N202 Advanced Concepts of Nursing

Coordinating Client Care

2023

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. <u>Effective teams</u>
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. <u>Ineffective Teams</u>
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 (198101994)- 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 <u>prevent illness</u>!
        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?