

Medical Model

In the **medical model** the physician directs all care (Figure 5.1). This model can be effective in physician offices and sometimes in acute care settings when few professionals outside of medicine and nursing are involved in the patient's care. It is not an effective model in rehabilitation settings because the philosophy and goals are not consistent with rehabilitation practice, which includes all levels and disciplines of staff working together, communicating treatment plans, and collaborating on a consistent basis as they provide care.

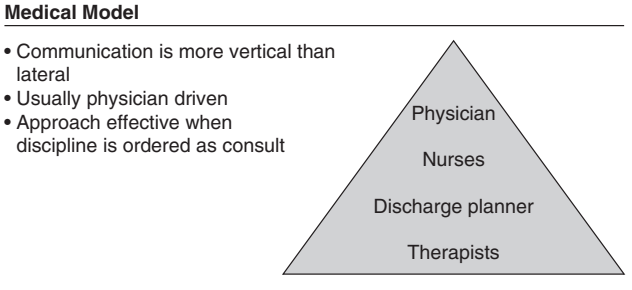

FIGURE 5.1 The medical model.

Multidisciplinary Model

Professionals in the **multidisciplinary model** (Figure 5.2) usually work independently to accomplish discipline-specific goals. Sharing information and making decisions based on that information, these team members may not directly communicate with all team members regarding care planning (Albrecht, Higginbotham, & Freeman, 2001). Communication is more vertical than lateral, and team members do not usually participate in team conferences. Sheehan, Robertson, and Ormond (2007) note that members working independently often lack a common understanding of issues that could influence interventions. Therefore, this model is not seen as being as effective for rehabilitation programs as some others.

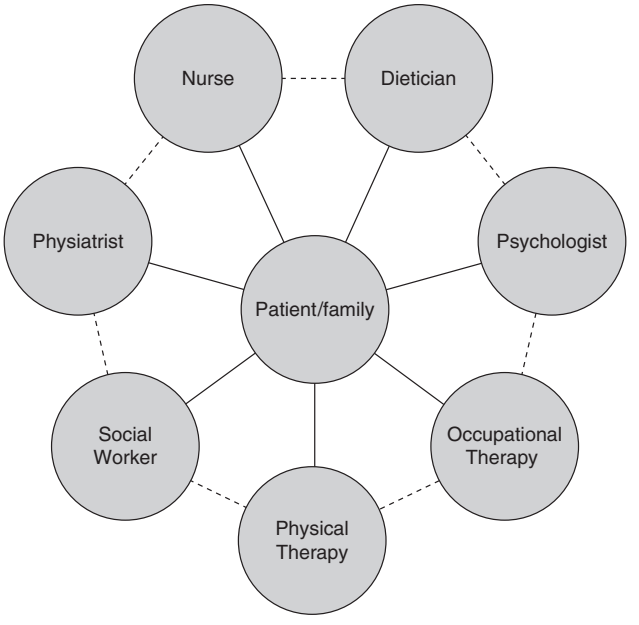

FIGURE 5.2 Multidisciplinary model.

An example of this model might be seen in an acute care setting when a physician orders physical therapy for ambulation education and occupational therapy to assess activities of daily living with a person who sustained a lower extremity fracture and sprained wrist as result of an accident. Each therapist would perform an assessment, treat according to their discipline, and document their interventions without any collaboration with other team members.

BOX 5.3 Don't Forget the Silent Team Member!!

Hovering in the background, but never far from the action, are the payers: managed care entities (Blue Cross/Anthem, United Health Care, Aetna, etc.), Medicare, and Medicaid. They review team documentation, either concurrently (managed care) or retrospectively (Medicare), and base hospital payment on outcomes achieved in a timely manner. The nurse case manager or utilization review nurse usually plays a pivotal role in keeping the team aware of the requirements and limitations of these "silent team members" as well as acting as an intermediary between the team and the payer.

