

Collaborative Nursing Practice in BC

Resources and Tools

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1st Edition

Collaborative Nursing Practice – Resources and Tools

Table of Contents

	Page Number
Introduction.....	2
Schools of Nursing Resources and Tools	
Purpose.....	3
Orientation for New Nursing Students.....	3
Orientation by Regulatory Bodies.....	3
Skills Labs.....	4
Clinical and Pre/Post Conferences.....	4
Collaborative Nursing Practice Workshops.....	4
Word Association Exercise - Collaboration.....	5
Ten Essentials of Teamwork.....	6
Facilitators and Barriers to Collaborative Nursing Practice.....	7
Attitudes and Attributes of Collaborative Nursing Practice	8
Interpersonal Relationship and Communication Skills.....	9
Managing Conflict	
Conflict Scenerios.....	10
Conflict Models.....	11-13
Developing Shift Schedules.....	14
Care Planning and Assigning Patients.....	15-16
Case Scenarios	
Residential Care Facility.....	17
Medical Unit Case Study.....	18-25
Surgical Case Study and Orthopedic/Gynecological Case Study.....	26-29
Acute Psychiatric Unit Case Study.....	30-32
Resources for Collaboration	
Print Resources for Collaborative Practice.....	33-34
Web Based Resources for Collaborative Practice.....	34-35
Resource Web Pages – Tools and Techniques.....	35
Partnership.....	35
Appendix - Sample Guidelines for Assigning PCAs, LPNs, RNs in Acute Care (VCHA August 2004).....	36-47

Introduction

The document, *Collaborative Nursing Practice in BC*, serves as a foundation document for Registered Nurses (RNs), Registered Psychiatric Nurses (RPNs) and, Licensed Practical Nurses (LPNs). Tools and resources have been developed that support discussion of the foundation document and to support nurses to learn about collaborative nursing practice. The purpose of this document is to present tools and resources that could assist educators and managers to introduce and support Collaborative Nursing Practice (CNP) in BC.

The CNP Resources and Tools include teaching and learning activities (for both practice settings and education programs), care planning, assigning activities and other resources (print and web based). Nursing education program educators may wish to integrate the resources and tools into specific courses in their curricula. The expectation that nurses practice collaboratively is included as an entry-level competency for RNs, RPNs and LPNs. To support nurses in the practice setting, educators may find the resources and tools useful in both orientation and in-service education. Mentoring nurses to practice as team members and developing quality work settings will also facilitate CNP.

Educators in nursing education programs and managers/educators in practice will need to define their goals/objectives regarding preparing nurses for collaborative practice. Goals and objectives should be congruent with the type of education program (e.g., orientation, in-service, semester one or preceptorship, etc.) and the participants. Goals and objectives have not been pre-determined in the CNP Resources and Tools as they will vary depending on the participants and the setting. Evaluation of learning and feedback on the sessions should be based upon the goals and objectives of the session.

The resources and tools are presented in a conceptual way so that educators can take a key idea and develop it to suit their situation and their audience. Educators will draw on the resources and tools that suit the learner and the situation. For example, the word association exercise can be used in many teaching and learning situations, with first semester students or experienced practitioners. On the other hand, first semester students may not have the requisite knowledge and experience to work through the care planning and assigning patient activities. The CNP Resources and Tools vary in complexity. The *Ten Essentials of Teamwork* is a straightforward exercise with each participant responding in the negative or positive. It can be used as a consciousness raising exercise to introduce teamwork. In contrast, the exercises on managing conflict, care planning and assigning patients are much more complex. The group leader would need to feel confident in his/her facilitation skills to use these more complex resources and tools.

The time frame for using the CNP Resources and Tools has not been pre-determined. As noted above some of the Resources and Tools are complex and will require a substantial amount of time while others can be accomplished quickly. It is anticipated that facilitators will mix and match the Resources and Tools to meet their needs. Sample one and three hour sessions were developed and are included in a separate CNP Facilitator's Guide (Tab 3). In initial pilot sessions, these time frames seemed reasonable. As with any teaching and learning session, adjustments should be made depending upon the needs of the participants.

