Improving team meetings to support discharge planning

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Following the establishment of a discharge working group, several concerns were raised about the management of multidisciplinary team (MDT) discharge meetings throughout the trust. A project was established to observe MDT meetings, identify good practice and produce practice guidance to improve standards and achieve consistency throughout the organisation.

Delays in hospital discharge have a significant impact on patients, their carers and the NHS. Prolonged and unnecessary hospital stays can (National Audit Office (NAO), 2003):

- Increase dependency;
- Increase the risk of developing complications such as healthcare-associated infection;
- Have an adverse effect on the use of resources in the NHS, such as lost bed days resulting in other patients having to wait longer for treatment;
- Increase the stress experienced by staff.

Effective discharge planning can reduce delayed discharges and therefore support the achievement of The NHS Plan (Department of Health, 2000).

**The project**

A practice development project was established at Queen Elizabeth Hospital NHS Trust, London, to improve multidisciplinary team (MDT) meetings and support effective hospital discharge.

A multiprofessional and interagency discharge working group was established in order to improve discharge planning.

The group held a series of focus group meetings with clinical staff from all professional groups across the organisation to establish the areas of discharge planning that were a cause for concern. Many areas were highlighted as having potential for improvement. The results of this approach indicated that the most common method of coordination between professional disciplines within the trust was in the form of MDT meetings held on a weekly basis in most adult clinical areas.

The following concerns were identified relating to MDT meetings in the organisation:

- There were discrepancies and variations in relation to the purpose of MDT meetings across the organisation;
- There were poor MDT working practices in some areas with variations in the timing and frequency of meetings. Some MDT meetings were not decision-focused and had no standard format. This implied that there was no clear structure and agenda for these meetings. There were some concerns expressed about the lack of leadership during some of these meetings;
- There was poor documentation of decisions following these meetings and therefore it was difficult to keep track of priorities and actions that followed meetings.

Following the results from the focus groups, an action plan was developed to address the issues that emerged from this initial work. A practice development project was established to observe MDT working practice across the trust and identify areas of good practice and develop guidance for the conduct of MDT meetings.

The objective was to agree best practice, provide consistency, enable staff to enhance their knowledge and skills in discharge planning, support training and education of staff, and provide a benchmark to evaluate practice.

**Methods**

It was decided to use a qualitative approach to identify the various practices that were in place within the trust and highlight areas for improvement and development.

The methods used in the assessment of practice were as follows:

- Observation: A total of 12 wards were included from both medical and surgical adult areas. An independent observer studied the MDT discharge meetings over a period of 12 weeks, looking at style of leadership, the structure and process of meetings, and documentation.
- Semi-structured interview: A series of semi-structured interviews were conducted with various professionals. A total of 42 staff were interviewed, comprising 18 nurses, three doctors, seven occupational therapists, five physiotherapists, six care managers, and three discharge coordinators. These interviews ranged in length from 20 to 30 minutes.
Defined roles and responsibilities around their meetings. There was also a lack of clearly structured decision-making and no standard format. Overall, 62% of clinical areas did not have a clear structure to leadership observed. Medic-led MDT meetings provided information about clinical progress and strengths and weaknesses of the professional style of leadership which influenced the structure and focus of the meeting. Table 1 shows the observed strengths and weaknesses of the professional style of leadership observed.

Medic-led
- Recognised leadership and authority
- Indicated clinical progress
- Clear treatment and diagnosis decisions
- Formal defined decision in relation to expected date of discharge

Weaknesses
- At times could be authoritative, not taking account of the input of some therapists
- Junior doctors may lack understanding of their role
- Focus on medical issues, less focus on social issues

Nurse-led
- Recognised leadership and authority
- Good knowledge of social issues
- Taking into account views of patients and carers

Weaknesses
- Depending on the experience and skills of the nurse leading the MDT meeting, leadership could be weak
- Inability to make formal decisions on expected date of discharge

Allied health professional-led
- Provided good coordination between professionals
- Good at supporting discussion between professionals

Weaknesses
- Lack of leadership and clear authority
- Lack of structure and decision-making

Findings
Following observations of MDT meetings in all 12 clinical areas it was found that 80% had regular weekly MDT discharge meetings.