Interdisciplinary Practice Model

The **interdisciplinary model** (Figure 5.3), which may also be referred to as an interprofessional model (Sheehan et al., 2007), uses a more collaborative approach. The key factor that makes this model different from the multidisciplinary model is that team members work together

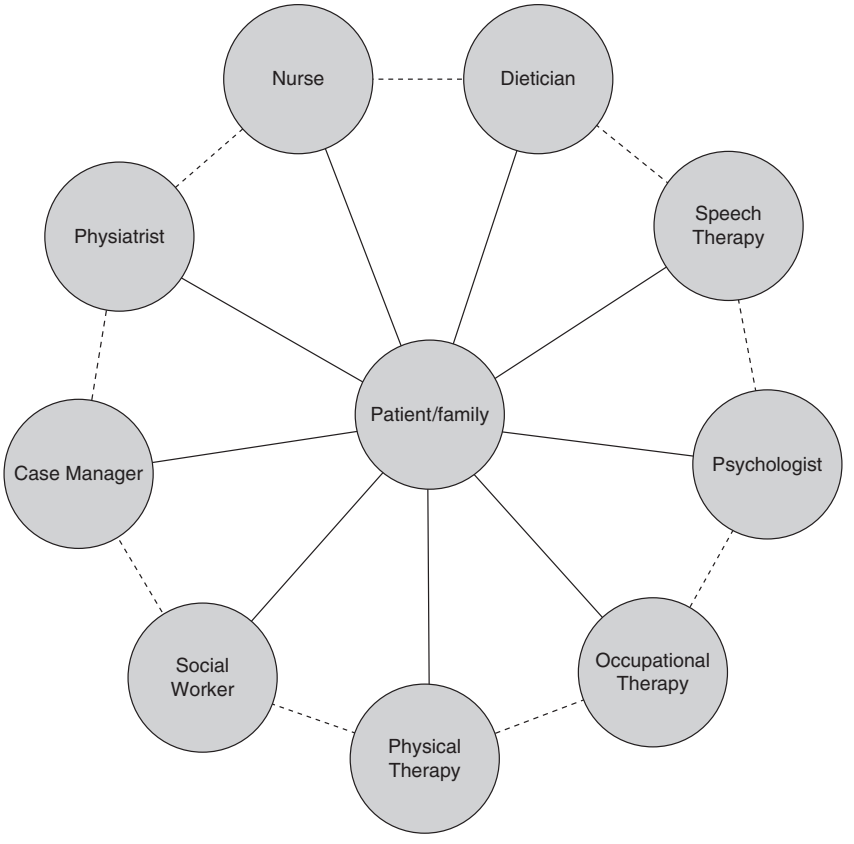

FIGURE 5.3 Interdisciplinary model.

in goal setting, treatment, decision making, and ongoing problem solving to ensure continuity of care and a more holistic approach (Albrecht et al., 2001). Patients and families are an integral part of the team. Communication between all members of the team is crucial to ensure all members, including the patient, are part of the decision and care planning process.

In comparing the two most common models (interdisciplinary and multidisciplinary), it can be seen that in rehabilitation settings the interdisciplinary approach is more effective because it allows for a more holistic, collaborative, and patient-focused approach. From the time of admission to discharge the patient and team work together to establish, evaluate, and accomplish mutually agreed on goals.

Transdisciplinary Model

In this model one team member is the primary provider (Figure 5.4). Guided by the other team members, the primary team member provides services to the patient. Team members are cross-trained in several areas besides their own specialty. Although the nurse may be the primary provider, a therapist who receives direction from other therapists could also be the primary provider. Because of a blurring of roles, this model requires not only flexibility but willingness of all team members to function

