Perceptions of multidisciplinary case conferencing in residential aged care facilities

Elizabeth J Halcomb, Bernadette M Shepherd and Rhonda Griffiths

Abstract

Objective: To explore the understanding about and perceptions of, multidisciplinary case conferencing in residential aged care from the perspective of residential facility staff, residents, carers and general practitioners.

Methods: Focus groups and in-depth interviews were conducted with nurses, residents, carers, allied health workers and general practitioners from two residential aged care facilities during February–March 2008. Conversations were analysed using thematic analysis techniques.

Results: Thematic analyses highlighted four key themes. Most notably, respondents identified a degree of confusion regarding the purpose of case conferencing and its role in resident health care. The ad hoc development of the conferencing model led to unclear role descriptions for participants that contributed to role confusion and the lack of a collaborative culture. Underpinning much of the discussion was the need for a framework to support the organisation of the conference process.

Conclusions: While the process of multidisciplinary case conferencing in residential aged care has significant potential to improve resident care and health outcomes, the development of an explicit framework is required to support the effective conduct of these meetings. Key stakeholders need to be engaged to develop a team approach to conducting case conferences that facilitates the active participation of providers, residents and their carers.

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What is known about the topic?

Multidisciplinary care has been shown to improve health outcomes for those with chronic disease. Although the Australian health system has item numbers to support multidisciplinary case conferencing in residential aged care, the uptake has been variable.

What does this paper add?

This study demonstrates that despite the conceptual allure of multidisciplinary case conferencing to improve health outcomes in residential aged care, the development of a framework is required to promote engagement by key stakeholders in the conferencing process.

What are the implications for practitioners?

This paper provides practitioners with an insight into the various experiences of residential facility staff, residents, carers and general practitioners regarding multidisciplinary case conferencing in residential aged care. Understanding the issues raised through the experiences of others may assist the practitioner in developing strategies to promote more effective case conferencing within their practice.

CURRENT PROJECTIONS OF population ageing in Australia predict an increase from 1.3 million Australians aged over 65 years in 2002, to 2.2 million Australians aged over 65 years by 2020.[1] The increase in those aged over 85 years is projected to nearly double over this period.[1] Current reports suggest that some 6% of Australians aged over 65 years live in residential aged care facilities, with 29.5% of those aged over 85 years requiring residential care or an aged care support package.[2] If current trends in rising chronic and complex disease remain unchanged, the ageing of the population will significantly increase the demand for residential aged care

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services in the near future.[2,3] This increased demand will necessitate dramatic restructuring of the current health system, including the development of innovative new methods of care delivery and interdisciplinary collaboration.[4,5]

Residential aged care facilities provide not only accommodation, personal care and support services,[6] but also, increasingly, complex health care services designed to maximise residents' health status and quality of life while minimising adverse events (eg, falls, medication errors, unplanned hospital admissions).[7,8] Additionally, increasing emphasis is being placed upon advance care planning, where residents and their family or significant others are encouraged to make decisions about the treatment that they choose to have, or refuse, in the future if they are unable to make decisions or communicate their wishes.[6] While maintaining and improving the quality of health care provided to this group is essential to their wellbeing,[9] the provision of health care services within residential aged care facilities has received less than optimal attention.[10] The establishment of strategic and sustainable partnerships between residential aged care and sectors including general practice is sorely needed.[10] This study aimed to explore the understanding about, and perceptions of, multidisciplinary case conferencing in residential aged care from the perspective of residential facility staff, residents, carers and general practitioners.

Methods

Participants and questions

Focus groups were conducted with registered nurses (RNs), enrolled nurses, assistants in nursing and allied health staff employed in two residential aged care facilities and carers of residents in these facilities. Individual or small group interviews were conducted with residents, GPs within the local Division of General Practice and RNs not able to participate in the focus group sessions.

Participants were recruited via study advertisements placed in the participating residential facilities and direct provision of information to potential participants via mail. Care was taken to recruit residents with a range of both high and low care needs across the participating facilities. Given the need for residents to provide informed consent and be able to understand the nature of the questions, it was only possible to include residents with sufficient cognitive capacity to participate. Staff at each facility provided the researchers with this information. Participants who had a diagnosis of dementia, but who were still regarded as having sufficient cognitive capacity to participate were included in the study.

Each focus group lasted between 30 and 90 minutes and was comprised of 5–12 participants from a similar background (eg, assistants in nursing, RNs or carers). Individual interviews were considered a more appropriate form of communication with residents to promote optimal communication and avoid the potential disclosure of personal health information within a group setting. As it was not possible to engage general practitioners to participate at a single focus group they were interviewed in their practices in either individual or small group sessions. Similarly, not all RNs were able to attend a focus group session at the same time. Individual or small group interviews facilitated participation of additional nursing staff.

The sessions were conducted by an experienced facilitator (EJH), with a second researcher taking field notes (BS).[11] Each session followed a semi-structured format whereby key questions were asked to prompt discussion (Box 1 and Box 2).

