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Interprofessional team work: Making it the norm in our care

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We often hear the term “interprofessional team work” in discussions about the best care for persons with diabetic foot ulcers. I suspect if we asked 10 healthcare professionals about how they define and carry out interprofessional team care, we would hear varied responses. These would range from differences in what constitutes team care, to who is on the team to when and how such teams work best. However, I am sure most would agree that we do not have enough interprofessional team care especially for people needing diabetic foot care.

Current views of the interprofessional team usually include the patient and family, and multiple caregivers working together within and across settings to achieve common goals for provision of comprehensive care. We do not all have the same knowledge and skill sets, so we come together and share our knowledge, skills, insights and solutions, using best evidence, experience and input from the patient and family.

However, as a care provider, there are questions to ask:

- How easy and timely is it to connect with a specialized nurse, allied health, chiropodist/podiatrist, social worker, physician, or specialist to obtain expertise in wound management?
- How easy is it to discharge a patient from one sector to another and transfer the care to another professional sharing the patient’s profile and next steps in the plan of care?
- How easy is it to incorporate the patient’s goals into the plan and have everyone who comes into contact with the patient and family appreciate them as legitimate goals?
- How easy is it to have the perspectives of social work, nursing, medicine, primary care, psychology, allied health and others especially those with wound care expertise present from the beginning to gain a holistic view and to formulate a comprehensive plan of care with the patient?

Interprofessional team care works best when the entire team can be available at the time of initial assessment and care planning to provide perspectives, recommend interventions and identify expected outcomes and deadlines.

We are often very effective in pulling the entire team together when care has reached a crisis stage, quickly arranging the team meeting, and bringing in the patient and family as well. While laudable, this at times can be too late to impact patient clinical and quality of life outcomes, and patient and provider satisfaction. If we are serious about team-based care, we need to frame the care experience in the context of the team at the outset, especially in those situations where patients are at high risk.

The most appropriate providers should be identified following a comprehensive assessment, take the lead, and regularly update and bring in other team members with the required expertise as necessary. Such approaches to interprofessional team care would greatly enhance our care of people with diabetic foot ulcers, and do much to prevent many of the outcomes that make this condition so dire.

This edition of the journal is rich with information about how to provide exceptional and evidence-based care for our patients.

Two articles in particular strike a chord about team care. First, the commentary, which serves to remind us all about incorporating patient views into the plan of care, and involving the necessary expertise on the care team based on the patient’s health profile. In the article on glycaemia management, the author shares a helpful table related to organising the best team for specific care needs. In addition, in the article on mobile healthcare monitoring, we are reminded of the vast impact that technology can have, in particular to assist patients and providers alike access necessary expertise. Finally, the article on consensus statements for diabetic foot osteomyelitis demonstrates intraprofessional team work in action. Enjoy the read!
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