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Chapter 1 : Developing an Interdisciplinary Model of Care in a Progressive Medical Care Unit

Developing an Interdisciplinary Model of Care in a Progressive Medical Care Unit Juan Ray Quintero, RN, MSN, CCRN Juan Ray Quintero is a nurse clinician III at Virginia Commonwealth University Medical Center, Richmond, Va.

In the current global climate, health workers also need to be interprofessional. Several weeks ago, I was part of an interdisciplinary team of faculty that developed an IPE educational experience focused on health reform. We provided a scenario and asked our teams of medical, nursing and social work students to design a care transitional program that would reduce 30 day hospital re-admissions of Medicare patients. Five key lessons I learned included the following: On interdisciplinary teams, decisions are reached collectively by the group. It is this collective decision making that makes the interdisciplinary team different than a multidisciplinary team where there is more parallel play and one person usually makes the treatment decisions. The concept of everyone being involved and participating is key to effective interdisciplinary work. In our IPE work, we did find that there are students who have not yet begun their professional careers that resist efforts to be involved in interdisciplinary teamwork. Allowing the students to discuss their perceptions of the case scenario was very important and highlighted the differences in approach to the care of geriatric patients. This was certainly true in our scenario before the facilitators pointed out the importance of goal setting. Our medical students were most interested in making sure that patients had received adequate treatment to prevent readmission. The social work and nursing students had a clearer understanding of the range of transitional care issues that needed to be considered beyond the medical care. After reviewing the scenario,we asked the students in each discipline to describe what their role could be in the achievement of the common goal. Students are often surprised about the knowledge and clinical abilities of other disciplines. This is important because finding the time to arrange for interdisciplinary meetings can be daunting in health care environments. Interdisciplinary teamwork is an important component in reducing health care costs, promoting patient safety through more effective communication and can help reduce workload through shared responsibility. We also promoted the personal satisfaction and friendships that can evolve from being on a highly functioning team. As I observed our students working together on their teams, I realize that this interprofessional education work is very valuable. Historically, we have not taken the time to require disciplines to work together on a regular basis before they enter practice settings. IPE education is just the beginning â€” teamwork takes practice and these efforts also need to take place in practice settings.

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Chapter 2 : Interdisciplinary Collaboration Improves Safety, Quality of Care, Experts Say - RWJF

Interdisciplinary Models of Care Integrated, interdisciplinary care is essential to address the multiple and complex needs of displaced people. Navigating fragmented systems of care is often impossible for these individuals, particularly those who are ill.

