

N202 Advanced Concepts of Nursing
Coordinating Client Care
2022

1. Collaborating with an interprofessional team
 - a. "Occurs when multiple health workers from different professional backgrounds work together with patients, families, caregivers, and communities to deliver the highest quality care." (WHO, 2010)
2. Components of Collaboration
 - a. Sharing
 - i. Responsibilities, values, and resources
 - b. Partnership
 - i. Honesty, demonstrate mutual trust and respect
 - c. Interdependency
 - i. Work together to achieve a common goal
 - d. Power
 - i. Shared
3. Nurse Qualities for Effective Collaboration
 - a. Good communication Skills
 - b. Assertiveness
 - c. Conflict negotiation skills
 - d. Leadership skills
 - e. Professional presence
 - f. Decision-making and critical thinking
 - g. Nurse's Role
 - i. Coordinate the interprofessional team
 - ii. Holistic understanding of the patient
 - iii. Allow the client to be a partner in their care
 - iv. Provide information to the team during rounding
4. Communication
 - a. An interactive sharing of information
 - b. Being assertive is a key component
 - i. Being honest and direct in a respectful manner
 - ii. Encourages trust and teamwork
 - iii. Maintaining eye contact
 - iv. Conveying empathy
 - v. Being comfortable with silence
 - vi. Focus on behaviors and issues, never attack a person
 - vii. Use "I" statements
 - c. Barriers to communication
 - i. Effective communication is key!
 - ii. Many challenges impede this communication:
 1. Low health literacy
 2. Cultural diversity
 3. Cultural competence of health-care providers
 - d. Interprofessional communication
 - i. Breakdowns in verbal and written communication
 - ii. TJC attributes a high number of sentinel events to poor communication

- iii. Communication is a core competency to promote interprofessional collaborative practice
 - iv. Goal: collaboration among health-care professionals to promote continuity of care & facilitate communication
 - 1. SBAR tool
 - 2. ICARE Bedside Shift Report
 - 3. Nurse Navigators
- 5. Building an Interprofessional Team
 - a. Focus on the needs of the patient
 - b. Common Goal: Quality patient care
 - c. Each team member
 - i. Collaborates
 - ii. Shares
 - iii. Recognizes each other's area of expertise
 - iv. Participates in open communication
 - d. All members participate
 - e. Characteristics of an Effective Interprofessional Health-care team
 - i. Care provided to a group of patients
 - ii. Goals and outcomes are developed
 - iii. Each team member has a specific role
 - iv. Information is shared effectively
 - v. Implementation of plans is supervised
 - f. Effective vs. Ineffective Teams
 - i. Effective teams
 - 1. Positive work environment
 - 2. Open discussions
 - 3. Mutual understanding
 - 4. Willingness to listen to one another
 - 5. Respect for one another
 - 6. Allow members to disagree
 - 7. Cooperate with each other
 - ii. Ineffective Teams
 - 1. Dominated by a few members
 - 2. Leadership is autocratic
 - 3. Communication is stiff and formal
 - 4. Members are uncomfortable with conflict or disagreement
 - g. Stages Team Formation
 - i. **Forming Stage**
 - 1. The group is new
 - 2. Excited/ anxious feelings
 - 3. Uncertainty
 - 4. Positive and Polite behaviors
 - ii. **Storming Stage**
 - 1. Conflict
 - 2. Time of trial and error
 - 3. It may seem that the group is falling apart but they are actually getting stronger
 - iii. **Norming Stage**

1. The group creates their own set of rules
2. Members share their ideas
3. They begin to trust each other and appreciate their differences
- iv. **Performing Stage**
 1. The team reaches an optimal level of performance
- v. **Adjourning Stage**
 1. Celebrate success
 2. Closure
 3. Mixed feelings: may feel anxiety if their future is uncertain
- h. Ten Qualities of an Effective Team Member
 - i. #1 - Demonstrates dependability
 - ii. #2 - Communicates constructively
 - iii. #3 - Listens actively
 - iv. #4 - Functions as an active participant
 - v. #5 - Shares openly and willingly
 - vi. #6 - Cooperates and pitches in to help
 - vii. #7 Exhibits flexibility
 - viii. #8 - Loyalty
 - ix. #9 - Works as a problem-solver
 - x. #10 - Treats others in a respectful and supportive manner
6. Generational Differences
 - a. What makes one generation different from another?
 - b. Generational Differences
 - i. Baby Boomer (1946-1964)- Motivated and hardworking
 - ii. Generation X (1965-1980)- Practical, self-starters
 - iii. Generation Y (1981-1994)- Ambitious
 - iv. Generation Z (1995-2010)- Highly innovative
 - c. Generational Differences:
 - i. Can affect how members function within a team
 - ii. Principles to use to work together:
 1. Embrace flexibility
 2. Foster collaboration
 3. Use technology creatively
 4. Develop your own talent
 - iii. Consequences of not working together...
 1. Lack of communication and poor teamwork
 2. Decreased job satisfaction and decreased employee retention
 3. Decreased patient safety and poor patient outcomes
 4. Organizational struggles
 5. Decreased health of individuals, families, and communities
 - iv. Workplace should be accepting of generational differences
 - v. Educating employees on generational differences
 - vi. Understanding of different perspectives and how the differences can positively impact patient outcomes leads to a positive environment
 - vii. Empathy is essential!
 1. Take a walk in someone else's shoes!

