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research article

Interdisciplinary team members' experiences of family meetings in an Irish rehabilitation hospital: a social work action-research project

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This study set out to gain a better understanding of how family meetings are facilitated and experienced in an Irish rehabilitation hospital setting from the perspectives of interdisciplinary team (IDT) members, patients and their family members. This article reports the findings from IDT members' perspectives. A critical-realist action-research approach was utilised that involved medical social workers ($N = 15$) and a social work academic. A quantitative, descriptive study design was adopted, which utilised a cross-sectional survey of IDT members. A total of 85 clinical staff responded to the questionnaire, of which 69 were fully completed. Four key themes emerged: pre-meeting engagement and preparation – a critical step; the impact of organisational structures; supporting participation; and mechanisms for effective family meetings. Findings indicate the importance of pre-meeting preparation, the mutuality of the relationships between participants, a standardised approach and the use of patient-centred and inclusive practices to achieve truly participatory family meetings. Family meetings involve complex processes in which mutual influence, context, preferences, values, information shared, the nature of the relationships involved and the communicative style of participants all play significant roles in both the process and decision-making outcomes. This study concluded that social workers are perhaps in a unique position to work with IDTs in clarifying the reality of the limits of choice and the involvement of the patient and family in rehabilitation hospital settings. In preparation for the role of family-meeting facilitation, the implementation of education and training programmes for IDT members is strongly recommended.

Keywords family meetings • social work • action research • interdisciplinary • participation

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Introduction

Health service delivery in Ireland and internationally is now increasingly characterised by an ethos of partnership, reflected by the growing emphasis on providing comprehensive services through teamwork, interdisciplinary team (IDT) member collaboration and active collaboration with patients, their families and their caregivers (Dogba et al, 2016). Although the primary rationale for sharing decisions between patients and IDT members is based on such values as respecting the right to self-determination and autonomy, there is evidence that supported decision-making leads to better outcomes (Stacey et al, 2017). Advocacy, empowerment, upholding human rights and social justice are fundamental to social work, arguably placing the values and principles of assisted decision-making strongly aligned with the ethos of the profession (Donnelly, 2021). The original impetus for family meetings arose from policy drivers that, over the last two decades, have become increasingly focused on human rights, autonomy, self-determination, independence, patient participation and discharge planning, particularly for hospital patients (Donnelly et al, 2013). Formal IDT family meetings, therefore, provide an important opportunity for communication and supported decision-making between patients, families and rehabilitation professionals (Foster et al, 2012).

A family meeting involves the patient, a number of family members and IDT members in purposeful discussions concerning the patient's illness, treatment and plans for their discharge or care outside the hospital (Jonas et al, 2020). The IDT may comprise such professionals as doctors, nurses, psychologists, occupational therapists (OTs) and physiotherapists, speech and language therapists (SLTs), and social workers, who have a vital role in facilitating and enabling the active participation of patients and carefully consider the patient's wishes (O'Leary et al, 2012). IDTs are widely viewed as the best way for teams in rehabilitation settings to work. IDT working occurs when all members of the team work collaboratively together to plan, review and achieve common goals (Nancarrow et al, 2013). In Ireland, the National Clinical Programme for Rehabilitation Medicine strongly encourages IDT approaches to promote, maintain and restore the physical, psychological and social well-being of the person with rehabilitation needs (Health Service Executive, 2017: 9).

Despite the increased utilisation of family meetings in many healthcare settings (Donnelly et al, 2018b), there is no universal understanding or definition of the concept. A range of different terms are used to describe the same or similar processes, including 'family meetings' (Hannon et al, 2012), 'family conferences' (Duffy and Healy, 2011), 'discharge planning conferences' (Bångsbo et al, 2014) and, more recently, 'care planning meetings' (Donnelly et al, 2018b). The term 'family meetings' will be used in this article, as that is the working terminology for the process of group meetings with patients and families in the hospital under study.

Although originally designed to respond to crisis situations, family meetings are now routinely used in a more proactive manner (Loupis and Faux, 2013) and, when carried out well, are thought to build important organisational bridges between hospital and community care (Donnelly et al, 2013). Family meetings are a useful intervention for addressing and meeting carer needs and can lead to a reduction in carer distress (Reed and Harding, 2015). In rehabilitation settings, they also create an important opportunity to provide the patient and their family with targeted education about their specific illness/injury (Foster et al, 2012) and facilitate discussion about the potential life-altering implications of that illness/injury.

In the Irish context, participation in decision-making is underpinned by a policy and legislative framework. The Health Service Executive's (2022: 11) *National Consent Policy* states that 'Adults who have to engage with healthcare workers have a fundamental ethical and legal right to control their own lives, to make informed decisions on matters that relate to them and to decide what happens to their own bodies.' The Assisted Decision-Making (Capacity) Act 2015 has established a legal framework for assisted or supported decision-making. The act replaces the 'best interest' model and applies a functional test to determine capacity, which is time, issue and context specific. It introduces a model of will and preferences, where people's values must be central to all decision-making and 'unwise' decisions are to be respected. There is also an onus on health and social care professionals (HSCPs) to take all practicable steps to enable participation in decision-making by adapting their communication styles, tailoring information and communicating information in a manner that is accessible to each individual (Donnelly et al, 2021). The legislation was fully commenced on 26 April 2023, and all HSCPs are expected to embrace its underlying principles and philosophy in practice contexts (this study was carried out prior to the commencement of the act).