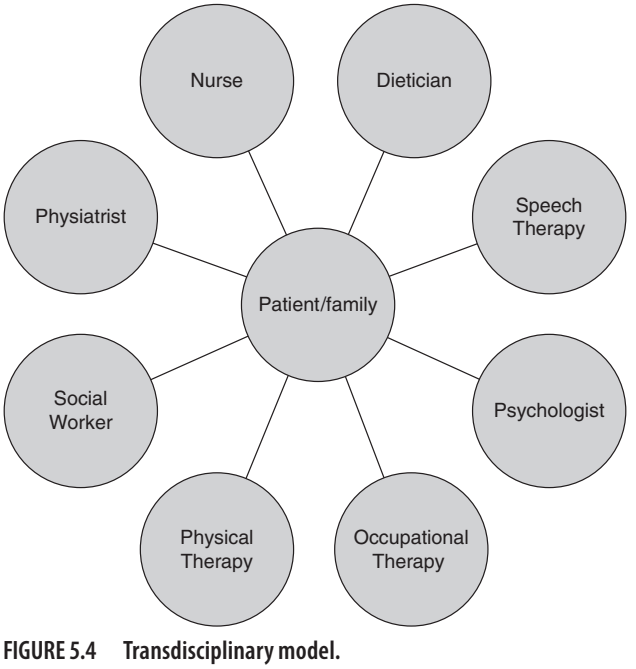

FIGURE 5.4 Transdisciplinary model.

in this framework (Mumma & Nelson, 1996). Nursing home facilities may use this model in their restorative care program. If a resident has a change in status, a therapist may be ordered to reevaluate a resident and make recommendations. It is then the nurses' responsibility to see that those interventions are incorporated into the resident's care plan and carried out on a daily basis.

For this model to be effective, staff must be cross-trained to perform any duties that are normally discipline specific so the patient receives appropriate treatment regardless of who is caring for the patient. This is time consuming and often presents a level of discomfort for team members to learn skills that were not included in their basic educational program. However, in some instances, for example with infants and children, this model can be an effective method to provide early intervention services, using a developmental approach to interventions versus discipline-specific approach.

BENEFITS AND CHALLENGES OF MODELS

Benefits of functioning in an effective IDT include increased continuity of services, collaboration toward goal achievement, shared understanding and problem solving between professionals, valuing of team members, and greater patient, family, and staff satisfaction (Sheehan et al., 2007). Although IDT functioning offers numerous benefits to the patient and family as well as their team members, studies have shown there can be challenges as well. According to Strasser, Falconer, and Martino-Saltzmann (1994), two challenge areas are conflicts regarding professional boundaries and defensiveness from team members who believe their professional judgment is being questioned. The tendency to function within the professional boundaries in which one was educated can lead to disciplinary silos and impede efforts toward collaborative thinking (Herbert et al., 2007).

Communication is a key factor in thinking and functioning collaboratively as a team, and discipline-specific language, or jargon, has been identified as a limiting factor when creating a well-functioning team. Nurses, like other disciplines, are educated within certain domains and have their own "language"; therefore, when we work with other members of the team there is potential difficulty in speaking with a unified, interdisciplinary voice. Bokhour (2006), in a study on communication in interdisciplinary team meetings, found that "**collaborative discussion**" occurs when team members step out of their discipline-specific framework and focus on patient's needs, allowing for a more open dialogue and exchange of ideas. Sheehan et al. (2007) found that more effective teams used inclusive language in their discussions. Other factors identified that can have an enormous impact on the success of a team include personality differences and emotional intelligence (McCallin & Bamford, 2007), addressed later in this chapter.