7. Case Management

- a. The coordination of care from beginning → end of care
- b. GOAL: to avoid fragmentation of care and control cost
- c. Must have knowledge and advanced training in this area
- d. Can be a nurse or social worker.
- e. They do not provide direct client care.
- f. Principles of Case Management
 - i. Collaborates
 - ii. Plans care
 - iii. Monitors outcomes
 - iv. Oversee a caseload of clients who have similar disorders or treatment regimens
 - v. Review patient's insurance and coordinate the most cost-effective care.
- g. Community Case Management
 - i. Purpose:
 1. Coordinating
 - a. appropriate
 - b. effective
 - c. affordable care
 - d. Services
 - e. For individuals at high risk in managing their own health care needs.
 2. Stresses collaboration between:
 - a. patient
 - b. family
 - c. health team
 3. Their mission is to encourage wellness and prevent illness!
 - ii. Clients:
 1. Chronic Illness
 2. Impaired ability to manage disease
 3. Multiple hospital/ED visits
 4. Difficulty coping with disease
 5. They do not typically need more than one home visit per week on an ongoing basis
 - iii. Services provided:
 1. Ongoing assessment of needs
 2. Develop a plan of care
 3. Coordination of available resources
 4. Medication management
 5. Symptom management
 6. Crisis intervention
 7. Liaison for the patient & family
- h. Patient Centered Medical Home
 - i. Provides accessible, continuous, coordinated & comprehensive patient-centered care
 - ii. Key Elements of the Patient Centered Medical Home Model (PCMH)
 1. 1. Facilitates communication and collaboration among providers
 2. 2. Improves patient care outcomes
 3. 3. Reduces health care expenditures
- i. The Financial reality

- i. Potential Cost to Beebe and our community:
 - ii. 1 in 5 Medicare patients discharged from the hospital are readmitted within 30 days
 - 1. Costs \$26 billion/year; approx. \$10,000/per patient
 - 2. 20% of patients make up 90% of health care costs in the US
 - iii. Medicare does not reimburse!
 - j. Beebe CAREs Program:
 - i. CAREs stands for:
 - 1. Care coordination
 - 2. Access
 - 3. Referral to community-based resources
 - 4. Empowerment of patients
 - ii. Qualifications
 - 1. Clients with complex health and social service needs
 - 2. Frequent hospitalizations (2 or more in the past 6 months)
 - iii. Provided free of charge for qualifying participants
 - k. Nurse's Role in Case Management
 - i. Coordinate care for patients
 - ii. Facilitate continuity of care
 - iii. Improve efficiency of care and utilization of resources
 - iv. Enhancing quality of care provided
 - v. Limiting unnecessary costs and lengthy stays
 - vi. Advocate
8. Continuity of Care
- a. Consistency of care → through the health care system.
 - b. This is desired as clients move from:
 - i. One level of care to another
 - ii. One facility to another
 - c. Nurse's responsibility:
 - i. Documentation
 - ii. Reporting
 - iii. Collaboration
 - iv. Initiation, revision, and evaluation of the plan of care
 - v. Admission, transfer, discharge, and post discharge prescriptions
 - vi. Reporting client status to provider and charge nurse
 - vii. Facilitating referral
 - d. Documentation
 - i. Documentation facilitates continuity of care.
 - 1. Trends → VS, abnormal assessments, change in condition
 - 2. For a change in patient status Document thoroughly!
 - 3. Nursing Care Plans
 - a. Allow for goals to be identified
 - b. Improves patient care
 - c. Must be individualized for the patient
 - d. Nursing is responsible for charting in the plan of care.
 - e. Communication and Continuity of Care
 - i. Poor communication = adverse outcomes
 - ii. Change of shift report
 - 1. Communication between the oncoming and outgoing nurse

- 2. Why is this important?
 - iii. Communicating with the provider
 - 1. Changes in condition
 - 2. Recommendations
 - 3. Document
 - 4. What happens if the provider does not call you back?
- f. Discharge Planning
 - i. Started on admission
 - ii. Involves the patient & family
 - 1. Home Health
 - 2. Respite Care/ Hospice
 - 3. Physical Therapy
 - iii. Special Circumstances
 - 1. AMA
 - a. Can a nurse stop a patient from leaving?
- g. Communication Tools
 - i. I-SBARR
 - 1. I- Introduction
 - a. Identify who you are
 - 2. S- Situation
 - a. State pt's current situation
 - 3. B- Background
 - a. Historical or current pertinent pt data
 - b. Adm dx, meds, vitals, labs, synopsis of tx
 - 4. A- Assessment
 - a. Summary of current situation
 - b. Pt condition
 - 5. R- Recommendation
 - a. Resolution?
 - b. Tx, tests, etc
 - c. This step involves interaction
 - 6. R- Read-back
 - ii. Communication Tools
 - 1. ICARE Bedside Shift Report
 - a. Introduce nursing staff to patient/ family. Include AIDET
 - b. Conduct a verbal SBAR report
 - c. Assess the patient. Inspect: wounds, incisions, IV site, drains, IV tubing, catheters, infusions
 - d. Review tasks that need to be completed
 - e. Evaluate the patient/ family's needs or concerns: any questions?
Ask: what is your goal for the next 12 hours?