Although family meetings are an increasingly common part of the practice of social work and interdisciplinary teamwork, it is uncertain how and by whom the voice and wishes of patients are given due priority (Donnelly et al, 2013). Despite early optimism about the potential value of family meetings, the aspiration of the active participation and empowerment of patients and their families in decision-making is often not met in clinical practice because of resource demands and organisational difficulties (Reed and Harding, 2015; Donnelly et al, 2018a; 2021). In addition, all professionals are dependent on each other in their decision-making processes, as the decision of one professional affects the decisions of the others within the IDT (Duner, 2013). Within rehabilitation settings, family meetings are an integral part of the medical social work role of enhancing patients' and family members' progress through inpatient rehabilitation, and important interactive work is required to integrate patients into discharge discussions (Schoeb et al, 2019). While there is a considerable body of literature on how to involve patients with cognitive and communication deficits and other complex needs in care planning and decision-making, there is little specific guidance on how to best plan and facilitate family meetings for these patients. The lack of empirical knowledge about how the participation of patients in family meetings is best accomplished is a cause for concern (Bångsbo et al, 2014), and a number of questions remain unanswered about the purpose and efficacy of such meetings (Milte et al, 2015; Donnelly et al, 2018b).

Several studies highlight the importance of giving voice as a way of relieving much of the distress experienced by patients and family members (Foster et al, 2012; Hannon et al, 2012). Yet, family meetings can be restricted by the structure and process of meetings, which often do not accommodate the needs of all patients (Milte et al, 2015). For this reason, it is of great interest to gain a better understanding of family meetings from the perspective of patients, family members and IDT members who participate in and facilitate family meetings. In addition, social work practitioners now increasingly seek to embrace research knowledge and develop the skills needed to undertake research as an integral component of their professional practice. In an environment of budget constraints and escalating demands in health and social care, social workers are under pressure to demonstrate the effectiveness of their practice and its contribution to quality care through research (Joubert and Webber, 2020).

Irish social work has, however, been slow to develop a research culture and professional structures to support research capacity (Donnelly and Anand, 2016); therefore, a secondary aim of this study is to develop and increase the skills and research knowledge of social work practitioner-researchers.

Study context

The study was carried out in a rehabilitation hospital in Ireland. The hospital provides a comprehensive range of complex specialist rehabilitation services for patients from throughout Ireland who, because of injury or illness, may have acquired severe physical and/or cognitive disabilities. It delivers three adult programmes; the Brain Injury Programme (including stroke); the Spinal Cord System of Care Programme; and the Prosthetics, Orthotics and Limb Absence Rehabilitation (POLAR) Programme.

Family meetings are an integral part of the rehabilitation journey, with each patient/family having at least one meeting of 45–80 minutes duration with the IDT team during their in-patient stay. An information leaflet outlining the purpose and structure of the meetings is available, and social workers play a lead role in the preparation and planning of family meetings. Staff spend a substantial amount of clinical time at family meetings. Approximately 150 staff each year are involved, with the treating consultant or the IDT social worker acting as the facilitator for family meetings.

As the social work department plays an integral role in family meetings, it was interested in how they are experienced by patients, families and staff. There was a concern that family meetings sometimes became formulaic and a 'tick-box' exercise, with tokenistic patient participation and little collaboration or discussion between patients, family members and staff. This study, therefore, set out to gain a better understanding of how family meetings are facilitated and experienced in a rehabilitation hospital setting from the perspectives of patients with complex neurological needs, their family members and IDT members. This article reports solely on the IDT staff survey findings.

Ethical considerations

Full ethical approval was granted by the hospital's Ethics Committee and this approval was subsequently endorsed by the UCD Human Research Ethics Committee (Humanities). Ethical challenges related to the fact that research was being carried out by the social work practitioners, who adopted an 'insider' position, thus raising issues of potential bias. However, it could also be argued that this provided a heightened sensitivity to the data collection and analysis process.

One limitation of the study is the Irish-specific context. This study provided a number of insights into how IDT members perceived family meetings across three clinical programmes in a national rehabilitation hospital in Ireland. The study findings cannot be extrapolated to similar hospitals in other jurisdictions. The issue of the insider status of the social work practitioner-researchers and medical consultant also raises questions as to the objectivity of the data collection and analysis process; however, the inclusion of an experienced social work academic as part of the research team helps to mediate the impact of any potential bias.

Study design and methodology

A mixed-methods approach was utilised. This approach focuses on research questions that call for real-life contextual understandings, multi-level perspectives and cultural influences, employing rigorous quantitative research assessing the magnitude and frequency of constructs, as well as rigorous qualitative research exploring the meaning and understanding of constructs, utilising multiple methods (Creswell et al, 2011). Our study addressed three key research questions:

- Context: what are IDT members' opinions and experiences of family meetings?
- Mechanisms: what are the perceived enablers and barriers to effective family meetings?
- Outcomes: are IDT members satisfied with the levels of participation and decision-making of patients and their family members during family meetings?