Schools of Nursing Resources and Tools

Purpose

Schools of nursing in BC use a variety of teaching and learning activities to assist students to learn about CNP. Surveys of schools of nursing were done to elicit resources and tools to support students to learn about CNP. Resources and tools for nursing education programs are presented below under the headings of: orientation for new nursing students; orientation by regulatory bodies; skills labs; clinical and pre/post conferences; and collaborative nursing practice workshop for nursing students. The resources and tools in this section focus on schools of nursing but can also be adapted for the practice area. It is anticipated that this section will grow as more resources and tools are developed and shared across the Province. The resources and tools can be used or adapted at different levels in the curriculum.

Orientation for New Nursing Students

A new orientation for all new nursing (RN and LPN) students was developed by University College of the Fraser Valley (UCFV). The intent was to start students thinking of themselves as team players from the very beginning of the program. In an analogy with sports teams it is clear that team members need to learn together. We cannot teach a goalie in one place, a defence position in another and then expect them to play effectively together.

The content of the UCFV orientation program included:

- Who's who – staff
- How school is organized – programs/labs, etc.
- Importance of teamwork

The orientation session introduced the importance and value of working together. The facilitator emphasized that the future is CNP. Students completed a small group task of identifying three things they had in common.

A similar approach has been developed by Vancouver Community College (VCC). At the beginning of the year a “rally” of all health science students was held in the common area (atrium) of VCC. All student groups in the health field were introduced with a brief description of each health care provider's role. The shared commitment to quality care was emphasized as was respect for each member of the health care team.

Orientation by Regulatory Bodies

Many nursing education programs invite their regulatory body to participate in orientation sessions for nursing students. This approach is highly valued and would be enhanced by inviting representatives of all appropriate nursing regulatory bodies to attend and present in a panel fashion. By collaborating at this level, the regulatory bodies provide leadership and role model collaboration to the students.

Skills Labs

Schools of nursing are encouraged to consider opportunities to combine nursing groups for shared competency/skills labs. For example, basic wound care labs could be organized to include all three groups or two groups of students (RNs, RPNs, and LPNs). In addition, practice lab times could be set up for combined groups of nursing students to practice together. Having simulated patient scenarios can enhance discussion. Peer review checklists can be a helpful tool to assist learners to focus on key aspects of the skill as well as practicing giving constructive feedback. Nursing education program representatives would need to collaborate to plan and schedule labs before the term/semester begins. Computer labs and communication labs are also key areas that could accommodate combined groups of students.

Clinical and Pre/Post Conferences

Clinical practica offer an important opportunity for nursing students (RNs, RPNs, and LPNs) to learn together. When students from two nursing groups are working on a unit or are scheduled back to back, there is an opportunity for them to communicate and report to each other. For example if LPN students are on the day shift and RN students are on afternoon shift, the LPN students could provide end of shift report on their patients. The two clinical instructors of the RN and LPN groups would need to organize this with the students and staff.

Combined pre/post conferences could also be organized during a rotation where nursing students from two groups are working back to back. The two clinical instructors of the RN and LPN groups would need to organize this with the students. The topic of CNP could be the focus of the pre/post conference selecting from the resources and tools that are most appropriate for the student groups.

Collaborative Nursing Practice Workshops

Workshops can be set up for different groups of nurses to learn about each other's practice. Faculty can provide an overview of scopes of practice, *Standards, Competencies*, etc. The *Collaborative Nursing Practice Working Draft* can be used as a source of content. The *Resources and Tools for Collaborative Nursing Practice* can be used as a source for interactive, experiential learning activities.

Opportunities to support students to learn together can be a very creative venture. A drama production dealing with challenging issues in health care (elder abuse, sexuality, substance abuse, etc.) can provide an energizing and creative approach to introducing a significant topic. Facilitated discussion groups with mixed groups of nursing students would provide an opportunity for the students to share their learning and to learn about each other's practice.

