



Communication in health and social care

Facilitating rehabilitation

Commentary:

You'll hear three workers from the primary care rehabilitation team in Sandwell discussing the importance of communication and relationships in their work. First, Judy Bryan and Kate Nixon explain their roles.

Judy Bryan:

My name is Judy Bryan. My title is Clinical Nurse Specialist for the Older Person but I'm actually within intermediate care and don't tend to do my actual job title.

Kate Nixon:

My name is Kate Nixon. I'm a locum Occupational Therapist working in intermediate care and my job involves treating people that are staying in an intermediate care bed, doing assessments and treatment planning, home visits, those sorts of things that get people back home again.

Judy Bryan:

I tend to do the generic assessments of people who are placed within intermediate care. I do love care management, I do a lot of the nursing assessments as well, and also the following up on the social work input, working with Kate and our rehab support workers, and some of the management role.

Commentary:

Judy and Kate describe the range of people they interact with on a typical day.

Judy Bryan:

The beginning of the day we always have a handover with Kate, the Occupational Therapist, and our two rehab support workers, and our physiotherapist, if we have one. We go through all the patients on our caseload to see what point we're at, what needs doing, particularly that day. We then go out and meet the carers who are looking after the patients, as well as the patients. It may involve new assessments which will then involve either face-to-face or telephone contact with social workers, relatives, carers, sometimes community nurses, or specialist nurses, they're also involved with delivering the patient's care.

Kate Nixon:

Communication like with the team in the morning and then social workers, the care staff at the actual homes that the patients are staying in temporarily, care managers, social workers, stores where we get lots of our equipment from, social services, occupational therapists, same sorts of, district nurses, doctors, everything really right across the board.

Commentary:

How would Kate describe the relationship they have with service users?

Kate Nixon:

We only actually get to see the patient maybe twice a week, and we sort of facilitate their rehabilitation so we'll go in and carry out assessments, and then it's up to the care staff that are there all the time and our support workers to go in and actually carry out their day-to-day rehabilitation.

Commentary:

Facilitating patients' rehabilitation involves working closely with other agencies, as Judy explains.

Judy Bryan:

We often take forward patients' views to other agencies because a patient when they're actually in an intermediate care bed there's a choice of either going back home, staying within the environment they've moved to, or moving on maybe somewhere like sheltered accommodation, or a nursing home, and often at the beginning it's a journey for them and we actually take forward their wishes to the other agencies so we very much advocate for them as well. Because I've worked for a long time within Sandwell so I know a lot of the other professionals through a long period of time, so I would generally say that communication's very good because even if it's by telephone, or sometimes by reports or letters, we still know the people we're actually dealing with, and regardless of the type of relationship, who the professional is, because you actually know somebody I think you communicate easier. We do try to have face-to-face communication which I personally find a lot better, or by telephone, then sort of written.

Commentary:

Kate describes how they ensure effective communication between all of the different agencies involved.

Kate Nixon:

During their stay in intermediate care we have what we call case reviews and we try and have one two weeks into their placement, and then four weeks into their placement, where it's an opportunity for the social worker to come, or anyone's welcome really, but it tends to be the social worker, the rehabilitation team, the family, the patient, and it's just a really good opportunity for everyone to talk about, and particularly the patient to sort of say what their hopes are, what their wishes are, what they want to get out of their stay in the intermediate care bed. And it's a good opportunity for the rehab team and the family to say any concerns that they have or any hopes that they have as well. That's one of the really good face-to-face contacts that we have.

Commentary:

What kinds of problems does Kate believe can arise when different agencies have to work together?

Kate Nixon:

The sorts of problems that we perhaps do have is when we do need to speak to a social worker or a doctor, you know if you are relying on leaving messages by telephone, it's then waiting for those to be replied, and obviously everyone's very busy anywhere in health and social care, so that can be the frustrating, one of the frustrating points.

Commentary:

Judy describes some specific problems in inter-agency communication and suggests some possible solutions.

Judy Bryan:

I mean specific problems would be with GPs surgeries because of the opening time. We tend to be out and about doing our day-to-day work when we could actually contact a GP, so the times that we're able to ring they're usually not in their office, but we use message centres as well. And the same with district nurses because they're out and about, we're out and about, but we're quite flexible and use our own mobile phones for people to contact us. When we go into the intermediate care homes we use their paperwork to write, but we actually highlight where we've actually written so that if any other agencies come in, or professionals, they know we've been in. I know in the hospitals when I go in I've always written in patients' notes which is good because it's the one system in Sandwell so everybody writes in the same notes anyway, and I've just really taken that outside into the community, but I think patient-held notes would be better where they're accessible to everybody. We actually get patients to look at their care plans in some instances and sign them.

Commentary:

As Kate suggests, this also means that the service is more patient-centred.

Kate Nixon:

I've always, in my view, made the patient fairly central anyway, but I think it's perhaps something that not everyone has always done, so now by patients having to be aware of a care plan, agreed treatment goals, and then having to sign it is a way of making it more standard that the patient is sort of central.

Commentary:

Finally we hear from Anuradha Sowent, a physiotherapist. How does Anuradha describe her role, and who does she interact with on a day-to-day basis?