An online cross-sectional survey was deemed the most efficient approach to gather a wide range of responses from IDT staff in the hospital on the opinions and experiences of family meetings. Surveys are frequently utilised to accurately collect information that measures the attitudes, knowledge and behaviours of respondents (Creswell and Creswell, 2018). The survey consisted of a mixture of open-ended, closed-ended and multiple-choice questions. Free-text boxes were used to gain additional insights into participants' subjective experiences and gather suggestions for improvement. The survey gathered information on a number of topics, including: professional experience and length of time in the current IDT; the extent of formal training received on family meetings; confidence levels when communicating information; the participation of patients and family members; decision-making processes; and organisational support available in relation to family meetings. The survey was electronically distributed via the hospital's internal email system. Two reminders were emailed within the response period.

Critical realism and an action-research approach

Critical realism has been identified as a useful philosophical framework for social science researchers to explore the structures and mechanisms that lie beneath the surface of the area under investigation and to identify the causal mechanisms that generate events occurring, in this case, in family meetings (Fryer, 2022). This means researchers becoming conscious of the context, structures and discourses that give shape to interaction. Critical realism suggests that there are three levels of reality: the empirical level, consisting of experienced events; the actual level, comprising all events, whether experienced or not; and the causal level, embracing the unseen mechanisms that generate events. It views the social world as comprising a myriad of interconnecting systems – personal, familial and institutional, to name a few – each with their own generative mechanisms (Houston, 2010).

Emancipatory objectives form part of a critical-realist research agenda underpinned by the understanding that when phenomena are under investigation, it may be possible to identify how these features may be influenced via mechanisms in order to ameliorate harmful effects or to enhance beneficial effects (Haigh et al, 2019). Action research is a methodological approach that embraces critical-realist premises, as it is concerned not only with programme evaluation but also with emancipatory change. In addition, the focus on the interplay between human agency and social structures is central to critical realism and to the focus of this study (Houston, 2010).

This study utilised an action-research approach with participatory elements, whereby 15 medical social workers, along with the first author, a social work academic and a medical rehabilitation consultant, engaged in the study design, data collection and analysis. The first action-research cycle set out to explore patient, family and IDT perspectives and experiences of family meetings. The second cycle – the development and implementation of a protocol for family meetings – is currently under way. This article describes one element of the first cycle: IDT members' perspectives on family meetings. Patient and family member experiences of family meetings were also explored via administration of the survey questions in a face-to-face interview format.

All IDT members in the rehabilitation hospital (*N* = 350 staff) were invited to complete an electronic survey if they had direct experience of participating in a family meeting. The survey was developed using Survey Monkey® and distributed via email to all clinical staff in the hospital. The development of the survey was informed by clinical experience and previous literature in this field (Donnelly et al, 2013). Demographic data on survey participants were gathered to explore any gender, interdisciplinary or programmatic differences in family-meeting experiences.

Data analysis

Data analysis of the free-text questions/qualitative data followed a five-step critical-realist approach to thematic analysis, as outlined by Fryer (2022). Data were grouped by identifiable similarities and trends by three social work practitioner-researchers (AO'L, PB and ER), the social work academic (SD) and the medical consultant (PC). Convergent themes were noted and developed, and supportive quotations were identified over a six-month period. Due to workload pressures in the rehabilitation hospital, time to engage in the data analysis became a significant issue, resulting in the process becoming drawn out and protracted.

Emerging themes identified from the qualitative data were extracted and shared with all members of the medical social work department. One two-hour 'confirmation' focus group was then held, whereby all members of the social work department completed an in-depth review and analysis of one of the survey questions, with consensus sought in relation to emerging themes. The medical social workers struggled to critically engage with the data-analysis process, however, preferring to 'default' to the expertise of the core research team. One additional data-analysis meeting was held in 2023 with all authors as part of the review process for this article, whereby causal explanations of family-meeting experiences were explored.

Results

A total of 85 clinical staff responded to the survey questionnaire, of which 69 were fully completed (see Table 1). Table 2 provides an overview of the 69 respondents' demographic data broken down by clinical area, including gender, professional

Table 1: Survey question responses

Question	Yes (%)	No (%)	Sometimes (%)	Unsure/ other (%)
Have you had formal training?	15	53	0	1
Would guidelines or training be helpful?	52	6		11
Do you generally meet family members in advance?	43	2	24	0
Does sufficient planning take place in advance?	21	14	34	0
Does it help to meet family before?	61	1		7
Are patients involved enough?	20	14	33	2
Are patients lacking capacity included differently?	48	3	0	18
Are family members involved enough?	27	7	30	5
Do patients and families get enough information during meetings?	17	4	14	34
Do patients and families understand key messages during meetings?	27	58	34	0
Is there adequate clinical supervision provided?	31	14	24	0

discipline, number of years of professional experience and the length of time working in their current IDT. Four core themes emerged from the analysis of open-text responses:

- pre-meeting engagement and preparation – a critical step;
- impact of organisational structures;
- supporting participation; and
- mechanisms for effective family meetings.

Pre-meeting engagement and preparation – a critical step

IDT survey respondents were asked about pre-meeting preparation, and the majority (62 per cent) reported always having an opportunity to meet with family members in advance of the family meeting, with almost half (49 per cent) of respondents acknowledging that advance planning generally took place before the family meeting. Interestingly, only three respondents believed adequate planning always took place. More than a third (35 per cent) reported that they only occasionally had the opportunity to meet with family members in advance of their family meeting, while two respondents reported never having the opportunity to communicate with family members before the meeting.