This article has been cited by other articles in PMC. Abstract Background Interdisciplinary team work is increasingly prevalent, supported by policies and practices that bring care closer to the patient and challenge traditional professional boundaries. To date, there has been a great deal of emphasis on the processes of team work, and in some cases, outcomes. Method This study draws on two sources of knowledge to identify the attributes of a good interdisciplinary team; a published systematic review of the literature on interdisciplinary team work, and the perceptions of over staff from 11 community rehabilitation and intermediate care teams in the UK. These data sources were merged using qualitative content analysis to arrive at a framework that identifies characteristics and proposes ten competencies that support effective interdisciplinary team work. Results Ten characteristics underpinning effective interdisciplinary team work were identified: Conclusions We propose competency statements that an effective interdisciplinary team functioning at a high level should demonstrate. Interdisciplinary team work, Competencies, Intermediate care, Transitional care, Allied health, Systematic review, Evidence synthesis, Qualitative research Background Interdisciplinary team work is a complex process in which different types of staff work together to share expertise, knowledge, and skills to impact on patient care. Despite increasing emphasis on interdisciplinary team work over the past decade, in particular the growth of interdisciplinary education [1], there is little evidence as to the most effective way of delivering interdisciplinary team work [2]. This difficulty is compounded by the multifactorial nature of team work, which comprises the skill mix, setting of care, service organisation, individual relationships and management structures. Most existing research explores the impact of one or a few of these aspects, rather than examining the relationships among several of these components on a range of staff and patient outcomes. Similarly, interventions designed to improve interdisciplinary team work tend to focus on specifics of team work activities such as: To date, there is not a systematic framework around which these activities, or characteristics, of interdisciplinary working can be structured. Terminology A wide range of terms are used to describe collaborative working arrangements between professionals [11]. Terms such as interdisciplinary, interprofessional, multiprofessional, and multidisciplinary are often used interchangeably in the literature to refer to both different types of teams and different processes within them [12]. They are also often used in conjunction with the term team work. However, there are some consistent distinctions that are useful to understand. Other authors have suggested use of the prefixes multi-, inter- and trans- to reflect differing intensities of integration [17]. Interdisciplinary team work Previous research has investigated the fundamental concepts and features associated with team work. A concept analysis [18] to explore the basic understanding of team work in the healthcare context drew on both healthcare and literature from other disciplines such as human resource management, organisational behaviour, and education, and proposed the following definition for team work in the health care context: This is accomplished through interdependent collaboration, open communication and shared decision-making. This in turn generates value-added patient, organisational and staff outcomes. This definition may be more optimistic and aspirational than realistic as it makes several assumptions about the characteristics that a team will possess. Enderby [19] identified these characteristics to include a definable membership, group consciousness, shared vision, corporate sense of purpose, clear interdependence and interaction, and co-ordinated action. Molyneux [20] identified three indicators for positive team work: Further literature reviews [11] have identified the importance of two themes on interprofessional team work, team structure and team processes within which specific categories emerged: Collaboration is acknowledged as an important component of team processes. A concept analysis undertaken by Henneman et al. Respect and trust, both for oneself and others, is key to collaboration.

Identified factors that contribute to successful collaboration were: However, further reviews [22] have found that the reality of shared planning and decision-making, and shared power is very different from the ideal. Shared power and leadership may also be a challenge when complex traditional hierarchical relationships, particularly those involving medical practitioners, play a larger role and impact either implicitly or explicitly on team processes [23 , 24]. McCallin [23] suggests that shared leadership occurs only in smaller teams privileged with being free to choose all team members. When considering the characteristics important for interprofessional team work within the context of organisational development, McCray [25] points out that little attention appears to have been paid to the actual processes of interprofessional practice within organisational strategy, local workforce development planning, and individual continuing professional development. Necessity of interdisciplinary team work The need for interdisciplinary team work is increasing as a result of a number of factors including: Workforce re-structuring to meet these needs requires that interdisciplinary teams must integrate changing organisational values with new modes of service delivery [13]. While these changes impact across healthcare as a whole, there are certain sectors where these organisational challenges have encountered more widespread debate, in particular primary care, rehabilitation, and care of the elderly. Of these, primary care is perceived to have the least likely level of success with interdisciplinary team work. Indeed, some commentators suggest that an interdisciplinary culture may only be possible as new generations of healthcare professionals enter the workforce [27]. Similarly, there is a lack of data identifying the processes of interdisciplinary team work and linking these with outcomes. Studies tend to focus on processes or outcomes, but rarely both; or explore components of what defines an interdisciplinary team, without providing a clear guide on the attributes of good interdisciplinary team practice. This paper draws on a published systematic review of the literature [28], combined with empirical data derived from interdisciplinary teams involved in the delivery of community rehabilitation and intermediate care services CRAICs , to develop a set of competencies around effective interdisciplinary team practice. CRAICs in England are community-based services frequently offering care for the elderly aimed at preventing admissions and facilitating earlier discharge from acute care. They exemplify the practice of interdisciplinary team work. Typically, CRAICs employ at least four different staff types, including nurses, physiotherapists and occupational therapists [29]. They often exhibit high levels of joint working and role sharing, and employ a large proportion of support workers who, when used appropriately, have been shown to facilitate interdisciplinary practice in this setting [29]. However, previous research by our team found a great deal of variety in the way that teams work together, and their levels of effectiveness as teams [30]. In response, we developed an Interdisciplinary Management Tool IMT which was implemented iteratively, using an action research approach with 11 teams to explore the impact of the tool on those teams and their patient outcomes [31]. Methods This research formed part of a much larger project designed to develop, implement and evaluate an intervention to enhance interdisciplinary team work [28] through the development of an IMT [32]. The IMT is a structured change management approach which marries published research evidence relating to interdisciplinary team work with the tacit knowledge of the particular team to develop a tailored approach to optimize their interdisciplinary team work [33]. Development of the tool involved three systematic reviews, interactions with team members using an action research methodology, and capturing extensive, detailed qualitative and quantitative feedback from teams and service users. The findings presented in this paper draw on a systematic review of the literature relating to the components of interdisciplinary team work and the qualitative data derived from the implementation of the IMT. Themes from these two perspectives were then examined for areas of agreement and dissonance to arrive at a set of competencies for good interdisciplinary team work. Systematic review The systematic review, reported and published in full in the main study report [31], first considered quantitative studies; in particular randomised controlled trials RCTs published and unpublished between and , that evaluated the process and outcomes of different interprofessional staffing models. Reference lists associated with the identified reports and articles were also searched for additional studies. Results were limited to English language articles in recognition of the importance of cultural factors in