Leadership of MDT meetings
Three styles of leadership were observed and related to the person who led the meeting – medic-led, nurse-led and allied professional-led. There were no observed MDT meetings led by social services. Each of these professionals had their own particular style of leadership which influenced the structure and focus of the meeting. Table 1 shows the observed strengths and weaknesses of the professional style of leadership observed. Medic-led MDT meetings provided information about clinical progress and decisions on expected date of discharge (EDD). However, there was less emphasis on some social issues relevant to discharge planning. The nurse-led MDT meetings provided a social focus but leadership skills could sometimes be weak and clinical decisions relating to EDD were not addressed.

Structure of MDT meetings
Various patterns of MDT meeting organisation were observed across clinical areas. Some ward areas gave the meetings a high profile, with a clear structure and regular attendance by all professionals. Others had unclear leadership, poor focus upon decision-making and no standard format. Overall, 62% of clinical areas did not have a clear structure to their meetings. There was also a lack of clearly defined roles and responsibilities around the management of discharge. Although each professional interviewed was able to state their role and contribution to MDT meetings, approximately 60% of clinical areas were unclear about roles and responsibilities for actions following meetings.

Documentation
It was found that the documentation used by nursing staff on the admission of patients into clinical areas was often not completed fully. Therefore accurate information about the patients’ pre-morbid condition and social circumstances was not effectively communicated in meetings. A total of 45% of all nursing documentation reviewed was incomplete. Each clinical area had identified problems with documentation and had produced its own documents to overcome these issues. Therefore there was no consistency in the documentation used and the information collected for each patient.

Various practices in the documentation of the discussions and agreed actions of the MDT meeting were observed. A total of 46% of meetings had no documentation of actions and decisions following the meeting with no clear responsibility documented for the follow-up of identified actions. It was observed that each professional attending the meeting kept their own documentation and there was no common summary of the discussion.

Guidance for meetings
Guidance was produced, following the results of the project. It was important to clarify issues about decision-making and to clearly define certain aspects of the discharge process.

TABLE 1. OBSERVATIONS FROM MEETINGS LED BY DIFFERENT PROFESSIONAL DISCIPLINES

<table>
<thead>
<tr>
<th>PROFESSIONAL DISCIPLINE</th>
<th>STRENGTHS</th>
<th>WEAKNESSES</th>
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<tbody>
<tr>
<td>Medic-led</td>
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REFERENCES


This article has been double-blind peer-reviewed.

For related articles on this subject and links to relevant websites see www.nursingtimes.net
The objective of an MDT meeting is to discuss all patients needing multidisciplinary input and focus on patients for whom an action plan can be set for their discharge because they are no longer acutely ill, are improving or are medically more stable. The aim should incorporate who is going to implement the action plan and when it has to be carried out. It is important therefore that every MDT meeting agrees who has the appropriate experience and will do the following:

- Lead and take control of the meeting, ensuring that it keeps to time;
- Make sure that all relevant patients are discussed appropriately;
- Make sure that there is a summary of the MDT discussion and the agreed goals, discharge plan/date actions in the patient’s record along with clear lines of responsibility and time frames for needed actions;
- If there are disputes between carer and patients, disciplines or others that cannot be resolved at the MDT meeting, ensure a case conference is organised as soon as possible.

It is important that each MDT meeting agrees where shared information is documented and that a nominated member takes responsibility for the following:

- Making notes throughout the meeting in the appropriate documentation;
- Ensuring a summary of discussions and outcomes in terms of goals, discharge planning and planned/predicted discharge date;
- Documenting action plans with identified responsibility for actions and follow-up.

It is important that professionals attending the MDT meeting have a clear understanding of their role, responsibilities and contribution to the meeting (Box 1).