One respondent reflected on the value of developing a relationship and rapport with families in advance of the family meeting: 'Having developed a rapport with the family makes it easier as a therapist, and I feel it also makes it easier for the family' (Respondent #23). Several respondents spoke about the challenge of

Table 2: Respondents' demographic data

	Spinal IDT	Acquired Brain Injury IDT	POLAR IDT	Cross-programmatic IDT	Total
Gender					
Female	10	32	1	18	**61**
Male	4	4	0	0	**8**
Profession					
Physiotherapist	3	7	1	5	**16**
OT	4	8	0	2	**14**
SLT	0	5	0	1	**6**
Dietician	1	0	0	0	**1**
Social worker	2	6	0	3	**11**
Nurse	2	3	0	4	**9**
Doctor	1	5	0	1	**7**
Psychologist	1	2	0	1	**4**
Music therapist	0	0	0	1	**1**
Number of years of professional experience					
< 1 year	1	3	0	0	**4**
1–5 years	3	11	0	6	**20**
5–10 years	2	8	1	4	**15**
10+ years	8	14	0	8	**30**
Length of time working in current IDT					
< 6 months	3	7	0	2	12
6 months–1 year	1	9	1	2	13
1–5 years	3	13	0	11	27
5–10 years	4	2	0	0	6
10 years+	3	5	0	3	11

having planning conversations between IDT members prior to a family meeting and how this negatively impacted on the family-meeting process. One respondent commented: 'Sometimes treating team members do not attend the IDT meeting (weekly case conference) and thus do not have insight/opinion of other team members until just before the meeting; this can prove problematic' (Respondent #61). Another respondent reflected on the emotional impact of the information that is communicated during meetings and the importance of patients and their family members having time to receive and process this information before the family meeting:

> We are often involved in telling people they are unlikely to walk again, difficult to do so but I tend to speak to the patient in advance of the meeting to prepare them for any feedback they will get so they have time to think about it, prepare any questions in advance and discuss it again with the wider team as needed. (Respondent #27)

Some respondents noted that even though the IDT members often meet for a five- to ten-minute discussion before the family meeting (in addition to the weekly case discussions between the IDT members), this was deemed inadequate, as it did not allow for comprehensive IDT preparation, reflection on the specific case and treatment planning so that a consistent IDT position/approach could be taken:

> The IDT should be singing from the same hymn sheet and prepare for the family meeting well in advance. Open and appropriately frank engagement with patient and family from Day 1 of admission. No surprise/bad news delivery during the meeting – should have been discussed/flagged well in advance. Preparation of patient and family with intentions and outline of format discussed in advance. (Respondent #3)

Some commented that the nature of the social work role in family-meeting preparation varied depending on the rehabilitation consultant involved or the rehabilitation programme in question. Respondents elaborated on the role of social work in the preparation of family meetings, and there was a consensus that social workers played an important role in pre-meeting engagement with, and preparation of, patients and families:

> Often the social worker is the professional that family members feel closest to and whose role they best understand. Additionally, social workers often have the best knowledge of the many other complex issues (relationships, communication, dynamics) within the family and may be in the best position to provide advocacy for the patient. (Respondent #53)

It appeared that when the social worker had completed the preparatory work with the patient and their family, then this specialist set of skills and knowledge offered a broader overview of the issues than that of other IDT members: 'Given this patient-centred knowledge, [the] MSW [medical social worker] is usually best equipped to facilitate rather than nursing/therapy/doctor led as MSW can enable a global/holistic overview' (Respondent #46).

Impact of organisational structures

The impact of organisational support in relation to training, as well as the impact of the organisational environment of the rehabilitation hospital on family-meeting processes, was another key theme. Most respondents (77 per cent) reported that they had not received any formal training on participation in, or the facilitation of, family meetings, and just over a fifth (22 per cent) considered that it would be helpful to have specific training. Less than half (45 per cent) reported receiving adequate clinical supervision in relation to family meetings, with approximately a fifth (20 per cent) stating that they received inadequate support concerning this aspect of their work during clinical supervision, indicating unmet needs in this area of practice. A total of 75 per cent of respondents reported that they felt it would be helpful to have additional guidance and skills training specific to family meetings.

Respondents did, however, identify a number of supports available to them if they were involved in a particularly difficult or challenging family meeting, including peer support, supervision and support from other IDT members, IDT social workers, occupational health staff, line managers, IDT psychologists and hospital management staff (see Figure 3). One respondent felt that post-meeting debriefing and specialist psychology interventions could enable staff to better deal with challenging meetings:

> I think a formal debriefing chaired by an objective observer trained in the psychology of effective communication would be a valuable addition to the more challenging meetings.... By providing feedback to each member of the team in a safe environment, humility and compassion can be nurtured, trust and rapport built, and an excellent team can become an even better team. (Respondent #34)

Another suggested the need for specific IDT training focused on role clarity, team building and the impact of family meetings: 'Formal training for IDT members to engage together to work on team building and enhanced role understanding and acknowledgement of the impact of family meetings on patients/family would be beneficial' (Respondent #4). Many respondents also suggested that the introduction of guiding principles or a protocol would be helpful, with one respondent stating: 'I think it might be useful to have some agreed principles to the family meeting, a protocol and maybe also a summary and/or information that can be given to the patient and family' (Respondent #37). Other respondents commented on the impact of the organisational environment on patient participation in family-meeting processes: 'In my opinion, at times, in a busy hospital environment the "person" can get lost in the "patient". We strive to provide person-centred care; however, the "operational agenda" can sometimes overshadow this' (Respondent #42).