Anuradha Sowent:

My name is Anuradha Sowent, and I'm a Senior Physiotherapist here at the rehab team. The rehab team, it caters for the needs of patients with varied problems like, say, we can have patients with neurological deficits, with cardiac problems, or with just the elderly who have falls and things like that, and then they need some treatment and things like that. So basically I'm here to do the initial assessment that is required and decide on a treatment plan that is required for these patients. I would say sixty percent of my day is face-to-face with patients, 60-70%, sometimes it can be more, and the remaining part is with the, either with the other professionals within the team, or with the professionals outside the team. We work with the relatives of the patients, the carers, they are a group of people who provide care to the people who cannot care for themselves, so there are care agencies, and then we have the general practitioners whom we have to liaise with, there are the district nurses, the nursing staff. We also liaise with another agency here which is called the home loans agency and they are the people who are responsible for providing any specialist equipment to the patients, and we have to liaise a lot with them so that if the patient is requiring any particular kind of thing to enable them to do a particular activity, we need to liaise with them as well. Very often because ours is a community care we have referrals from different hospitals like, say, if there is a demarcation between acute care physiotherapy and community care physiotherapy, and because of this demarcation when the patient has had some amount of care during some phase of his disability, he gets passed on to the physiotherapist working out in the community, and very often we have to liaise with the therapists who have worked these patients before, in order to get much more information for us to be able to work better with these patients as well.

Commentary:

In Anuradha's opinion, what helps to facilitate good communications between professionals from different backgrounds, and what can get in the way?

Anuradha Sowent:

To my mind the first thing that we need to do is we need to identify who we are passing on the information to, and we need to give them at least a brief idea as to what we have done with the patient, and what problems or what good aspects of the patients we came across. It could either be in the form of a discharge summary that you pass on to the ex-patient, or you just call up the person who is going to take over and say in what way you are involved with the patients, because then the person who is doing that actual care can get back to you if they need any further information as well. Here I've worked for NHS for two years and the most important thing that I've found is that very often we don't get enough information about the patient's real problems. We don't get much information from the other agencies as to what exactly they have done with the patient, or what exactly are the problems with the patient, and that really makes the work very hard, very difficult.

Commentary:

What would make things better?

Anuradha Sowent:

Either having patient-held record where the patient is holding the records by himself, where I make a note of what I have seen and if these notes the patient goes, then wherever a patient goes, we can trace these records, at least I get a view of the people who are involved with the patients, that could be one idea. Second thing is having one person, a kind of a key worker named for the person who can liaise with the different agencies and keep the person informed about the different agencies, that is another thing that can happen. The third thing is the

internet, having records on the internet, like suppose I have seen the patient today and then instead of keeping the paper notes of the patient, and paper files of the patient, if we have a server on which we can keep all the records, like as soon as I type in that patient's name and that patient's address, things like that, the whole set of notes pops up, and that also gives me a brief idea as to the people that are involved with that patient, and even they can access what I have done with the patient, and that can increase the communication.

Commentary:

How does Anuradha describe her own role in relation to service users?

Anuradha Sowent:

We really have to play multiple roles, specifically because we go out into the community, we go into the patients' own homes and so we really have multiple roles there because we are going on premises that are not owned by the agencies that pay us, so it becomes a completely different relationship there. Very often we become the target of the patients' dissatisfaction with the agencies, like we become the points where the patients will tell us about all the problems they have had whilst accessing their care, and things like that, and to which we have no control over that, but we just have to sit there and we have to listen, because we also represent the agency for which we're working and it is at present NHS, so we have to listen to all what the patient has to say, and although we may not be able to do anything about it, that gives the patient a satisfaction and they have, they've had a chance of letting out the steam onto someone.

Commentary:

Anuradha has worked as a health professional in a number of different countries. How do relationships between professionals and service users differ from one country to another, and how are things changing in the UK?

Anuradha Sowent:

I've worked over four countries. A lot of it depends on from where the finances are coming from. Very often that is what really changes our roles like, say, in a country like Bahrain or somewhere, it's a Middle East country where the finances are unlimited and the money, the patients can have access to therapy as long as the patient wants, and not as long as the patient needs, so that changes the way you treat the patient and the way you would assess the patient. In a country like India, again things are different, the way money comes from the patients' own pockets and things like that so, there again it would change, but here in this country also it has changed. I mean initially I wouldn't look at the patient with a multidisciplinary point of view as to how the other agencies would be able to help the patient because that is not the way we practise in India. We just have, we have the patient come in for physiotherapy and we just say to the patient you need this, this, this, and then if the patient can have access by himself to another agency that's up to him, but it's not up to us for us to make a way for him to access other agencies. That it's in your jurisdiction, you have more in a multi-professional team; therefore the way I would look at a client is totally different.

Commentary:

Finally, Anuradha suggests that different patients have different expectations of the relationship with professional workers.

Anuradha Sowent:

Some patients are demanding by nature, some patients are just not demanding because they think it will be very inappropriate for them to behave in a particular way with a professional, so they don't come out with it like sometimes I have had to push the patients and say, now, you are eligible for this benefit and you must go, and you must do this. There are some patients by nature are demanding, like they'll say now, I want this, I want that, and then it's sometimes it's a hard time to make the patient understand that, look, I do understand that you do have that on your mind but you're not going to benefit out of it, I can get it for you if you want it, but you're not going to benefit out of it, you get the range, same range of patients who expect too much, who don't expect, who will just take what they can get.