Interprofessional Group Project

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Honor Code:

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Interprofessional Collaboration Applied to a Palliative Care Patient

This paper explores the integration of the Interprofessional Education Collaborative (IPEC) core competencies to a standardized patient (SP) with complex comorbidities in order to develop a comprehensive plan of care. Issues will be prioritized after assessment and interview with patient and caregiver. The formal plan of care will meet the needs of patient and caregiver, and validate the efficacy of the IPEC core competencies. The IPEC competencies are guidelines for practice and have four domains: values/ethics (VE), roles/responsibilities (RR), interprofessional communication (CC), and teams/teamwork (TT) (IPEC, 2011). Quality treatment is the result of a committed effort among team members to work within these domains (IPEC, 2011).

In our case, assessments were made by the advanced practice nurse, counseling, physical therapy (PT), and social work roles. This reflects Roles/ Responsibilities competencies (RR6) "communicate with team members to clarify each member's responsibility in executing components of a treatment plan or public health intervention" and (RR9) "use unique and complementary abilities of all members of the team to optimize patient care" (IPEC, 2011, p. 21).

Standardized Patient Case Scenario

Mrs. Chris Peters is a 65 year-old female with Lewy Body Dementia. She has metastatic hepatic cancer with a life expectancy of a few months. There were two visits with Mrs. Peters and her spouse/caregiver, Mr. Peters. The initial visit evaluated: pain management, comfort assessment, self-care level, caregiver's coping status, caregiver's ability to provide home-based

care, need for support services, familiarity with technology and benefits of use. The second visit was a telehealth follow-up to evaluate the treatment plan.

Mr. Peters plans to care for his wife in the home. This goal is supported by (VE1), "place the interests of patients and populations at the center of interprofessional health care delivery"; (VE6) "develop a trusting relationship with patients, families, and other team members", and (VE7) "demonstrate high standards of ethical conduct and quality of care in one's contributions to team-based care" (IPEC, 2011, p.19).

Identification of Patient/Caregiver Issue

The care team displayed good communication; giving instructions, actively listening to concerns, and utilizing tele-technology in light of Mrs. Peters' mobility issues. This satisfies competencies (CC1) "choose effective communication tools and techniques, including information systems and communication technologies..."; (CC2) "organize and communicate information with patients...avoiding discipline-specific terminology when possible"; and **(**CC4) "listen actively, and encourage ideas and opinions of other team members" (IPEC, 2011, p. 23)

Advanced practice nurse. Mrs. Peter's issues are: pain, confusion, a chipped tooth, and a history of falls. She has periods of confusion and lacks focus when performing activities of daily living. Nutrition status is a priority. She has frequent nausea and vomiting, and lost 15 lbs. in six months. She has frequent pain from the cancer, and pain from her chipped tooth. She has radiation burns resulting from cancer treatment. Medication changes will be made. Her current regimen is under review for better options.

Counseling. Mr. Peters has stress and is overwhelmed; he faces role strain and needs activities that meet his needs. Mrs. Peters faces the risk of disengaging from health promoting

activities. The couple's support network is lacking; children live far away, and visit via phone and Skype Also, Mr. Peters doesn't yield any caregiver duties, resulting in isolation.

Physical therapy. Primary issues for PT are mobility and safety. Mrs. Peters has a quad cane which she rarely uses; falls are frequent. There are no other assistive devices. Recommendations for durable medical equipment (DME) are welcomed by Mr. Peters.

Social work. Mr. Peters suffers from caregiver burden. He is unaware of community support services. He has neglected his own health and welcomes ideas that support their wish to stay in the home.