MEMBERS OF THE REHABILITATION TEAM

The interdisciplinary team consists of a number of disciplines and is dictated by the service needs of the patient. The core team for most inpatients in a rehabilitation setting includes

- Patient and family
- **Nurses:** registered nurses and licensed practical nurses
- **Advance practice nurses:** clinical nurse specialists and nurse practitioners
- **Physiatrists:** doctor of physical medicine and rehabilitation
- Therapists: **Physical** and **occupational therapists**, **speech-language pathologists**, recreational therapists, and respiratory therapists (as needed)
- **Psychologists**
- **Case managers** (some facilities will have related positions such as utilization review nurses, care coordinators, nurse navigators, MDS nurses, and coding specialist that may also be part of the team)
- **Social workers**
- **Dieticians**
- Chaplains

Depending on the size of the facility/organization and extent of services provided, patients may also receive services from vocational specialists, orthotists/prosthetists, biomedical engineers, and audiologists as needed. Additionally, alternative services, such as music and pet therapy, may be available.

Role of Team Members

Professional members of the team may function in several roles: as a care provider, patient advocate, or a coordinator of care. Larger interdisciplinary teams, common in most rehabilitation units or facilities, often include both a social worker/discharge planner and a case manager. Case managers are routinely seen as the coordinator of care and may share the role of team leader with the physician. Each member of the team brings with them discipline-specific expertise. Table 5.1 provides brief descriptions of each team member.

TABLE 5.1 Team Member Roles With Examples

Discipline	Primary Role in the Team	Examples of Collaboration With Other Team Members
Physiatrist	Responsible for physical medicine and rehabilitation management of patient's care.	Often leads the team. Orders assessment and ongoing treatment in collaboration with team.
Staff nurse	Coordinates and provides day-to-day patient care. Educates patient/family regarding medical and health issues as well as skills needed to provide safe health care (i.e., catheterization skills, bowel programs, skin maintenance/wound management). Patient advocate.	Supports and coaches patients to practice newly learned skills. Cues them as needed. Provides feedback to therapists re: patient ability to follow through with skill and if there are cognitive, behavioral, or physical changes during the day that are impacting patient's ability to consistently perform on unit.
Physical therapist (PT)	Maximizes patient function by working with patients to improve gross motor skills. Focuses on mobility, including ambulation, balance, W/C skills, Provides modalities for pain management.	PT and OT work together to develop strength, balance, and teaching skills needed for ADLs. Patient works on W/C transfers, whereas OT incorporates what PT has taught patient to practice toilet transfers, and instructs patient on clothing management, personal hygiene.
Occupational therapist (OT)	Assist patient gain maximal function in areas of ADLs.	OT and PT collaborate to assist patient to become functional with all components of skills/ADLs.
Speech-language pathologist (SLP)	Evaluates and treats cognition, communication, swallowing disorders, and hearing deficits.	Communicates with team regarding patient communication needs, how to cue patient when learning an activity, impact of cognitive deficits on ability to learn and retain information. Communicates with team regarding feeding and swallowing disorders and works with physicians, nurses, and dieticians about appropriate food and liquid consistencies, compensatory strategies to maintain safe swallow.
Therapeutic recreation (TR)	Assists patients to reenter their community and helps patients adapt so they can enjoy leisure activities.	Incorporates what patient has learned from other disciplines to assist patient with community reentry and leisure activities in preparation for patient discharge.
Respiratory therapist (RT)	Evaluates and treats a patient's breathing, including assist of ventilation as needed.	Supports maintenance of respiratory status and prevention of complications related to inactivity. Works with PT to increase tolerance for increased mobility.
Neuropsychologist	Evaluates cognitive and behavior status, assists in the adjustment to illness/disability. Provides support to patient and family as they come to grips with issues related to illness/disability.	Works with team regarding cognitive and behavioral needs of patients, developing appropriate plans of care related to cognitive and behavioral management.
Case manager	Coordinates implementation of treatment plan, communicates insurance benefit information to patient/families and the team. Advocates for services. Acts as liaison between patient, hospital, and payer. Provides updated information to insurance companies. Coordinates optimal use of available benefits.	Coordinates team to look at patient days, status of insurance to assist in planning for discharge, and to keep members mindful of time allotted to accomplish goals