Faculty may wish to host the College of Licensed Practical Nursing of BC/College of Registered Nurses of BC Workshop, *Working Together: Practice Expectations for RNs and LPNs*. The workshop would be an opportunity to bring RN and LPN students together to learn about collaborative practice.

Word Association Exercise - *Collaboration*

Purpose

A word association exercise using the term *Collaboration* is an excellent starting point for a discussion on collaborative nursing practice. This activity can be an ice-breaker or a warm-up exercise.

Teaching and Learning Activity

Using a flip chart or whiteboard, the facilitator invites participants to supply one word that comes to mind when the term “*collaboration*” is used. Go around the group until all terms are included on a white board or flip chart. As a summary of the exercise, the facilitator can emphasize key terms that are important for the session to focus discussion on goals and objectives. It is suggested that you leave the Collaboration Word Association information on the flip chart or white board and return to it to reinforce key points during your teaching and learning session.

Collaborative Nursing Practice - Ten Essentials of Teamwork

Purpose

This tool provides an opportunity for participants to think about what is essential in teamwork. Participants review the ten essential needs of well functioning teams and also apply them to their own situation.

All teams or groups have key needs and these needs must be met for the team to function well. Ten essential needs are listed with questions to help participants assess team effectiveness.

1. *Shared vision* - Do we have a shared goal of vision (e.g., quality nursing care)?
2. *Shared leadership* - Are members willing and able to take on the risk of leadership?
3. *Interaction and involvement* – Do all members actively contribute to create synergy and group spirit?
4. *Maintenance of self-esteem* – Do the team and the leader enhance the self-esteem of each member?
5. *Open Communication* – Are channels of communication open and is there ample time to communicate?
6. *Power* – Does the team focus on things that it has the power to address or influence?
7. *Attention to process and content*– Does the team pay attention to the process they use to accomplish their work as well as the work itself?
8. *Mutual trust* – Does the team build and maintain trust?
9. *Respect* – Do team members demonstrate respect for each and every team member?
10. *Constructive conflict resolution* – Does the team address conflict in a healthy way?

Teaching and Learning Activity

Use the ten essentials of teamwork as a group activity and/or individual checklist. If you are meeting with nurses who are currently working together, they can assess their team for how well it is currently functioning. If participants do not know each other, ask them to think about a team in their work setting. You may wish to use a likert scale for participants to rank each item from 1 to 4 with 1 = “always”, 2 = “usually”, 3 = “most of the time” and 4 = “rarely”. As another approach you could ask small groups to rank order the five most important items in their work setting. Once individuals or small groups have had time to review the questions, prompt discussion by eliciting examples of when they have experienced one or more of the essential needs of teamwork.

This section is adapted from: Rees, F. (1991). *How to Lead Work Teams: Facilitation Skills*, San Diego: Pfeiffer.

Facilitators and Barriers to Collaborative Nursing Practice

Purpose

This tool provides an opportunity for participants to consider and discuss facilitators and barriers of CNP that are identified in the *Collaborative Nursing Practice in BC Working Draft*.

Teaching and Learning Activity

Divide participants into small groups or dyads. Groups should review the list of factors below that support collaboration. For each factor listed identify *one* example from practice when the factor **facilitates** collaboration and *one* example of when it is a **barrier**. (See sample below). Ask the groups to share one example with the large group. (Advise participants not to use actual names/situations to ensure confidentiality.)

Communication

Participation

Consensus

Shared leadership

Adequate resources

Administrative commitment and support

Teamwork

For example: **Communication** – To exemplify this factor as facilitating collaboration:

“The team functions well when Mary is the Team Leader. She listens attentively and is clear and concise when communicating.”

To exemplify it as a barrier, an example is:

“The team flounders when Barbara gets stressed. When she is anxious, she doesn’t hear and things get missed.”

Attitudes and Attributes of Collaborative Nursing Practice

Purpose

This tool offers participants the opportunity to explore attitudes and attributes that are important for CNP. At minimum this tool is an opportunity to raise consciousness regarding attitudes that affect CNP.