team work, and issues relating to differences in terminology for example, multi-, inter-, trans- and cross-disciplinary working. A total of studies, including 11 systematic reviews or meta-analysis, were reviewed and analysed; however, only were usable based on the supporting level of contextual detail. Data on team effectiveness was extracted along with details on team processes, coordination, and leadership; all elements identified as important in the earlier concept analysis of the interdisciplinary team [18]. In the absence of mixed-method studies, suggested as a priority for future research by a recent review [34], the team designed a supplementary review strategy. This strategy examined findings from qualitative research on interprofessional team processes, independent from the RCTs. Inclusion criteria for the supplementary review were studies between and involving an interprofessional team in CRAICs which included data focused on team processes. This complementary review identified 20 studies to supplement previous findings. The findings of the separate evidence bases from qualitative and quantitative studies were brought together and isolated to a data extraction table. Themes were identified using a constant comparative method [35] and then each study was coded appropriately. The constant comparative method involves the incorporation, collation and comparison of newly collected data with existing or previous data collected from earlier studies. Thematic synthesis was used to look for common patterns across studies [36]. Team perspectives Eleven CRAICs, including staff were recruited to participate in an action research study, which examined the impact of implementing the IMT on service provision and outcomes for patients and staff. All participating team members provided written consent for their involvement in this research. The IMT intervention was implemented through a series of semi-structured workshops with the support of a trained facilitator. The workshop outcomes were detailed in reports and action plans that guided the implementation of their proposed changes. These reports and plans provided the basis of the data for the team perspectives. The data were entered into NVivo version 8. Results Results from the thematic synthesis of the literature Through the use of the constant comparative method, the thematic synthesis of the literature identified sixteen analytical themes with up to 12 descriptive characteristics in each theme. Table 1 Results from the thematic synthesis of the literature Themes.

Chapter 3 : Ten principles of good interdisciplinary team work

16 The third is an interdisciplinary group that includes the authors, which has developed and implemented an interdisciplinary conceptual model, process, and educational resources: Evidence Based Behavioral Practice (EBBP).