TABLE 5.1 Team Member Roles With Examples *(Continued)*

Discipline	Primary Role in the Team	Examples of Collaboration With Other Team Members
Social worker/ discharge planner	Focuses on psychosocial support. Prepares patients and families for discharge. Identifies supportive services, resources needed after discharge. Links patient/family to community physicians, services, home health care, long-term care facilities, and medical equipment providers.	Communicates patient/family wishes regarding necessary services. Collaborates with team regarding patient's needs. Communicates status of services obtained. Works with case management in coordinating all written information that will go home with patient. Provides necessary information about patient to community providers to ensure continuity of care.
Dietician	Oversees patient's nutritional status and works with physician to provide necessary dietary requirements; provides patient/family education on diets.	Collaborates with team to adapt diet according to patient's needs. Monitors calories, labs as patient's needs change. Works with patient/family to provide foods of preference within dietary restrictions. Communicates nutritional status to team.
Advanced practice nurse (CNS /nurse practitioner)	Conducts comprehensive assessment. Integrates education, research, and consultation into clinical practice	Collaborates with nursing peers, interdisciplinary team, including physician, regarding evidenced-based practice. Integrates education, research and consultation into clinical practice.
Chaplains	Supports patients in their spiritual/religious practices. Provides encouragement and support.	Guides team to provide support while coping with illness/disability, consistent with patient's faith/beliefs.
Vocational services	Evaluates impact of illness/injury on vocation. Assists patients with adaptations to return to present vocation or retraining/education.	Communicates status of patient's vocational needs. Works with therapists to develop, adapt, or improve skills required for return to work or school.

ADLs, activities of daily living; CNS, Clinical Nurse Specialist; W/C, wheelchair.

Responsibilities of IDT Members

Well-functioning and effective team members need to understand their roles and responsibilities. Although roles are dictated partially by the discipline of each member, responsibility for an effective IDT falls on all team members. Members need to value and demonstrate a collaborative approach with patients, family, and other team members when setting goals, coordinating care, and providing education and discharge planning. Secrest (2007) describes a number of components required to have an effectively functioning team: trust, mutual respect, communication, coordination of care, knowledge, shared responsibility, and a commitment to each other. Box 5.4 provides additional information on IDT competence.

BOX 5.4 How to Achieve Team Competence

- Technical competence is the focus of most professional programs in health care.
- Both technical and team competence are critical to ensure safe patient care.
- Healthcare professionals who understand each other's roles and work together effectively provide higher quality care (Barnsteiner, Disch, Hall, Mayer, & Moore, 2007).
- Members of collaborative teams enjoy greater job satisfaction (Chaboyer & Patterson, 2001).

Freeman (2000) states there are three individual philosophies of teamwork that impact its role, comprehension, and communication: directive, integrative, and elective.

Those who have a directive philosophy view their role as a team leader. Persons with an integrative approach are often therapists, social workers, and nurses who view their role as upholding collaboration and being a team player. Those with an elective philosophy favor brief communications and work more autonomously. Differing philosophies among team members can contribute to turf issues and negatively impact attempts to have a cohesive and collaborative team. The responsibility of addressing any negatives within the team falls on each member of the team; often there are senior, more experienced team members who understand and practice the philosophy of interdisciplinary and collaborative care who will assume a leadership role to address issues. Characteristics of an effective team are discussed in the following section.

CHARACTERISTICS OF AN EFFECTIVE IDT

In rehabilitation one thing is certain: No one discipline and no single approach can provide the comprehensive services needed to facilitate recovery from complex injuries and mitigation of multiple deficits. However, in recent years empirical research has emerged identifying the well-functioning IDT as one of the determinants of improved functional gains for rehabilitation patients. Optimal outcomes require the integration of complex medical, financial, psychosocial, educational, and vocational resources across diverse specialties and multiple systems in a highly visible setting with patients and families involved at all levels (Strasser et al., 2008).