Teaching and Learning Activity

Post or circulate the following list of attitudes and attributes.

Identify that the attitudes are important for successful collaborative relationships. In the full group or in small groups, ask participants to choose two attitudes and attributes from the list to:

- 1) develop a working definition; and
- 2) identify three behaviours that nurses can use to demonstrate the attitude.

Attitudes and Attributes of Collaborative Nursing Practice

Respect

Trust

Assertiveness

Autonomy

Cooperation

For example, participants may contribute the following:

1. Working definition of *cooperation* – *working together to achieve a shared goal*
2. Behaviours to demonstrate attitude of cooperation:
 - offering to help team member;
 - asking colleague how s/he is doing;
 - offering positive feedback at the end of the shift; and
 - remembering to say: ‘please’ and ‘thank you’.

Interpersonal Relationship and Communication Skills

Purpose

Interpersonal relationships and communication skills provide the foundation for CNP. Nurse educators/managers will be able to draw from many teaching and learning resources to address relationships and communication. To prompt thinking and to trigger addressing this topic an example used in a BC hospital is offered.

Interpersonal Relationship and Communication Skills - An Example

Lions Gate Hospital (LGH) has developed *Collaborative Practice Workshops* for nursing staff at the hospital. Two different workshops were created, one for staff and one for leaders.

Enhancing Collaborative Practice for Leaders

Workshops were developed for Acute Care Managers, Clinical Resource Nurses, Clinicians and Patient Service Coordinators at LGH to complement the workshops for staff described below.

Description: As a result of the re-design process, staff work roles, responsibilities and relationships have undergone tremendous changes that have introduced their own dynamics and challenges, which leaders have had to deal with on a daily basis. The Collaborative Practice workshops for Leaders were designed to equip leaders to support their staff by using a common language, framework and skills. With this in mind, two Leaders workshops were offered, namely the Leaders' Support workshop and the Leaders' Coaching Skills for Collaborative Practice workshop.

Goals - *The half-day Leaders' Support Workshop will:*

- Provide participants with an overview of the skills covered in the staff workshop to enhance use of the same language and models; and facilitate a dialogue to develop a process for a consistent approach to be used to support staff.

Goals - *The one-day Coaching Skills for Collaborative Practice workshop will:*

- Build and enhance coaching skills to strengthen effectiveness as a leader; demonstrate how to use a coaching conversation roadmap; teach how to ask powerful questions that help to resolve workplace issues; and enable leaders to mentor staff around communication and conflict management issues.

Enhancing Life Skills through Collaborative Practice Workshops

The LGH workshops for RNs, LPNs, and Care Aides were intended to enhance the quality and tone of both home and work relationships.

Goals: At the end of the one-day session, participants will:

- Understand the impact of change and transition on relationships;
- Explore ways of communicating that can support you at home and at work;
- Learn about communication styles and how they impact the quality of your communication with others; and
- Learn practical skills that will enhance your relationships with family, friends and colleagues!

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Collaborative Nursing Practice - Managing Conflict

Purpose

Managing conflict is a critical competency area for every nurse. When groups or teams are expected to work together, conflict can also be expected. Conflict should not be viewed as the problem because it is the norm with human beings. Conflict can provide rich opportunities for growth, change and development. Individuals use a variety of approaches to deal with conflict and self-management as well as stress management enter into this topic. Nurse educators/managers will want to draw on a variety of teaching/learning activities to assist participants to manage conflict. This section includes conflict scenarios and offers two conflict management models that can be used in group discussions.

Teaching and Learning Activity

The facilitator may choose to review one of the conflict management models provided or draw on one from his/her own repertoire. Choose a conflict scenario. Use the scenarios below or draw on participants' own examples of conflicts. You may wish to ask group members to role play the scenario. In small groups or dyads apply the selected conflict management model to the scenario. Give the small groups a designated amount of time to discuss the scenario, apply the model and ask the small groups to report back to the large group. The facilitator will want the group report to focus on particular issues that are relevant to the group, e.g., learning how to separate the conflict into issues and interests; recognizing how many possible options emerge; respecting differences of opinion, etc.