Analyses

Following each focus group or interview the researchers reviewed the discussion and made additional field notes. These field notes were then reviewed in conjunction with the audio recordings in a process of reflexive, iterative analysis that has been previously described.[12] Key themes were identified where similar issues consistently arose from a range of participants.

Ethics approval

Institutional ethics committee approval was obtained from Human Research Ethics Committees of both the Sydney South West Area Health Service and the University of Western Sydney.

1 Health professional focus group questions

1. What do you understand we mean by case conferencing?
2. What role do you currently have in planning resident care?
3. What role do you see for other team members in planning resident care?
4. What additional roles do you think that (employment category of participants [eg, RNs]) could have in planning resident care?
5. What education/skills do you think that (employment category of participants [eg, RNs]) need to undertake these additional roles?
6. What outcomes do you see that would signify successful case conferencing?

2 Resident/carer focus group questions

1. What do you understand we mean by case conferencing? (description of Medicare definition provided by researcher after participants' response)
2. If you (ie, resident or family member) were to participate in case conferences, how could this improve your (your family member's) care?
3. What aspects of your (your family member's) care do you see could be improved through case conferencing?
4. Which of your care providers would you like to see involved in case conferencing?
5. What do you see as the biggest problem with conducting case conferencing?

Results

Participants

A total of 46 individuals participated in the focus groups and individual interviews. This consisted of 17 nursing and allied health staff from the residential facilities, 13 residents, 8 family/carers and 8 GPs. Four residents were classified as high care, while 9 were classified as low care. The length of stay of participating residents ranged from several months to 20 years in residential care. Similarly, participating carers reported that the duration that their significant other had been in residential care ranged from several weeks to 20 years.

Residential facility staff had varying levels and duration of experience both in their professional role and in relation to their involvement in case conferencing. While all participating general practitioners serviced residential aged care facilities, not all reported that they currently undertook case conferencing in accordance with the Medicare schedule.

Themes

Four key themes related to the perceptions of case conferencing in residential aged care arose from the data, namely; (1) confusion over the role of case conferencing in resident care, (2) role confusion, (3) lack of a collaborative culture, and (4) need for a framework to support case conferencing (Box 3).

Theme 1: Confusion over the role of case conferencing in resident care

One of the most noticeable findings of this study was the apparent uncertainty over what was meant by multidisciplinary case conferencing and the potential role that it could play in the health care of residents. While most participants articulated that case conferencing involved health professionals and residents/carers coming together to discuss care, there was disagreement about the types of "care" issues that were appropriate for discussion in this forum. For example, some staff participants identified this as an opportunity to provide information to carers about residents' personal care needs or discuss carers concerns about the type of services being provided within the facility. Comparatively fewer staff participants spoke about the need to review the residents' current health status and develop a strategic plan to manage both current health issues and future health needs. Some nursing staff reported that they "already spoke with GPs about residents' needs and the GPs were too busy to be bothered any more".

3 Key themes

1 Confusion over the role of case conferencing in resident care
2 Unclear role descriptions for participants
3 Lack of a collaborative culture
4 Need for a framework to support the organisation of the conference

Residential care staff reported a range of problems either in engaging the family in interactions or what they perceived as the family's "unrealistic expectations of residential care". However, many family members and carers reported that they had difficulties in communicating with GPs and staff about the resident. Most communication occurred "in the corridor" or "when problems arise", rather than being planned discussions. For these family members and carers, the case conference was seen as the only formal venue they had to raise concerns regarding the care that their significant other was receiving from health care providers.

While most GPs agreed that the conference was an important opportunity to plan resident care and communicate with family and carers, others saw limited benefits of the process to residents' healthcare. The wide variation in the conceptualisation of case conferencing, the variation in support for the process from the facilities and the focus of the conferences may account for the apparent reluctance on the part of some GPs to engage in the process.

Theme 2: Unclear role descriptions

The confusion over participant roles in the case conferencing process stemmed from the uncertainty regarding the conference purpose. Participants expressed confusion in both their own roles and those of other members of the multidisciplinary team. It was generally agreed that the RN was a key conference participant. However, it was identified that their significant workload and subsequent time pressures frequently impeded their capacity to be involved in conferences. Enrolled nurses and assistants in nursing expressed a desire for greater planned involvement in the conferencing process, given their close relationship with residents on a daily basis. They identified that they would be able to provide current data about the residents' well-being as well as advocate for their issues to be heard. Currently, they reported that they were often left out of the planning of case conferences and received short notice, if any, to attend.

There was divided opinion among participants regarding the role of the GP. While some residential care staff identified the GP as an important decision maker in relation to care planning, others identified that they did little more than serve as an authority figure to reinforce the information being given by residential care staff. It was clear from the study data that the participants' understanding of the purpose of case conferencing was strongly related to their perceptions about the GP role.