With the ever-changing landscape of long term care, it is becoming necessary for organizations to take a hard look at current systems and processes. Historically, many organizations have used a multidisciplinary approach in delivering care to their patients. Some organizations have implemented a team-based approach to patient care. In doing so, they are positioning themselves to ensure success in the new era of health care delivery. The team-based model permits the seamless and accurate flow of information throughout the interdisciplinary team and ultimately to the patient and family. It also facilitates integration of patient services as patients transition from one health service need to another. As a result, reengineering geriatric care into a team-based model leads to optimal clinical and operational outcomes across the health care continuum. As a single patient presents with multiple comorbidities, the clinical team often comprises an increasing number of clinicians from many different disciplines and specialties. As the team grows, the challenges of ensuring coordination and a free-flowing communication process among the various providers tend to grow proportionally. When a patient transitions from one provider to another or from one level of care to another, timely, accurate, and effective communication is necessary to ensure optimal care outcomes. It is ideal for each clinical decision maker to have access to comprehensive information when making his or her own patient care determinations. To optimize care delivery, the team model is structured to facilitate the integration of components that most often had previously functioned independently. Communication Fosters Collaboration To better understand the benefits of implementing this new team-based model of geriatric care, it is important to outline the shortcomings of the now outdated approach to care delivery. Previously, care teams were multidisciplinary, siloed, and inefficient. Clinicians would often function independently in making decisions for their patients, and often failed to communicate discipline-specific plans to other team members. Unilateral decision making based on the clinical specialty would occur without considering the impact on other clinicians who were treating the same patient. This approach often led to less than ideal care outcomes such as duplication of prescriptions and services, unnecessary hospital admissions, or prolonged courses of care. Outcomes noted above are often characterized by increased cost to both the patient and to the facility resulting from unnecessary services rendered and time wasted. In stark contrast, the team-based approach encompasses many of the elements necessary to optimize clinical and operational outcomes. Enhanced communication among team members ensures that patient care decisions are made with consideration of information from multiple clinical specialists, expedited delivery of services, and cost-effective methodologies. Additionally, this approach often results in the avoidance of negative clinical outcomes and operational inefficiencies. The team-based approach encourages all team members to work toward a common goal in which every team member is held equally accountable. Members of a cohesive team find support from their peers during the decision-making process and tend to share ideas more readily and without fear of criticism. To achieve the desired outcomes, proper team structuring in this patient care model is of the utmost importance. The needs of geriatric patients are often met in the community or nursing home setting. The clinicians involved often include physicians, nurses, rehabilitation therapists, social workers, dietitians, and therapeutic activity professionals. Each team member is expected to focus on a common goal while working collaboratively to ensure the patient is receiving comprehensive care. All team members are expected to participate in and contribute to the care planning process and to hold other team members accountable for their performance. Selection of team members should be based on the core clinical skills required to align with team goals and expectations. For example, a newly diagnosed diabetic patient requires coordinated service delivery among the endocrinologist, primary care physician, nurses, dietitians, and rehabilitation therapists to manage medication dosages, food intake, and physical activity tolerance. If clinical team members fail to communicate regularly,

insufficient information could result in negative clinical outcomes, such as incorrect blood sugar management strategies or duplication of services rendered in the form of labs. Following selection of team members, certain elements must be put into place to ensure effective team structure. Identification of a leader for the interdisciplinary team is critical. Clearly identifying and communicating performance expectations is critical to ensuring coordination among the various team members. The subacute service is based within the skilled nursing facility. A single administrator has been identified as being responsible for the performance of all interdisciplinary team members, regardless of professional discipline. This administrator is involved in the selection, performance review, and discipline of all subacute staff. The RiverSpring rehabilitation program staff members have been selected based on their clinical competencies and their attention to achieving the highest levels of customer satisfaction. All registered nurses participate in clinical education and skills competency assessments. All certified nursing aides receive advanced clinical education to ensure their competency in caring for medically complex subacute patients. The staff of a national rehabilitation provider delivers rehabilitation services. Likewise, pharmacy services are delivered via a national pharmaceutical provider. Inclusion of national providers as members of the interdisciplinary team leverages the provider resources, such as regulatory compliance, clinical and billing audits, enhanced technology and specialty software, and marketing expertise. Restructuring of the social services and discharge planning departments into a single care management department has resulted in integration between the two previously discrete functional groups. Communication among various team members is further facilitated with the addition of a customer service supervisor to the clinical team. As a result, the clinical team members can focus on the medical, social, and emotional patient needs. To further enhance seamless transitions from hospital to the skilled nursing facility, The Hebrew Home has worked with a local hospital partner to have a hospital-employed physician as the attending physician on one of the subacute floors. The addition of the hospital-based physician facilitates information sharing between the two organizations, resulting in improved patient care. For example, one of the subacute patients reported the onset of upper arm pain. The physician ordered X-rays, which were performed at the skilled nursing facility. The X-ray report indicated the presence of a humeral fracture of indeterminate age. Integration between the skilled nursing facility and the hospital permitted the attending hospital-based physician to compare the new upper arm X-ray with an older X-ray previously performed at the hospital via access to the hospital electronic medical record. As a result, the comparison revealed that the humeral fracture preexisted and was not a new condition. Consequently, the patient did not have to be transferred off site to see an orthopedist to address a new humeral fracture. A second example of team-based geriatric care focuses on preventing avoidable hospitalizations. Initially an interdisciplinary team was identified to form a hospitalization committee whose purpose was to complete a monthly review of all patient hospitalizations. Led by the medical director, the team includes the vice president of nursing services, the vice president of administration, the assistant vice president of administration, the assistant director of nursing services, the infection control nurse, and the associate director of clinical documentation and reimbursement. A single spreadsheet is utilized to track all patients who are transferred to a hospital, specifying the physician who requested the patient transfer and the day and time of the transfer. The quality assurance document is then reviewed by the hospitalization committee to determine whether the hospitalization was avoidable, potentially avoidable, or unavoidable. Based upon the committee review, care team members are educated on their clinical performance and areas for performance improvement are identified. Through this initiative, a curriculum of education and training for clinical team members has been developed and implemented. Clinical care paths have been developed and customized for such diagnoses as congestive heart failure, upper respiratory infection, pneumonia, urinary tract infection, sepsis, and anemia. The protocol was developed for nursing home patients who were evaluated for anemia, following which a clinical decision was made for a blood transfusion without pursuing an extensive diagnostic workup and an inpatient admission. Reasons for exclusion from the protocol included active bleeding, hemodynamic instability, and a patient or family request for inpatient admission. Through a clinical collaboration with a