Interprofessional Plan of Care

Advanced practice nurse. Several changes were made to Mrs. Peters' medications. Priority is control of nausea and vomiting. Oral Phenergan 12.5 mg was changed to Zofran 4 mg dissolvable tablet. It is effective for radiation-related nausea and vomiting in the elderly (GlaxoSmithKline, 2014). Mrs. Peters will eventually be unable to report or describe her pain; Mr. Peters needs to learn about non-verbal pain cues. Because PRN oral pain medications may lead to undermedication (Monroe et.al, 2011), Oxycodone dosage was converted to Fentanyl transdermal patch (25mcg/hr). Mr. Peters will give Tylenol 650 mg oral suspension every 8 hours PRN for breakthrough pain. Mrs. Peters has no medication for her Lewy Body Dementia. A cholinesterase inhibitor may help with treatment of LBD (Ballard, Kahn, & Corbett, 2011), so Aricept 5 mg oral dissolving tablet was added to her medication regimen. As her symptoms progress, the team will assess the need for antipsychotics and/or antidepressants commonly used with LBD (Ballard et.al, 2011). Because Mrs. Peters gets distracted and confused, the team encouraged Mr. Peters to read aloud to her, as a method of calming. Reading aloud is a form of

communication between the two and will become more valuable as her disease progresses, benefiting both (www.alz.org).

Pain from a radiation burn on her abdomen was being addressed by keeping the area clean and dry to encourage healing. Also, a chipped tooth is causing weight loss. According to Powers (n.d.), "patients lose weight for a variety of reasons. Dentists should assure that oral disease is not limiting oral intake" (p. 4).

Counseling. Being part of the palliative care team gave the counselor insights to promote the physical health of Mrs. Peters and help improve the emotional health of both. Palliative/hospice services will offer relief to Mr. Peters, giving him time for self-care. Cognitive behavioral therapy homework, in which the clients complete one activity per day that they have interest in, will maintain a piece of positivity within each day, countering the hardships they are experiencing.

Social work. Palliative care is appropriate; however, with her multi-morbidities, hospice services may be the better choice. It frees up resources and is covered 100% by Medicare (Meier, 2011). The social worker can help with Medicare paperwork, advanced directives, funeral planning, and referrals to local agencies and support groups, and respite care (Dempsey, 2013). The social worker will institute telehealth; Mr. Peters reports he is tech-savvy and most comfortable communicating via IPhone, email, and Skype. A follow-up meeting with the entire team will take place two weeks later via Skype.

Physical therapy. PT addressed safety and mobility. Upon assessment, recommended DME included a walker, shower chair, and bedside commode. The PT will educate Mr. Peters on safe transfer techniques. PT prescribed exercises and treatments to address pain and increase strength and range of motion (Cobbe et al, 2013). The PT role adapts to changes in Mrs.Peters' condition; PT should see the the patient weekly. This satisfies RR-9, " use unique and

complementary abilities of all members of the team to optimize patient care" (IPEC, 2011, p. 21).

Interprofessional Plan for Follow-Up

The team will follow-up weekly to address any new problems as per telehealth meetings. This technology was appropriate and easy to use. The team received real-time vital signs, weight, and observed the patient's overall condition as well as an up-close picture of her radiation burn. The couple is satisfied with the care. They report decreased pain and nausea after changes to medication regimen. Her burn is healing. Her chipped tooth is repaired. Her appetite is fair and her weight is steady. The APN is able to coordinate care by communicating with all parties. The nurse and aide come several times a week. Mr. Peters is comfortable with home-based care, reports that he is much less overwhelmed, and wishes to continue care for his wife at home until her death. PT has obtained necessary DME and will continue to offer comfort services in the home. Counselor offers support and monitors progress of cognitive behavioral homework. She is available to the family as needed. A meeting to develop a firm advanced directive for Mrs. Peters is scheduled.

Conclusion

From the initial consult to the follow-up session, the team continually demonstrates patient-centered care:. Each member utilized their strengths: advanced practice nurses regarding treatment plan, counselor addressing mental health and coping, social worker regarding services and technology, and physical therapist with respect to safety and mobility. An established level of trust is observed, and also demonstrative high standards of conduct. This satisfies the following IPEC teams/teamwork competencies: (TT3) "engage other health professionals

-appropriate to the specific care situation-in shared patient-centered problem-solving"; (TT7) "share accountability with other professions, patients, and communities for outcomes relevant to prevention and health care"; and (TT10) 'use available evidence to inform effective teamwork and team-based practices" (2011, p.25).