Lack of time and the busyness of the hospital environment was a factor that was repeatedly highlighted as having a negative impact. One respondent stated: 'I don't think that enough time is given to family meetings. They are often rushed. considering that family meetings are the first opportunity for patients and families to meet the IDT they should be allocated more time' (Respondent #51). Another reflected:

> When there is division within the team regarding functional ability or discharge plan, lack of time to discuss the issues with the patient before the meeting, lack of support from the medical team in terms of explaining the complexity of patient presentation.... Time pressures where there may be three family meetings in one afternoon after a busy morning, meaning that these patients get shorter family meetings than if there is one or two scheduled. (Respondent #18)

Some respondents also reflected on the importance of the dissemination of the research findings at the organisational level and embedding quality-improvement processes: 'Present findings from this project to the hospital in general and to the individual teams to engender discussion on findings agree recommendations arising from feedback and findings. Implement recommendations seek short one page feedback from families and patients Review after six months' (Respondent #23).

Supporting patient and family member participation

The survey also explored IDT members' perceptions of patient participation in family meetings. Nearly a third of respondents (29 per cent) reported that they felt patients were sufficiently involved, with a fifth (20 per cent) believing that they were not involved enough. There were marked differences in responses from staff, depending on the rehabilitation programme in which they worked. While almost two thirds (64 per cent) of respondents from the Spinal Cord System of Care Programme believed that patients were included enough, only six (17 per cent) respondents from the Brain Injury Programme agreed. On the Brain Injury Programme, four (22 per cent) reported that patients were not included enough, while 22 (61 per cent) reported that they were only sometimes included enough.

The majority (70 per cent) of IDT respondents considered that decision-making capacity had an impact on patient participation. Just 4 per cent stated that it had no impact, while 26 per cent of respondents were unsure. Differences were again apparent between respondents, depending on whether they were employed in the Brain Injury or Spinal Cord System of Care Programme. While three quarters of respondents on the Brain Injury Programme (75 per cent) reported that decision-making capacity affected patient participation in family meetings, just over half (58 per cent) of staff on the Spinal Cord System of Care Programme agreed.

Respondents reflected that when patient and family views were sought, important issues for the patient were often identified and engaged with: 'Two-way information sharing; both patient and family interact with the team. Issues are discussed in a sensitive yet realistic manner, not overlooked, or avoided; we support the patient's agenda' (Respondent #2). If such meetings were not inclusive – for example, 'When the meeting is nothing more than therapists reading feedback and there is no discussion' (Respondent #35) – respondents recognised that issues may be missed by the IDT.

The importance of an individualised approach and careful tailoring of information with patients and families was highlighted:

> For many patients on the BIP [Brain Injury Programme], it can be 'information overload' during the family meeting because, naturally, all therapists want to give an overall summary of the key areas they are working on, but for the patient, sustaining their attention or processing all of that information can be very difficult. (Respondent #58)

Respondents reported varying confidence levels around communicating information to patients and families during family meetings. The overwhelming majority of respondents (90 per cent) rated their confidence levels at 7 or above on a scale of 1–10. These responses are captured in Figure 1.

Respondents were also asked how confident they felt dealing with conflict or emotionally distressing issues that may occur during family meetings. On a scale of 1–10, over 80 per cent of staff rated their confidence levels at 6 or above, with only 7 per cent of respondents rating their confidence levels at 3 or below (see Figure 2).

Figure 1: Confidence levels communicating information in family meetings

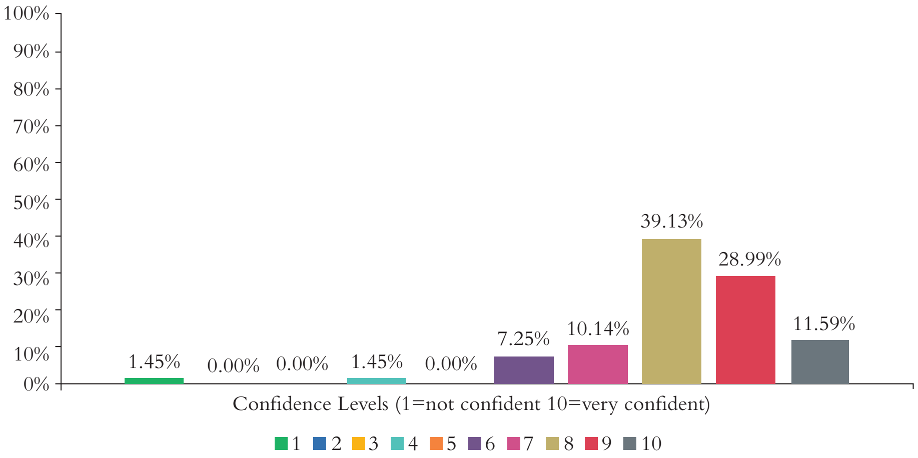
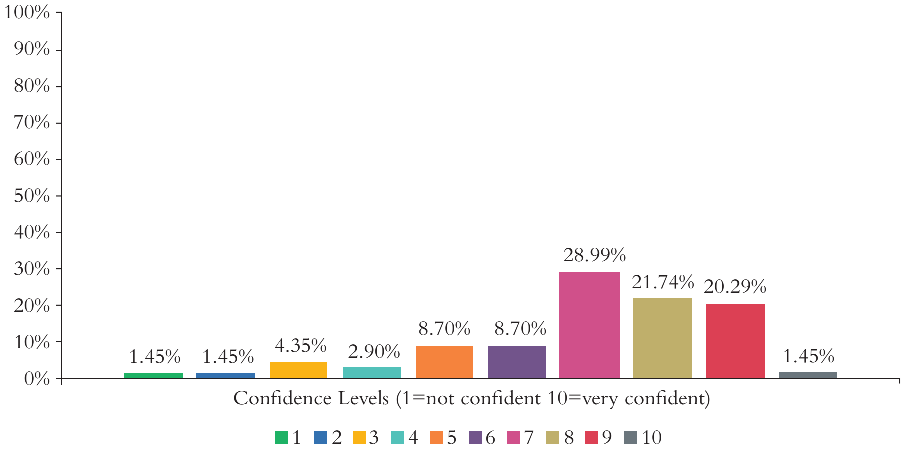