Conflict Scenarios

1) Residential Care – Care expectations

Mrs. Clark is an 86 year old patient with a diagnosis of: CVA, arthritis and glaucoma.

Mrs. Clark does not want to go for her tub bath. She feels tired and refused to go when Susan, LPN, went to take her for her bath. Susan feels that Mrs. C's needs should be respected. Barbara, RPN, is the team leader and she wants baths done on time and as per schedule. Barbara is frustrated because she thinks that Susan is not assertive enough with the residents.

2) Surgery Unit – Intra-professional conflict

Unit 6B is a busy surgical unit. In the past, everyone seemed to work well together but recently there has been increasing strife and a lot of staff turnover. Today, with two new grads (LPN and RN) and a float to cover one sick RN, work is behind. All have been late for coffee and lunch and the last RN/LPN team who went to coffee, were late returning. When they finally appear, the comments start to fly:

- “Nice of you to bother to come back!”
- “Well, it wasn't because you were here!”
- “It's not me that your letting down, it's your patients that suffer.”
- “You are implying that I'm not a good nurse.”
- “Well, if the shoe fits, wear it!”

- 3) Surgical Unit – Shared nursing competencies: Francine, RN and Wilma, LPN have only worked one shift together before but it seems that they see the world of nursing very differently. Francine has always worked in ICU in the past and is used to working with a total RN staff. She does not see the LPN role as a professional nursing role. Francine believes that Wilma is taking on skills (prn meds, changing dressings, maintaining IVs) that are beyond her and she wants Wilma to report to her. Wilma is a new graduate and feels prepared to take on the competencies and skills that she has learned. Both are frustrated. When Wilma finds that Francine has changed the dressing on her patient she confronts Francine.

Conflict Management Model I - Turning Conflict into Collaboration

Source: Levine, Stewart. (2000). *Getting to Resolution: Turning Conflict into Collaboration*. Berrett-Koehler Publishers.

The approach to resolving conflict offered by Mr. Stewart Levine is based upon a set of principles that include reference to forming long- term collaborative relationships. This reference to collaboration prompted inclusion in this set of tools/resources. Other principles that Mr. Levine speaks about include: believing in abundance (which can mean an abundance of solutions!); being ready to listen and share; being ready to learn; being creative; and fostering resolution. His principles feel familiar to nurses as they are drawn from good communication skills, principled relationships and skilled problem solving techniques, all of which are necessary in managing conflict.

His approach to resolving conflict incorporates key steps (Levine, 2000):

- 1st – Assume the attitude that resolution of the conflict is possible.
- 2nd – Tell your story
- 3rd – Listen for a preliminary vision of resolution
- 4th – Get current and complete
- 5th – Reach agreement in principle
- 6th – Craft a new agreement
- 7th – Achieve resolution.

The message from Levine is two-fold: there are underlying attitudes that are critical and there are necessary steps to achieving resolution. To apply his model, review your commitment to respectful listening and ethical problem solving. Both are critical to CNP. Listen to each other's story that brought you to a place of conflict. Be ready to find places of agreement and resolve easy points. Explore other options and ideas. Aim for an agreement in principle. Develop the details of what you can agree to do in the future. Acknowledge that you have resolved the issue and be prepared to move forward. In summary:

Commit to respectful listening and ethical problem-solving
Listen to each other's story
Identify any places of agreement
Explore all options and ideas/Brainstorm
Choose agreement in principle
Iron out details
Acknowledge resolution and move forward.

Conflict Resolution Model II - Justice Institute

Source: Justice Institute of BC. (1994). *Dealing with Interpersonal Conflict*. Vancouver, BC
(Permission to use: January, 2006)

This model offers a comprehensive structure to resolve conflict. Pairs should take a scenario and work through each stage.