geriatrician liaison at a local hospital, the team created a transfusion protocol and transfer form. Team-based geriatric care of patients with chronic anemia resulted in improved patient health outcomes and a reduction in the total cost of care. Additionally, a reduction in patient exposure to hospital-acquired infections, adjustment reactions, and functional decline was also achieved by avoiding unnecessary hospitalizations. In order to ensure direct connections with the local community, we regularly communicate with our hospital partners and with our community-based service providers. Committee membership fosters seamless communication between the organizations and enhances patient care outcomes. Through established interfacility connections, patient transitions from hospital to skilled nursing facility to home are efficient and effective. As evidenced above, a team-based approach to geriatric care provides many benefits to the patient, the clinical team members, and the organization. This article has outlined several different strategies for the implementation of alternative approaches to the delivery of geriatric care. It is critical that all levels of an organization embrace this model, form strategic partnerships, and support a culture change that supports creative thinking. Achieving this goal enables organizations to position themselves favorably as the health care industry continues to evolve. Development of an outpatient transfusion protocol to reduce inpatient hospitalizations of nursing home residents.

Chapter 4 : Interdisciplinary Evidence-based Practice: Moving from Silos to Synergy

Interdisciplinary Models of Care, Roxie Foster Index Library of Congress Subject Headings for this publication: Pediatric nursing -- Standards.