Figure 2: Confidence levels dealing with conflict or emotional distress



One IDT member reflected on the challenge of conveying emotionally distressing information and managing conflict in meetings:

> Obviously, effective communication during a conflict or an emotionally distressing situation or when discussing emotionally distressing issues is paramount and therefore is an area that I give due attention to. It is from these situations that a 'poor bedside manner' originates which can easily lead to distrust and/or further breakdown in communication between health care professionals and patients/families. (Respondent #72)

Another respondent noted: 'I do my best to manage conflicting or distressing situations by utilising supportive techniques, however, I would definitely benefit from further training' (Respondent #37).

Other respondents commented on the diversity of information needs among patients and families:

> Some people need a lot of information, some people need a little, and some need more discussion-based meeting rather than information giving.… I think that we have to reduce the amount of information given and make it more about the patient/family and less about what the staff are doing/reporting on. (Respondent #2)

Some expressed reservations, however, in terms of whether patients and family members understood the key messages being communicated, with 58 per cent of respondents reporting that they believed key messages were not understood. The majority of respondents felt that either more follow-up was required or that written information about key messages should be routinely provided by the IDT. One respondent observed: 'I think the key issues are generally understood at the time of the meeting but when there is a lot of information and people are anxious it can be difficult for them to retain the information so follow-up/reminders are often needed' (Respondent #29).

Mechanisms for effective family meetings

This fourth theme helps us to answer our final research question: 'What are the perceived enablers and barriers to effective family meetings?'. Respondents were asked to comment on what they believed contributed to a 'successful' or a 'difficult' family meeting; these findings are summarised in Table 3.

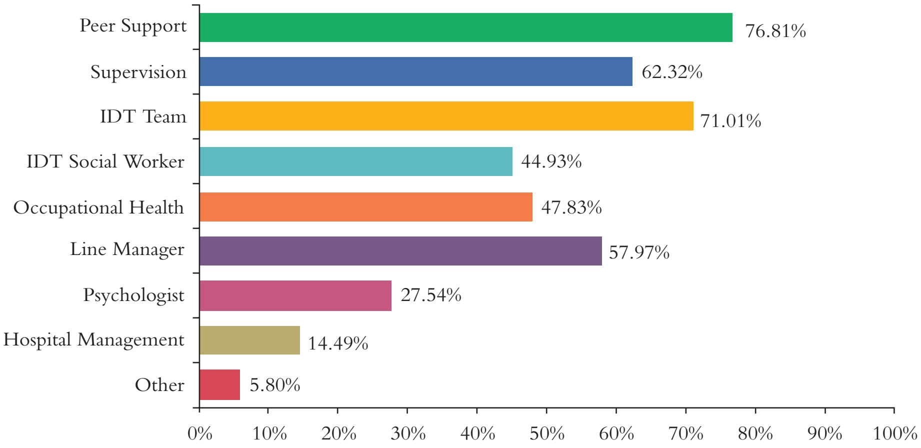
Respondents described 'successful' meetings as those where sufficient pre-meeting preparation had taken place and patient and family member expectations were met during the meeting process. The importance of not introducing 'new' information or 'surprises' was also seen as an important factor leading to a successful meeting.

Environmental and social mechanisms were also identified. These included the physical environment where meetings are held, as well as social resources, such as time, flexibility and skills. In addition, respondents stressed that there should be no interruptions and that meetings should be held in an informal, comfortable room. Many respondents highlighted the difficulty of finding a meeting time that suited

Table 3: Barriers to and enablers of family meetings

Barriers	Enablers
Poor meeting preparation	No 'new' information or surprises
Staff arriving late	Good pre-meeting preparation
Poor communication	Patient and family member expectations managed
Use of technical jargon	No interruptions during meeting
Physical environment	Informal, comfortable room
Lack of consistency in views of team members	Clarity on support services that can be accessed
Too much information	Written copy of information and key decisions
Fixed meeting times	Flexibility in meeting times
Poor facilitation skills	Skilled facilitator
Conflict and disagreement within IDT	Team consensus

Figure 3: Staff supports which can be accessed after family meetings



all participants and suggested that there was a need for greater flexibility within the scheduling and tailoring of the format of family meetings.