Stage 1: Setting a Positive Environment

- Timing: agree on when to discuss the conflict.
- Location: agree on a mutually convenient, comfortable and possibly neutral setting conducive to discussion.
- Express motivation to resolve the differences to future mutual benefit.
- Listen attentively.

Stage 2: Clarifying the Issue(s)

- State your own point of view with respect to what you want to talk about (the issues).
- Speak for yourself.
- Invite the other person to share their point of view with respect to what they want to talk about.
- Check with each other for clarity.
- Listen actively when he/she is speaking to ensure understanding.
- Combine both parties' issues (topics) into an 'agenda'.
- State the issues in a way that does not assign blame or specify an outcome.
- Depersonalize the conflict.

Stage 3: Exploring Interest(s)

- State and check out assumptions.
- Look for common ground.
- Explore the interests of the other person in regard to the issue(s). (Consider their hopes, fears, concerns, expectations, beliefs, etc.).
- Listen actively and continue to check for understanding.
- Be descriptive rather than judgmental.
- Ask open-ended questions.
- Speak about your interests in a respectful, assertive way.
- Speak for yourself.
- Use and encourage assertive, rather than aggressive or passive behaviours and words.
- Summarize interests (what is important to both parties) in regard to the issue(s).

Stage 4: Resolution

- Invite brainstorming (mutual generation of options based on the interests of both parties).
- Evaluate the options: Check for fairness – meeting the interests of both parties.
- Choose an option or combination of options that work for both parties.
- Form action plan: Who, What, When, Where, How and work out details.
- Design a way to evaluate the effectiveness of the solution.
- If a solution is not becoming apparent, you may need more information, more trust or energy, or less fear.
 1. You may need to break and come back to the discussion.
 2. You may agree to disagree or agree that you cannot reach an agreement at this time and set a time for future discussion.
 3. You may obtain the needed information, work to increase the trust, or reduce the fear.

Collaborative Nursing Practice - Developing Shift Schedules

Purpose

Developing shift schedules for RNs, RPNs and LPNs who are beginning collaborative practice will provide an opportunity for nurses to work together to prepare a useful guideline for normal shift routines. Some hospital units will have a shift schedule to assist new staff or casual and float staff to organize their care. Facilitators may draw upon materials already in use on the unit.

This tool is a good activity to underscore the importance of communication when working with others. When new categories of nurses begin to work collaboratively they will need to schedule in times for communicating into their daily shift routine.

Teaching and Learning Activity

Have pairs of nurses (e.g., a RN and a LPN or Registered Psychiatric Nurse (RPN) and LPN) work together to develop a shift schedule that includes typical shift activities. If time allows do two (12 hour) or three (8 hour) shifts. Ask the nurses to use their own units to make this activity most relevant. However, if the group includes nurses from a variety of units, use the medical or surgical or psychiatric examples included later in the *Resources/Tools* materials as sample units.

To develop the shift schedule start with report, and include rounds, AM or Hs care, treatments, meds, breaks for coffee and lunch, reporting and charting, etc. Include specific times in the schedule to communicate and report on care completed and issues arising during the shift. Nurses in collaborative practice need to build in time during the shift for communication.

Ask participants to post an example of their shift schedule and do a walkabout to review the samples posted. As participants review the sample shift schedules they should consider whether it would help them to plan and organize the shift.

Collaborative Nursing Practice - Care Planning and Assigning Patients

Purpose

Participants will have the opportunity to work with unit based case scenarios to assign care to RN/LPN or RPN/LPN or RN/RPN teams and/or to practice care planning together. Please see the following pages in this section for the following case scenarios.

1. A residential care facility exercise.
2. A medical unit case study.
3. A surgical unit assignment to be shared by a RN/LPN team.
4. A psychiatric unit patient listing for the RN/RPN team to assign to staff.

Teaching and Learning Activity

There are a number of different approaches available to the facilitator. Use the case scenarios of the typical units to set up patient assignments. The facilitator may choose to use a typical patient example from the practice setting. This tool is based upon the assumption that a collaborative practice model of care delivery is being used. If this is not the case, the facilitator should modify the tool accordingly.