While carers saw their role as being to raise resident issues, several residential staff reported experiences of the conference process being "hijacked" by carers to air their complaints about perceived inadequacies of care. Upon clarification it became apparent, however, that carers indeed had few opportunities to raise their concerns. Most residents placed themselves in a subservient position to their GPs who "know what's best". Few residents could see a role for health professionals other than the GP and RN to be involved in the conference as it was these individuals who they perceived to hold the power over their health management.

Theme 3: Lack of a collaborative culture

Underpinning the themes of the purpose of case conferencing and the roles of individual providers was the concept that few providers recognised the presence of a team culture or perceived themselves as a part of a health care team. Most providers spoke of themselves delivering care in a degree of isolation from other health professionals. Several GPs commented on the difficulties in developing relationships as a result of the turnover of staff and rotation of RNs within facilities. Registered nurses themselves reported working in relative isolation in the facility, with few talking of collaborations with other nurses, allied health providers or GPs. Rather than providers communicating with each other to explore the range of strategies to improve residents' care, each reported making their own decisions about what was the best strategy to address an issue.

Theme 4: Need for a framework to support case conferencing

An overarching theme that arose from the majority of interactions was the need for a clearly articulated framework to guide the organisation, conduct and

reporting of case conferences. This would allow all participants to become familiar with the intended purpose of the case conference, their role in the process and the potential outcomes that could be achieved. Having such a framework could assist in facilitating multidisciplinary teams from across health settings in working towards common goals in improving residents' health care.

Discussion

Our study of the experiences of residential facility staff, residents, carers and general practitioners highlights some of the barriers to implementing multidisciplinary case conferencing in Australian residential aged care. Much of the literature regarding chronic care is disease-specific or written with an acute care focus and, as such, does not well address the changing needs of the ageing population. The Australian Society for Geriatric Medicine[13] asserts that the complex needs of those in residential aged care are best met by a multidisciplinary team approach. Despite recognition of the likely efficacy of the multidisciplinary team and the importance of health care planning for residents of aged care facilities, these principles have not been translated into feasible and sustainable interventions for Australian clinical practice.[10] Contemporary health care services tend to promote compartmentalised, episodic interventions rather than multidisciplinary, planned care, resulting in inefficient service provision and frequent duplication of services.[14] Even with the introduction of the Medicare item number for case conferencing in residential aged care in 1999, there has been limited focus on developing the infrastructure and professional roles to support its implementation.[14]

Despite the small sample size, the findings of this investigation are consistent with other published literature.[14,15] Qualitative research, such as that reported in this study, must be judged not by the number of participants but rather by "whether it has captured the essential elements experienced by people".[16] (p. S48) Given the paucity of research in this area in the Australian literature and the significant differences in systems issues within the international literature, it is difficult to draw comparisons.

The first and fundamental theme that was elicited from participants was the issue of the role of care planning in residential aged care. Whilst there is increasing recognition in the literature of the potential benefits of multidisciplinary care planning in a range of disease-specific groups both in acute care and in the community,[17,18] this has not yet been translated into residential aged care. Two major challenges faced in this regard by the Australian health system are the relative isolation from other health professionals in which GPs have historically worked and also the difficulties in intersectorial collaboration between the federally funded community-based care, state- or territory-funded acute care settings and private practitioners.[14,15] Working collaboratively requires not only education and training, but also the development of cohesive teams of care providers who have a mutual understanding of each others' clinical skills and potential to contribute to resident care.

The second theme identified the unclear role descriptions related to case conferencing. Within this theme it became clear that there was limited understanding between practitioners of each others skill sets and competency frameworks. This was particularly the case in regard to the various skill-mix of nurses, where each group had significantly different educational preparation and clinical skills. Without mutual respect and shared understanding it is difficult to facilitate the development of effective teamwork and true multidisciplinary practice.[19]

The third theme extends upon the issues around role confusion and evidences the lack of cohesion and perceived absence of a team culture among the health providers. To facilitate the development of a team culture we need to not only overcome the interprofessional barriers described above, but also local organisational and health system issues which impede intersectorial collaborations.

Our study highlights a need to develop a model of case conferencing that is feasible and sustainable in residential aged care. Further research needs to be undertaken to develop and test potential models in clinical practice. The qualitative work that we report here is the first step in this process. Currently, a model of conferencing has been developed

and further work is being undertaken to evaluate its feasibility and sustainability within residential aged care. However, to improve the current situation we need to respond to the specific issues raised in this study and facilitate health professionals to develop skills in working together in truly multidisciplinary teams, foster mutual understanding of the roles and skill sets of various providers and provide practical infrastructure to support intersectorial collaboration. Despite the clear evidence that multidisciplinary care planning improves health outcomes, we need to ensure that this intervention is integrated into the usual care that is provided, not only in acute and community settings, but also in residential aged care.

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Competing interests

The authors declare that they have no competing interests.

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