Rehabilitation can be a lengthy and often frustrating process. Rehabilitation professionals have the dual challenge of helping families remain hopeful while preparing them for scenarios that may be disappointing. At the same time, being part of an IDT can be exhilarating, with daily collaboration among skilled professionals implementing exciting and creative, evidence-based care.

Personal commitment to the team and a willingness to put notions about differing status of members aside are prerequisites of effective IDT membership. Collaborative discussion demands communication skill and an ability to transcend professional jargon, shed the expectation of physician dominance, and become comfortable with blurred professional boundaries. Negotiation skills and an appreciation and valuing of diversity and individual differences are desirable traits for IDT members.

IDTs can be somewhat fluid, with members entering and leaving, as personal and professional lives change. Ideally, senior members of the IDT will assist the group to process the changes in group dynamics that inevitably follow alterations in team structure. During these times the group may experience an interruption in cohesiveness as members seek renewed commitment to the goals and purposes of the group. IDT members most likely to assist the group to understand these shifting dynamics are the psychologist, the clinical nurse specialist, and the nurse care coordinator (case manager) or social worker. The registered nurse is in an excellent position to prompt the team to refocus their shared commitment on the care of patients and families.

It is important that IDT members relinquish their perceptions of perceived professional boundaries and nurture a mutual respect for the value other members bring to the team. Even in teams highly skilled in working collaboratively, conflict is inevitable. However, if moments of conflict are viewed as opportunities to come together and achieve synergistic solutions, both the team and patients benefit. Well-educated professionals, taught to be assertive and think critically, will have conflicts. The key is to accept conflict as a natural outcome when creative energies collide and work to resolve it (Hall & Weaver, 2001). Box 5.5 provides keys to preparing for IDT membership.

BOX 5.5 How Do You Prepare for Membership on an IDT?

- Appreciate your own discipline and its unique contribution to rehabilitative care.
- As a student, seek every opportunity to observe and/or be part of an IDT.
- Do not be afraid to stretch outside the comfort zone of your own discipline.
- Participate in committees or groups that include other healthcare professionals.
- Experience with interdisciplinary collaborative practice as a student has been shown to be a determinant of positive attitudes about IDTs as students enter the job market (Florence, Goodrow, Wachs, Grover, & Olive, 2007).

TEAM COMPETENCE

Team competence derives from the ability of multiple disciplines to behave as a single system. Moving beyond task focus, IDTs are capable of achieving a level of team thinking and an environment of creative inquiry that exceeds what can be accomplished by individuals operating in professional silos.

Brookfield and Preskill (1999) describe habits of collaborative discussion inherent in interdisciplinary teams as "group talk," a blending of conversation, discussion,

dialogue, and cooperation. Although group talk is part of team competence, it does not ensure effective team function. Group talk is only useful if team members recognize, identify, and share important clinical and psychosocial cues. Nurses, with 24-hour presence and accountability, are in a key position to enhance effective team function through the timely transfer of critical information (Miller, Riley, & Davis, 2009).

Equally important to the ability to recognize and communicate critical information is **emotional intelligence**, defined as "the ability to perceive emotions, to access and generate emotions so as to assist thought, to understand emotions and emotional knowledge, and to reflectively regulate emotions to promote intellectual growth" (Mayer & Salovey, 1997, p. 6). The concept of emotional intelligence, introduced by Daniel Goleman (1995), asserts that an effective team needs more than technical and clinical skills. Nurses, to maximize their contribution to the IDT, need to be aware of the role emotional intelligence plays in team function. Nurses will benefit from supplementing their technical education with training designed to refine interactional skills that emphasize increasing awareness of the impact of team diversity and individual personality differences on team working relationships.

Emotional intelligence is the quality that allows IDT members to engage in dialogue, transcend stereotypes, and collaborate to achieve synergistic solutions. Although little is known about nurse performance on IDTs (Institute of Medicine, 2003), studies by Glaser (1998) and McCallin (2001) support the notion that nurses' ability to develop cohesive relationships within the IDT is pivotal to their success.