Divide the group into dyads and assign them the task of developing an appropriate assignment by considering patient/client status as well as individual and professional scope of practice. Participants should consider shared and unique competencies of the professional group as well as the individual competencies of the participants. For example, “As a LPN, using a glucometer is within my competencies, but as I am not familiar with the model used on the unit, I will need to review the procedure.”

While the expectations of practice settings vary, one very helpful example of guidelines for assigning Patient Care Aides (PCAs), LPNs and RNs is provided in these Resources and Tools. The appended document, *Guidelines for Assigning PCAs, LPNs and RNs in Acute Care* (VCHA draft, August 2004) serves as an example to assist nurses to focus on the particular competencies of each group.

In addition, a sample Medical RN and LPN assignment (with a rationale) is included after the typical patients on the Medical Unit. The facilitator should choose the type of unit that is most relevant to the participants. More specific guidelines include:

- 1) Form dyads of two different nursing groups - for example: one RN and one LPN; or one RPN and one LPN; or one RN and one RPN.
- 2) Select 6 - 9 patients from the surgical list and develop an appropriate assignment for the RN and LPN. Or alternatively, select 9 – 10 patients from the Psychiatric unit list and develop an assignment for the RN and RPN. Consider patient/client needs and review professional and individual scopes of practice to decide who can assume responsibility for clients/patients.
- 3) Be prepared to report back to the larger group on the following:

- a) Identify priority need(s)/problem(s) of patients/clients;
- b) Identify key nursing interventions;
- c) Identify how care will be divided between the two nurses in your dyad; and
- d) Ask the large group to validate your decisions or offer alternate suggestions.

Case Scenarios of Nursing Units

Residential Care – Clinical Decision Making
Medical Unit Case Study
Surgical Unit Case Study
Orthopedics/Gynaecological Case Study
Psychiatric Unit Case Study

Residential Care Facility - Collaborative Nursing Practice Clinical Decision Making Scenario.

Scenario: The residential care unit is made up of three wings with 20 residents per wing. There is one RN or RPN for the facility. Staffing includes one LPN and two health care workers in each wing.

Review the following scenario and discuss the roles and responsibilities of the involved nurses.

Mrs. Long is an 80 year old resident with mild to moderate cognitive impairment (MMSE 18). She is ambulatory with assistance and requires assistance with ADLs. On med rounds, the LPN discovers Mrs. Long in her bed, mumbling incoherently and unable to sit up.

Please consider the clinical decision-making required by reviewing the following questions. Scenario requires Assess/Plan/Implement/Evaluate

What would the LPN assess? What actions would the LPN take?

Collaborative Actions of RN or RPN and LPN

Who should contact the physician and family? The RN, RPN or LPN?

Who will take responsibility to monitor the resident?

Scenario continues...

Samantha Long, Mrs. Long's daughter arrives before staff have been able to contact her. She is very distressed and is wondering what is happening to her mother. She is asking questions about what happened.

What actions would be taken? By whom? Provide rationale for choices.

Physician arrives and assess resident and decision is required regarding whether to transfer to acute care.

Sample Key: LPN Assessment: Neuro Vital signs, mental status exam, urine dip if possible (may not be immediate)
Action: Withhold medications. Consult with RN.

Collaborative Nursing Practice – Medical Unit Case Study

Teaching and learning activity

Use the example of a medical unit below to practice assigning patients and also to discuss care planning/clinical decision-making. Please note that a sample assignment for the RN and LPN follows the patient information.

Scenario

Hospital X is located in a large urban community. The general medical ward has **24 beds**. **Staffing** on days (12 hr) consists of a Patient Services Coordinator, three RNs and three LPN and nights, three RNs and one LPN.