Some respondents reiterated the importance of individualised approaches: 'I would like communication preferences of families and patients of the hospital to be queried and then planned for accordingly, i.e., shyness, uncomfortable with large crowds of people, preference for smaller groups etc.…We need to move away from a formulaic one size fits all approach to family meetings' (Respondent #61). As highlighted earlier, tailored, jargon-free information provision was viewed as critical; the need to provide information on available support services within the hospital and in the community was considered fundamental, as was the provision of written information on key decisions. Finally, the importance of a skilled family-meeting facilitator and a team consensus in relation to the proposed discharge plan was also noted: 'I think that improvements could be made by introducing an open or rotating chair/facilitator on the basis of the best person for the job rather than on discipline' (Respondent #11).

IDT members reported that family meetings were usually facilitated by either the treating consultant or the social worker; however, many believed that social workers were often best placed to facilitate meetings because of their knowledge of patient and family dynamics:

> Sometimes I feel I may not be the best in dealing with emotionally distressing issues and have often observed the social worker intervening to support the family/patient when this comes up – as they have often built-up good rapport and relationship with the family. Social workers do this really well and provide a nice model of this which empowers me to deal with such issues in a more supportive way the next time it may come up. (Respondent #12)

Respondents also described barriers or contributory factors to 'difficult' family meetings, which mirrored many of the enabling mechanisms, such as pre-meeting preparation, the physical environment where the meeting takes place, language and the provision of information, as well as consistency in approach by IDT members. One respondent reflected on the potential negative impact of poor preparation by the IDT: 'Poor preparation by staff members, if it's the first time they've been contacted by the team/therapists, too much information given in medical speak, not given adequate time for questions' (Respondent #7). Many respondents commented on the impact on patients and families of the venue in which meetings took place: 'Many patients/families have reported they find the room daunting "like being brought to the principal's office" … meetings often do not run on time and people are left waiting in a narrow corridor.… The formality of the conference room can be intimidating for patients and families' (Respondent #44).

Others referred to problematic behaviours of IDT members and lack of consistency in the views of team members during the meetings. One respondent reflected on the challenge of power struggles between IDT members, for example, 'When a particular discipline or the consultant become locked in a power struggle on a particular issue leading to the difficult conversation/issue becoming shut down rather than opened up' (Respondent #53). The importance of making language accessible was repeatedly highlighted by respondents as a barrier and enabler, and was deemed a significant influencing factor to maximising patient and family member participation: 'No jargon … the meeting is for THEM, not us' (Respondent #65).

Discussion

This article has reported on the findings of a survey of IDT members' views of family meetings in an Irish rehabilitation hospital using a mixed-methods critical-realist action-research approach. This approach emphasises the role of agency and structure as causal tendencies (Houston, 2010) and has facilitated the identification of deep mechanisms operating at the 'real' level of family-meeting processes. While respondents reported that current practices in family meetings were generally of good quality, they also identified barriers to and enablers of successful family meetings and patient and family participation, as well as areas for quality improvement.

The quality of individual practitioners' communication skills and their ability to foster trusting relationships with patients and their families were viewed as fundamental to patient participation and effective family-meeting processes (Bunn et al, 2018). While the reported high confidence levels in communication and decision-making and dealing with emotional distress or conflict are reassuring, this appears to contradict another finding, specifically, that staff reported that communication in family meetings can often be poor. The importance of pre-meeting preparation, the mutuality of relationships between participants, and the use of patient-centred and inclusive practices as mechanisms to achieve truly participatory family meetings was evident. IDT members recognised how pre-meeting preparation could act as both an enabler of and a barrier to successful family meetings, suggesting that pre-meeting planning can be dependent on such factors as agency, tradition, professional value systems and personality rather than standardised guidelines or policies (Donnelly et al, 2018b).

Context was also important; despite concrete policy and legislative underpinnings to assist decision-making in the Irish context, this was not always evident in practice, with IDT members often struggling to deliver a consistent team approach to patient participation, communication and the tailoring of information. There were inconsistencies in how patients from different clinical programmes were involved in decision-making, suggesting a lack of standardisation in practice and differing skill levels among IDT members (Sinclair et al, 2019). Only a minority of staff from the Brain Injury Programme believed their patients were involved enough, suggesting specific challenges in how IDT members support and maximise the autonomy and participation of patients with a defined cognitive impairment. This is consistent with the previously reported 'tokenism' of patient participation within the family-meeting process for those with cognitive impairment (Bångsbo et al, 2014; Donnelly et al, 2018a). It appears that IDT members may revert to the comfort zone of giving a lot of complex information or advice, and that they struggle to achieve active participation for all patients, strongly indicating the need for communication training on providing individualised, tailored information (Nordh and Nedlund, 2017). Maximising the inclusion of patients with cognitive or communication difficulties can be challenging, and the importance of having adequate time available to employ these helpful supportive strategies has been highlighted (Tarzia et al, 2015).

