EP5 – Interprofessional Care

EP5: Provide one example with supporting evidence, of nurses' participation in interprofessional collaborative practice to ensure coordination of care across the spectrum of healthcare services

Example: Program Director of Nursing Affairs Ensured Coordination of Care to Optimize Patient Flow by Participating in Interprofessional Collaborative Practice Through the Implementation of the Multidisciplinary Discharge Rounds (MDDR) as a Project Team Leader.

At KFSHRC-J, interprofessional collaboration to ensure care coordination across the spectrum of healthcare services is aligned with the organizational Strategic Objective #2 to ***provide access to all who need our services***. Optimal patient flow minimizes waiting and is associated with quality healthcare. One area in which interprofessional collaboration was needed within the organization was optimizing patient flow when admitting patients through the Department of Emergency Medicine (DEM) to the inpatient units, followed by facilitating timely coordination of discharge to the outpatient departments for care.

NURSES' PARTICIPATION IN INTERPROFESSIONAL COLLABORATIVE PRACTICE

In January 2021, an interprofessional team was developed to coordinate care between DEM and the inpatient nursing units where the discharge planning would begin. Alanoud Abualsaud, MSN RN, Program Director, Nursing General Services, led the team with members including Basem Alraddadi, M.D., Director of Patient Flow, Nursing (DEM, Medical and Surgical units), Case Management, Central Patient Transport, Admissions Office, and Quality Management departments. The work started with identifying those patients that needed admission and improving the appropriate and timely transfer to the inpatient unit where the discharge planning would begin. **Evidence EP5.1 Optimizing Patient Flow from DEM to Inpatient Units Meeting Minutes January 8, 2021**

Members of the interprofessional team are seen in Table EP5.1 below.

Table EP5.1: Participants in Interprofessional Team to Create Coordination of Care Activities

Name & Credentials	Job Title	Department
Alanoud Abualsaud, MSN RN	Program Director, **Team Leader**	Nursing General Services
Basem Alraddidi, M.D.	Consultant, Director of Patient Flow and Capacity Management	Department of Medicine
Mowaffag Basheer M.D.	Chairman DEM	Department of Medicine
Meshal Althiban	Head	Case Management Department
Marwa Abid, BSN RN	Head Nurse	DEM
Reem Baljoon, MSN RN	Head Nurse	5N-Medical
Tareq Mahmoud, BSN RN	Acting Head Nurse	5S-Medical
Raneem Mukhtar, BSN RN	Assistant Head Nurse	Surgical
Anaam Khatatbeh BSN RN, MSc, CPHQ	Nurse Clinician	DEM
Amal Brnawi, BSN RN	Nurse Clinician	5N-Medical
Amani Assayed, BSN RN	Nurse Clinician	5S-Medical
Raji Joseph, Dip.N RN	Staff Nurse I (SN1), Clinical Nurse	DEM
Charles Barotilla BSN RN	SN1, Clinical Nurse	5S-Medical
Rhodo Laigo BSN RN	SN1, Clinical Nurse	Surgical
Sondos Abdulshakor	Case Manager, DEM	Case Management
Mohammed Alsulaimani	Case Manager, Surgical	Case Management
Hani Badokhon	Manager	Central Patient Transport
Sultan Alghamdi	Supervisor	Appointment and Admission Services

Implementing Change to Facilitate Care Coordination

The interprofessional team worked to establish the structure, processes, policies, and resources to coordinate care across the continuum. The following three key initiatives were implemented by August 2021:

- Implementation of the MDDR targeting bed readiness in the Medical and Surgical units
- Development of transfer criteria to include a telephonic handover between DEM and the inpatient staff nurse. **Evidence EP5.2 DEM Transfer Criteria and Flowchart**
- Coordination of the MDDRs

The aim of the MDDR was to focus on discharge-related issues and review patients with a long length of stay and those meeting discharge criteria, ensuring all needed resources are available to meet discharge needs and prevent discharge delays. Each unit's MDDR occurred daily and included the department Chairman/Co-chairman, Head Nurse, Case Manager, Patient Relations Officer, Social Worker, Clinical Pharmacist, Physiotherapist, and other healthcare members as needed. Alanoud followed up with the Head Nurses in the Medical and Surgical units to ensure consistency of the daily MDDR. The case managers assigned in each unit took on the role of MDDR coordinator, with key input from the unit charge nurses and Head Nurses. The case managers sent reports to the Head of Case Management daily to track the progress and efficiency of the MDDR and determine any challenges needing attention. **Evidence EP5.3 MDDR Case Manager Daily Report**

Improvements in Care Coordination

The implementation of the daily MDDR within all inpatient units by the interprofessional team facilitated the early discharge planning and targeted discharges before 15:00. The outcomes of the MDDR and improvements are demonstrated in the case example below:

The following example demonstrates how nurses collaborate between disciplines in the transition of a patient from the DEM to the Surgical unit, then coordinated care during the daily MDDR to facilitate timely discharge planning to home, utilizing all needed resources to ensure the patient's needs were met prior to discharge.

Case Example

On February 1, 2022, at 13:30, patient Mr. X arrived in DEM, complaining of left foot pain. Mr. X was triaged and assessed by a DEM physician, confirming a medical history of diabetic type 1, end-stage renal disease (ESRD), peripheral vascular disease, with left foot trans-metatarsal amputation (TMA) one month prior. Mr. X was referred to the vascular team for further assessment and management. The vascular surgeon on-call saw Mr. X and diagnosed him with a left foot infection and necrosis. A decision was made to admit Mr. X under the care of vascular surgery for surgical intervention with a plan for left foot debridement. The vascular surgeon explained the admission plan and obtained admission and procedural consent from Mr. X. Admission orders were entered at 16:48. The DEM charge nurse reviewed the transfer criteria and determined that Mr. X could be transferred by their assigned Patient Care Assistant, then informed the DEM staff nurse assigned to Mr. X to prepare for transfer. The DEM staff nurse completed the electronic transfer checklist in the Integrated Clinical Information System (ICIS), then called the Surgical unit staff nurse to complete the telephonic handover utilizing the Handover Communication Report in ICIS. At 18:30 on February 1, 2022, approximately two hours

after the admission order was entered, Mr. X was transferred and received to room 335 on the Surgical unit.

Mr. X underwent left foot debridement on February 6, 2022. An interprofessional team approach was required to coordinate the continuity of care for Mr. X. His case was initially discussed in the daily MDDR after his admission to the unit on February 2, 2021.

An early discharge plan was set to meet Mr. X's discharge needs in which he was expected to be discharged home in the care of his 48-year-old wife, who was his primary caregiver, with additional Home Health Care support for wound care management. Mr. X's discharge needs were relayed to wound care and nutritional support.

The MDDR assisted in arranging timely referrals to the dietician and HHC services.

A sample of some of the various interprofessional coordinated care is demonstrated in the electronic documentation ICIS. The notes in the MDDR and Nursing Plan of Care reflect the various healthcare team members providing care. **Evidence EP5.4 Clinical Documentation Extraction from ICIS including Surgical Progress Notes, Clinical Nursing Notes, Nursing Care Plan, Nurse Handover Reports, Dietician Referral and HHC Referral, and Discharge Checklist**