Individual clinical performance skills (task training) and the behaviors necessary for effective IDT function should ideally be taught simultaneously and valued by the organizations and professionals delivering care. The skills that enable IDTs to effect change in process and outcomes need to be taught at the team level. Whether by interactive workshops, structured online training, or group education connecting outcome data to team interventions, hospital systems and the various entities delivering patient care must endeavor to demonstrate the value placed on competent IDT function.

The primary action of the IDT takes place in the team meeting and during IDT rounds. Whatever the arena, the themes of consensus, professional synergy, and fostering a learning culture are of major importance for the IDT to achieve team competence (Shaw, Walker, & Hogue, 2008). Commitment to consensus avoids reliance on discipline-specific knowledge and is demonstrated by team acceptance of different viewpoints and knowledge bases.

Professional synergy is realized when team members relinquish autonomy in favor of using resources available within the entire team. Becoming comfortable with "team-ness," described by Shaw et al. (2008) as the ebb and flow of teamwork, is a process. In the rehabilitation dance, team members, comfortable with the talents they bring to the IDT, allow members with expert knowledge to step in and guide the team when it is in the best interest of the patient.

IDT members have a responsibility to contribute to the learning culture of the team and should demonstrate the capacity to learn from other team members. Embracing knowledge transfer and reciprocity (professional–professional, professional–patient, patient–professional), IDT members avoid the pitfalls of rote performance: doing things the same way because that's the way they have always been done. Instead, there is an understanding that team function and patient outcomes can always be better.

IDTs have leadership but not necessarily one leader. Successful team relationships, forged in the midst of practice, allow leaders to emerge when their expertise is needed and then blend again into "team-ness." This is the dynamic nature of teams. Professionals on the IDT are accountable both as individuals and team members.

New team members benefit from mentorship to ease the transition from discipline-specific practice to an environment where collaboration is expected. The nurse considering becoming part of an IDT will want to inquire about orientation to the process and available education to enhance these skills.

The final, but perhaps most important, requirement for team competence is this: embracing the idea that the patient is not simply part of the IDT but the center of it. Healthy People 2020 (2009), a report detailing national health promotion and disease prevention agendas, defines one of the determinants of health as individual behavior and personal choice. Involving patients and families in decisions regarding their care, to the greatest extent possible, along with coordinated, concurrent education from all involved team members, is key for successful patient recovery.

EVALUATING TEAM EFFECTIVENESS

There is no one prescription for effective team development, and no one model that can be deployed with a

guaranteed outcome. However, team function can be evaluated, both objectively and subjectively.

Objective data supporting team success can be found in the analysis of changes in functional independence measures that, when correlated with length of stay, speaks to rehabilitation program success and team efficacy. The Commission on Accreditation of Rehabilitation Facilities and The Joint Commission, in their accreditation surveys of program implementation and outcomes, look specifically at IDT function and, in fact, require IDT to be part of programmatic design (see Box 5.2).

Specific outcome measures, gleaned from length of stay, patient satisfaction, and return to productivity data, demonstrate team and individual effectiveness. When patients report satisfaction and show measurable improvement, IDT members experience enhanced job satisfaction. Mikan and Rodger (2005) describe effective teams as having a well-defined purpose, identifiable goals, good leaders, regular patterns of communication, and an environment of mutual respect—all qualities that can be observed and evaluated.

Effective teams also require an opportunity for team maintenance, often accomplished offline and separate from patient discussion. Taking time to reflect on teamwork successes or failures, appraise performance, and identify programmatic plans are hallmarks of a team that is proactive, not merely reactive. Effective teams design strategies based on data and best practice evidence and implement necessary program changes. Having a willingness to adjust to ever-evolving challenges is what ultimately defines effective teams.

CRITICAL THINKING

Read the two scenarios and answer the questions that follow by applying the material from this chapter.