**Discussion**

The results of the observation across the adult clinical areas in the trust supported the initial concerns raised from focus groups. However,
**Box 1. Roles and Responsibilities**

**Nurse**
- Give information about the pre-morbid state of the patient.
- Provide information on the level of function before admission, currently and predicted at discharge.
- Provide information on the social circumstances of the patient and any discussions with carers or family members.
- Discuss any referrals made or required.

**Doctor**
- Provide expert input into the clinical management of the patient, and outcomes in terms of placement and care following discharge.
- Provide advice and accept referrals for continuing care eligibility assessment.
- Communicate with the MDT about the projected date of discharge and predicted length of hospital stay.
- Ensure referrals are made as soon as possible.
- Inform the team on medical progress, including outstanding investigations.
- Maintain written records of decisions made at MDT meetings.

**Care Manager**
- Can advise the MDT of the sociolegal implications of decisions made at MDT meetings.
- Discuss any perceived needs that the patient will have on discharge.
- Provide feedback on the social care needs of the patient.
- Discuss the care plan, which sets out how any needs will be met and how risks will be managed.
- Report on the patient’s progress in the assessment and care planning process, including financial approval for any expenditure.

**Occupational Therapist**
- Share accurate information about the patient’s medical and social conditions and progress with rehabilitation.
- Avoid different professions repeating assessments unnecessarily or working in a contradictory manner.
- Give feedback from assessments and other occupational therapy input, such as discussions with the patient and/or family members.
- Contribute to treatment and discharge planning.
- Build rapport with other members of the MDT.
- Increase awareness of the role that occupational therapy plays and hence increase the accuracy of referrals and decrease the chances of patients being discharged inappropriately.

**Physiotherapist**
- Acknowledge receipt of any referral at the MDT meeting.
- Responsible for ensuring that the MDT is fully informed of the progress of the patient at MDT meetings.
- Inform the MDT of any outpatient arrangements, such as community physiotherapy and day hospital appointments.
- Inform the MDT team of any risks that may have been identified during physiotherapy intervention.

**Discharge Coordinators**
- Liaise with team members to ensure all patients have a realistic projected discharge date.
- Develop and maintain links with external agencies and inform the MDT of any discharge issues.
- Facilitate and promote early safe and effective discharge planning for all patients.
- Update on the progress of very complex discharges.

There were some areas of good practice and this formed the basis for the development of good practice guidance. Observations of the leadership style of each professional taking this role was interesting and reflected the prime focus for each professional’s care and treatment of patients. This result reflects a previous study by Healy et al (2002) in which different professional configurations of multidisciplinary teams influenced the type of referrals made and was also seen in the semi-structured interviews results. It has been argued that for collaboration to be effective between professionals, a clear understanding of all different roles is needed. This understanding will contribute to a recognition and respect for others’ opinions and contributions (Adler et al, 1995).

It is hoped that the guidance developed from this work will provide different professionals within the multidisciplinary team with an opportunity to recognise and understand others’ contribution to patient care and outcome.

Fostering understanding between professionals has been found to promote professional behaviour and accountability and improve the referral process between them (Halm et al, 2003).

The results indicated that the documentation of discussions in the MDT meeting and agreements of any actions were generally poor. It was not in the scope of this particular project to develop specific discharge planning documentation.

Previous research has discovered that the use of integrated care pathways (Sulch et al, 2002) and the use of MDT discharge pro formas can improve MDT care and documentation (Monaghan et al, 2005). However, it was felt that it was important to ensure that fundamental understanding about role and responsibilities was established before the standardisation of documentation could be fully addressed.

**Conclusion**

There are significant development implications for nurses arising from this practice development project. Nurses are actively involved in running and participating in MDT discharge meetings. It is important for the improvement of these meetings that all professionals are aware of their role and their contribution.

Nurses need to be clear about and understand different professionals’ roles and responsibilities in order to improve professional behaviour and accountability. It is hoped that the resulting guidance will provide a framework and act as a benchmark of good practice, and will open discussion and promote understanding among the professionals involved in MDT discharge meetings.

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**References**