Abstract Despite the assumption that health care providers work synergistically in practice, professions have tended to be more exclusive than inclusive when it comes to educating students in a collaborative approach to interdisciplinary evidence-based practice EBP. This article explores the state of academic and clinical training regarding interdisciplinary EBP, describes efforts to foster interdisciplinary EBP, and suggests strategies to accelerate the translation of EBP across disciplines. Moving from silos to synergy in interdisciplinary EBP will require a paradigm shift. Changes can be leveraged professionally and politically using national initiatives currently in place on improving quality and health care reform. An exponentially expanding evidence base, complex patient needs and health systems, and lack of preparation to work in interdisciplinary teams have stymied the ability of health care providers to deliver high quality care. The IOM has endorsed the need to promote rigorous systematic reviews and development of clinical practice guidelines as a health care priority. The terms multidisciplinary, interdisciplinary, and transdisciplinary are often used to describe the contribution of multiple disciplines, but actually describes a continuum of involvement of disciplines. Transdisciplinarity is the most advanced level, and includes scientist, nonscientist, and other stakeholders who go beyond or transcend the disciplinary boundaries through role release and expansion. The purpose of this article is to explore the state of academic and clinical training regarding interdisciplinary EBP, describe interdisciplinary efforts to foster EBP, and suggest strategies to accelerate the translation of EBP across disciplines. Interdisciplinary Education Initiatives Movement toward interdisciplinary education is already under way, being driven by the same inevitability that drives interdisciplinary research. Bringing the professions together to each do what they uniquely do well does more for the patient than having only one profession involved. HRSA has established an Advisory Committee on Interdisciplinary, Community-Based Linkages to advise and provide recommendations to the Secretary and Congress on advancing the cause of interprofessional education. Some of the recommendations they are considering include establishing a National Center of Excellence, improving alignment in accreditation requirements, engaging accreditation agencies in facilitating interprofessional approaches in the health care professions, convening a summit of the major health care profession accreditation agencies to compare guidelines and standards and to discuss opportunities for facilitating interprofessional approaches to education. Based on the evidence that interprofessional education enhances collaborative practice, and collaborative practice results in better outcomes for patients, WHO has developed a Framework for Action on Interprofessional Education and Collaborative Practice. Within the nursing curriculum, the content for teamwork is present, but the evidence for education of disciplines together is sparse. Leaders at seven academic health centers report that implementation of interdisciplinary education in dentistry is difficult because of curricular demands crowded curriculum would require that interprofessional education replace content instead of being added on , lack of support from both faculty and administration to develop and integrate new courses and experiences, and financial constraints. Including EBP in interprofessional education makes sense since the process and methodology for systematic review, generation of practice recommendations, and translation are a shared science. The need to develop clinical guidelines may help focus some of these interdisciplinary efforts. The evidence reviewed indicates a gap between actual and required skills, knowledge, and abilities in EBP for both faculty members and graduating nurses. There are, however, some models of interdisciplinary EBP initiatives that can inform the way forward. Two are knowledge synthesizers: These three examples will be described. Cochrane Collaboration and U. Preventive Services Task Force: Both entities have helped pave the way toward interdisciplinary EBP by engaging multiple disciplines. The review teams include physicians, nurses, psychologists, and other professional representatives. Team members use standard methodological approaches. Graduate education for all

disciplines should prepare health professionals to be knowledge utilizers of systematic reviews. At the doctoral level, graduates should be prepared to serve on teams that generate systematic reviews. The Cochrane Collaboration The Cochrane Collaboration was formed in to inform health care decisions by creating systematic reviews related to prevention, treatment, rehabilitation interventions, or testing. Results are widely distributed and publically available in a Guide to Clinical Preventive Services. The USPSTF synthesizes and disseminates evidence and is a source to guide standards of preventive care â€" but it does not focus on interdisciplinary adoption of evidence. As a standard of practice in primary and community care, educators use USPSTF recommendations to teach nurses best clinical practices. The resulting interprofessional Council for Training in Evidence-Based Behavioral Practice and its scientific and practitioner advisory boards include EBP experts from medicine, nursing, psychology, social work, public health, and library sciences www. The group collaborated to create a trans-disciplinary model of EBP. Each discipline represented in the Council brought its own profession-specific perspectives, language, and resource base to the development of the model, process, and competencies for health care providers. The EBBP conceptual model see Figure 1 uses an ecological framework as its foundation, and reflects shared decision-making among the practitioner, patient, and other affected stakeholders. The model was developed after review of existing EBP conceptual models from each discipline that represent how evidence-based decisions are made in practice. Details of the development of the conceptual model are published elsewhere.

Chapter 5 : Table of contents for Nursing excellence for children and families

The report recommends a variety of strategies to foster interdisciplinary education, including interprofessional orientation days and social events, joint faculty appointments, interdisciplinary coursework and clinic activities, and social networking sites that include students from a variety of health-related fields.