References

Adams, L. (2009). Managing Side Effects in Radiation Therapy Patients. *Radiation Therapist.* 18(2):109-123. Retrieved from http://www.asrt.org/docs/publications-archive/ther_f09_combined.pdf.

Alzheimer's Association. (n.d.). Communication Tips & Techniques. Retrieved from http://www.alz.org/texascapital/in_my_community_14326.asp.

Ballard, C., Kahn, Z., Corbett, A. (2011). Treatment of dementia with Lewy bodies and Parkinson's disease dementia. *Drugs Aging 2011, 28*(10), 769-777.

Brodaty, H., Green, A., & Koschera, A. (2003). Meta-analysis of psychosocial interventions for caregivers of people with dementia. *Journal of the American Geriatrics Society*, *51*(5), 657-664.

Caramanica, L., Cousino, J. A., & Petersen, S. (2003). Four elements of a successful quality program: alignment, collaboration, evidence-based practice, and excellence. *Nursing Administration Quarterly*, *27*, 336-343.

Cobbe, S., Nugent, K., Real, S., Slattery, S., & Lynch, M. (2013). A profile of hospice-at home

physiotherapy for community-dwelling palliative care patients. *International Journal of Palliative Nursing 19* (1), pp. 39-45.

Dempsey, D. (2013). Advanced care planning for people with dementia: Benefits and challenges. *International Journal of Palliative Nursing 19* (5), pp.227-234.

GlaxoSmithKline (2014) *Drugs.com*. Retrieved on July 19, 2014, from http://www.drugs.com

Interprofessional Education Collaborative Expert Panel. (2011). *Core competencies for interprofessional collaborative practice: Report of an expert panel.* Washington, D.C.: Interprofessional Education Collaborative

Meier, D. (2011). Increased access to palliative care and hospice services: Opportunities to improve value in health care. *Millbank Quarterly 89* (3), pp. 343-380.

Monroe, T., Carter, M., Feldt, K., Tolley, B., & Cowan, R. (2011). Assessing advanced cancer pain in older adults with dementia at the end of life. *Journal of Advanced Nursing*, 2070-2078.

O'Daniel, M., & Rosenstein, A. H. (2008). Professional communication and team collaboration. In R. G. Hughes (Ed.), *Patient safety and quality: An evidence-based handbook for nurses* (2 ed.). [Adobe Digital Editions]. Retrieved from http://www.ahrq.gov/professionals/clinicians-providers/resources/nursing/resources/nurseshdbk/nurseshdbk.pdf

Powers, R. E. (n.d.) *Dental Care and the dementia patient*. Retrieved from http://alzbrain.org/pdf/handouts/2050.%20dental%20CARE%20AND%20THE%20DEMENTIA%20PATIENT.pdf.

Robert Wood Johnson Foundation. (2011). *How to foster interprofessional collaboration between physicians and nurses?:Incorporating lessons learned in pursuing a consensus* (Grant ID # 70224). Retrieved from http://www.rwjf.org/content/dam/farm/reports/program_results_reports/2013/rwjf403637

Competency Framework. *Journal of Interprofessional Care*, *23*, 621-629. Retrieved from http://informahealthcare.com/jic

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ITEM	0 Points	Up to 8 points	9 - 14 points	12 - 16 points
Use of IPEC Competencies	Not done	1 or 2 competencies included	3 competencies included	All competencies included
Identification of issues for patient and caregiver	Not done	Few issues identified	Partial list completed	Thorough list completed
Plan of care for patient and caregiver identifying the role of each of the disciplines in your group	Not done	Discussed but brief/not well planned	Basic issues discussed	Thorough plan covering all issues
Plan for patient follow up with each discipline in your group	Not done	Discussed but not thorough or very specific	Plan covers most issues	Realistic plan covering all identified issues

APA or other Format	Not done	Most items correct	Some items incorrect	Accurate and consistent
ITEM	0 points	Up to 2 points	3 – 4 points	5 points
Peer Evaluation by team members	No participation	Participated < 75%	Participated 75 to 90%	Participated 91%to 100%
Self Evaluation	Poor contribution	Fair contribution to project	Adequate contribution	Fully contributed to project

TOTAL POSSIBLE POINTS = **100**