In relation to outcomes, a key enabler identified was 'knowing the patient and family', which was viewed as a significant factor in establishing the basis for successful family meetings but was often difficult to achieve. The building of a therapeutic relationship and creating an emotionally secure environment can help establish trust and understanding of the patient's and family's priorities and wishes (Sinclair et al, 2019). Family meetings represent an opportunity for the expression and exploration of the lifeworld of both the patients and their families; however, this fragile space can be vulnerable to manipulation or colonisation by healthcare professionals' systems world (Donnelly et al, 2013). IDTs that function where there is recognition and value placed on the differing skills, knowledge and contribution of each professional can clearly enhance family-meeting processes in the hospital environment (Waller et al, 2018). A significant barrier identified was when IDT member collaboration was not as strong or where the biomedical model was dominant, either by the influence of the treating consultant or through the impact of organisational structures like discharge planning pressures or inadequate organisational support for staff (Bunn et al, 2018). Time and the physical environment for family meetings were repeatedly cited as significant mechanisms to supporting patients' and their family members' participation. Sufficient time must be given for the patient to evaluate and make their decision (Lynch et al, 2022) and for IDT members to build a relationship with the person over time, in line with person-centred principles.

Family meetings should also be tailored to the needs of each individual patient and family, and there should be an explicit recognition that 'one size does not fit all', as highlighted by Respondent #61 earlier. Having several different professions involved in planning for each individual patient can be both an opportunity and an obstacle to individualised care planning (Rämgård et al, 2015). Patients appreciate having multiple healthcare professionals involved in their care, as long as the team members work together cohesively and communicate using clear and understandable language (Akter et al, 2023). For family meetings to be effective, a set of planned, standardised arrangements and pre-meeting preparations need to be put in place to promote and maximise the participation of all patients and their family members (Bångsbo et al, 2014; Lynch et al, 2022). Organisational pressures like discharge deadlines, limited resources and time constraints can contribute to hurried decision-making practices that can lead to the patient and family feeling coerced into processes and plans that are not sensitive to their needs or wishes (Dyrstad et al, 2015). The critical influence of the physical environment where family meetings take place should also be an important consideration in the context of sensitive conversations and decision-making taking place in a comfortable, relaxed environment for all participants.

Within healthcare teams, an IDT approach to assisted decision-making is influenced by each member's professional role, which, in turn, is fostered or constrained by organisational routines and/or innovations within teams (Légaré et al, 2011). Similar to previous studies, findings suggest a link between organisational 'buy-in' and an increase in IDT member engagement with, and prioritisation of, assisted decision-making in practice (Bunn et al, 2018; Donnelly et al, 2021). For example, identifying family meetings as an organisational priority, ring-fencing adequate time, the provision of appropriate rooms and the provision of organisational supports, such as clinical supervision, debriefing and training.

Finally, family meetings require high-level interpersonal skills in the areas of facilitation, negotiation and goal setting (Reed and Harding, 2015; Schoeb et al, 2019), and in practice, this task often falls to social workers. IDT members recognised the significant importance of having a chairing person who is proficient in facilitating small-group processes and decision-making. The study appears to confirm that social workers are well equipped to take on the facilitator's role given background training in interpersonal communication, group facilitation and family dynamics (Trevithick, 2000). This may not, however, be the case with other professions (Reed and Harding, 2015).

Conclusions and implications for practice

Family meetings involve complex processes in which mutual influence, context, preferences, values, information shared, the nature of the relationships involved and the communicative style of participants all play significant roles in both the process and decision-making outcomes. Mixed-methods research may place a higher burden on participants than single-method approaches but may also provide greater benefit (Creswell et al, 2011), and we believe that the qualitative data provide vital insights into the context, mechanism and outcome of family-meeting processes. Gaining insights into IDT members' experiences, as well as recognising and rethinking current practices and interventions, is vital for the ongoing quality improvement of the services that are provided to our patients and their families (Reed and Harding, 2015). Meaningful implementation of assisted decision-making for patients challenges long-held presumptions about who has access to valued decision-making resources and influence within a particular sociocultural setting. Arguably, internalised paternalistic norms associated with duty of care and beneficence remain legitimising forces for inequitable power relations in healthcare (Donnelly et al, 2021). There is a need to move away from the rhetoric of patient participation towards meaningful, pragmatic approaches that engage with patients and families. IDTs must come to terms with the 'elephant in the room' and recognise the power they have in relation to patients' lives (Donnelly et al, 2021), and this issue must be openly discussed and dealt with. IDT collaboration in family meetings may therefore be improved through organised interprofessional communication about knowledge, professional values and perspectives (Rämgård et al, 2015). Family-meeting guidelines and more comprehensive programmes of IDT education and training for staff are required in such settings to ensure that best practices are developed and adhered to. This could be achieved by developing a professionally accredited IDT training module on participating and facilitating family meetings. In addition, further education and training specific to family meetings with patients with cognitive impairment or communication difficulties is crucial given the imperative in law and policy for healthcare professionals to promote and ensure assisted/supported decision-making. Social workers are perhaps in a unique position to work with IDTs and to lead on pre-meeting preparation, facilitation and advocating for the routine involvement and active participation of all patients in rehabilitation hospital settings, ensuring that their voices are heard and will and preferences are acted on.

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Conflict of interest

The authors declare that there is no conflict of interest.

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