Table 5 Interdisciplinary planning of care on the progressive medical care unit: The team was now challenged to develop a process that connected these types of communication tools with the IMOC. Thus each member could express his or her ideas of what was needed to make the IMOC process successful and could suggest new ways of getting the daily plan of care to all healthcare professionals. The following is an example of one of the ideal models suggested. Each patient will be discussed briefly to determine his or her needs, questions for the medical team, and so on. The resource nurse or designee will make the appropriate referrals as needed. The contact coordinator is responsible for passing on pertinent information to members of the unit-based team. The Unit Staff Nurse Survey The group knew that the physician, the social worker, and the nurse had the 3 primary roles in the IMOC process and that the nurse was the pivotal provider of the team. Therefore, a nursing survey was developed to determine what information nurses were receiving about the plan of care for patients see Figure. We found that the nurses believed that they were working alongside the team and seldom were asked or reminded that medical rounds were starting. The communication with other healthcare providers usually occurred in the middle of the hallway. The changes to the plan of care were obtained by paging the physician, which was time-consuming and frustrating from the staff. Nurses agreed that they were too busy to attend morning rounds. The overall information collected assisted the team in finalizing the IMOC process. The group reached a consensus as to what each team member could do to make the process a success. The core process approved by the group is presented next. Interdisciplinary Model of Care: Each patient will be discussed briefly to identify new needs and ask the medical team questions. The care coordinator will telephone the team residents between 9 am and 9: The care coordinators will split the teams, and the CNS and resource nurse will cover as needed. The resident will briefly discuss each patient, identify new needs and discharge plans, and so on. The team physician will input all orders needed as discussed with the care coordination team. Orders that will expedite discharge or enhance care of patients will be entered by 9: The CNS or the resource nurse is responsible for passing on pertinent information to the staff nurses. The bedside nurse will make every attempt to do rounds with the team. Centralized IMOC Documentation The team quickly determined that no clear process existed for documenting the work being accomplished by each member of the healthcare team. Issues included the following: The CNS along with the nurses had developed a patient information form for the progressive care medical unit that specifically addressed documentation required by the IMOC. The patient information form was not a legally approved document and was used to support discharge planning and as a nurse-to-nurse change-of-shift report. The team recognized that it could easily be developed into an effective IMOC documentation form that could be approved by the medical records department. The IMOC group proceeded to adapt the patient information form. Key aspects of the newly revised interdisciplinary progress note included a place for the initials of all who attended the IDRs. The care coordinator, chaplain, CNS, resource nurse, geriatric nurse practitioner, home health worker, occupational therapist, physical therapist, respiratory therapist, and the 2 social workers were all required to attend. The form also included blank areas so that other consultations could be added. The interdisciplinary progress note also included an estimated date of discharge that could be readdressed daily, the plan for hospitalization, and all the other items that the patient information form had included. The interdisciplinary progress note was formatted to be user friendly and easily accessible. The interdisciplinary progress note maintained the features of centrality, connectivity, and communication. The location was central for easy access and allowed hour access. It worked well as a communication tool. It achieved the mission and adhered to the 3Cs concept, and the primary healthcare providers were all engaged and connected.

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Chapter 6 : Why Interdisciplinary Teamwork in Healthcare is Challenging - Emerging Nurse Leader

Developmental transition care: children, youth, and families receive care that supports development / Cecily Betz Translating research into practice / Charmaine Kleiber Interdisciplinary models of care / Roxie Foster.

Chapter 7 : Team-Based Care Optimizes Outcomes

Provides information on nursing care for infants, children, youth, and families. This book identifies various elements of nursing excellence. Each chapter begins with an introduction to a core.

Chapter 8 : Program Models in Family Foster Care - Child Welfare Information Gateway

Interdisciplinary team work is increasingly prevalent, supported by policies and practices that bring care closer to the patient and challenge traditional professional boundaries. To date, there has been a great deal of emphasis on the processes of team work, and in some cases, outcomes. This study.

Chapter 9 : ACE Model of Care - Highland Hospital - University of Rochester Medical Center

ROXIE FOSTERPhD, RN, FAAN trial models of care delivery. It is also clear that between and among the interdisciplinary treatment.