Scenario 1

Sally is a 67-year-old married woman who was admitted to the rehabilitation unit after being hospitalized for left-sided ischemic stroke 4 days ago. Upon admission, the rehab nurse completed an admission assessment and initiated care planning. Later that afternoon, the physical therapist (PT), occupational therapist (OT), and speech-language pathologist completed their assessments with Sally. Sally's husband came in during the session with the PT and assisted Sally in answering questions.

On day 4 of Sally's stay the team (including PT, OT, nurse, physician, psychologist, case manager, and social worker) convened for a conference to discuss her status, findings of their evaluations, and set up a plan of care and tentative discharge date. Each member of the team gave a report on their findings. The PT identified goals for mobility, the OT stated goals for activities of daily living, and the speech-language pathologist addressed swallowing and communication goals. The nurse addressed the status of Sally's bowel, bladder, and skin and stated goals for management. The team then chose a tentative discharge date. It was discussed that because Sally's husband was still working outside the home, Sally would need either to be fairly independent and able to be left alone for 7 to 8 hours a day or to have additional assistance in the home while he worked. Going to a long-term care facility was not an option Sally or her husband wanted to explore at this time. A psychosocial assessment completed by the social worker indicated that the home had five steps to enter but there were railings on both sides.

After the conference the case manager went to Sally's room to discuss plans for her stay and give her the tentative discharge date. The nurse case manager noted that the patient's managed care plan had authorized 7 days, but daily progress toward home discharge would be necessary.

Scenario 2

Bill is a 21-year-old man who sustained a C7–8 spinal cord injury as result of a motor vehicle accident. Once medically stable, he was transferred to a rehabilitation unit. Within 24 hours of admission the physician, nurse, therapists, dietician, case manager, and social worker had completed an assessment based on their discipline and role on the team. Bill attended his first conference with the team approximately 1 week after admission to discuss their findings, set goals, and develop a plan of care. The case manager shared what Bill and she had discussed related to the goals he wanted to accomplish while on the unit. The social worker shared that Bill's plan was to return home to his parent's house and that his parents were agreeable. House accessibility was also discussed. The PT and OT discussed what activities they had worked on the past week and future plans to help facilitate his ability to be as independent as possible and what changes would need to occur to make the house more accessible.

Bill expressed his concerns regarding bowel and bladder management, sharing he did not want his parents to have to do this unless absolutely necessary. The nurse, OT,

and PT addressed Bill's present functional level and plans to further assess his ability to perform skills, including transfers and assistive devices.

The team discussed with Bill what goals could realistically be accomplished during his stay and together prioritized what goals should be focused on initially, stating that each week they would reevaluate his status and goals and make adjustments accordingly.

Exercises

1. Choose the scenario you believe has a functioning and effective IDT.
2. Identify the behaviors or actions that led you to your decision and what behaviors/actions were missing from the other scenario.
3. What evidence of collaboration did you find in the chosen scenario?
4. Compare and contrast the level of patient involvement in each scenario.
5. If you were the patient, which scenario would make you feel more involved in the decision-making process of your rehab stay? Why?
6. What strategies were used by each team to identify problems and set goals?
7. What advice would you give to the team not chosen to help them function more collaboratively?
8. Based on your answers, what type of team do you believe the other scenario depicted and why?

PERSONAL REFLECTION

- Have you ever been a member of an interdisciplinary team? Reflect on that experience. Was the patient a part of the team? Were any members of the team more dominant than others, and if so, why? Were team goals explicit? Were goals mutually established? Were the team goals accomplished?
- Which team members do you most associate with in your role as a rehabilitation nurse? Why?
- What type of model does your facility or organization use? Do you believe this is the most effective model for patient care?
- What is the one characteristic of an effective IDT that most describes the team with which you work?
- Think of one area that you personally could improve upon in your role as a rehabilitation nurse to help the team function more effectively.

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