Typical patients on this unit

Mrs Smith –82 year old female

Diagnosis – diverticulitis UTI

Meds – Citalopram PO, KCL PO, Domperidone PO, Dexamethosone, Sennosides PO, Tylenol PRN, Lorazepam PRN, Morphine solution PO

Current condition – demanding ++, needs support for ADLs and frequent reassurance

Mr. Singh – 70 year old male

Diagnosis – CVA

Treatment – on tube feeds, IV with KCL at 100cc/hr, Foley catheter, glucometers QID

Medications – Cloxacillin IV, Cipro IV, Flagyl IV, Heparin SC, Ramipril PO, Sorvastatin PO, Valsartan PO, Indapamide PO, Slow K PO, Domperidone PO, Sliding Scale Insulin, Clopidogrel PO, Ventolin inhaler PRN, Tylenol PRN, Chloropromazine PRN, Oxazepam PRN, Laxatives PRN, Maxeran PRN

Current condition – full code, drowsy with open/closes eyes, follows commands, total care, and understands little English

Ms. Best – 67 year old female

Diagnosis – hyperosmolar metabolic acidosis; NIDDM, hypertension

Treatment – IV NS at 25cc/hr, palliative care

Medications – Cefotaxime IV, Flagyl IV, Patoprozole IV, Morphine IV infusion @ 1mg/hr, morphine IV PRN, Midazolam IV PRN, Fleet PRN, Gravol IV PRN

Current condition – unresponsive, total care

Mr Coorow – 57 year old male

Diagnosis – unstable angina; NIDDM, hypertension,

Treatment – Nitro, glucometer QID

Medications - Rosiglitazone PO, Naroparin SC, Ramipril PO, Simvastatin PO, Amlodipine PO, Nitro patch, EC ASA, Sliding scale insulin, Benadryl IV/IM PRN, Gravol PO/IV PRN, Ativan SL, Nitro spray PRN, Laxative of choice.

Current condition – no episodes of chest pain since admission, needs minimal assistance with ADLs

Mrs. Sarwecki 78 year old female

Diagnosis – CVA (six days ago) with left sided hemiplegia; hypertension
Treatment - symptom relief, discharge plan is for placement in a care facility
Medications – Metoprolol PO, Metofromin Hydrochloride PO, Enoxaprin SC, Olanzapine PO.
Current condition – needs assistances with ADLs, two person transfer, does not understand English

Mr. Samuels – 46 year old male

Diagnosis – ETOH withdrawal; Hep. C positive
Treatment – prevention of DT's, nutritional and medication support, IV NS with multi-vit 100 cc/hr
Mediations – Lorazepam PO/SL as per ETOH protocol, Vitamins PO, Maxeran IV PRN, Diazepam IV for PRN for seizures,
Current condition- independent for ADLs, aggression alert

Mr. Blythe– 62 year old male

Diagnosis – anterior MI X five days ago; hypertension
Treatment – received r-tpa in ER, spent two days in ICU
Medications – Captopril PO TID, ASA 80 mg PO OD, Propanolol PO TID, Enoxepain SC daily, Atorvastatin PO OD, Nitro spray PRN, Ativan SL PRN, laxative of choice PRN
Current condition- pain free, some assist with ADLs

Mrs. Angelus – 76 year old female

Diagnosis – COPD
Treatment – inhalers, continuous oxygen at 2L/min via n/p
Medications – Ventolin 2.5mg & Atrovent 500 mcg nebs q4h, Ventolin 2 puffs prn, Cipro 500 mg POq12h, Metofromin Hydrochloride PO, Oxazepam PRN, Laxatives PRN,
Current condition – on continuous oxygen, gets very SOB on exertion, needs assistance with ADLs

Mr. Sorbara – 87 year old male

Diagnosis - TIAs, CHF, Alzheimer's
Treatment – anticoagulants, treating ↑ BP
Meds – Hydrochlorothiazide PO OD, Furosemide PO OD, Clopidogrel PO OD, Donepezil PO QHS, Lipitor PO OD, Oxazepam PRN, Laxatives PRN
Current condition – confused +++, restrained when up, total care with ADLs, 2-person transfer

Mrs. Colins – 36 year old female

Diagnosis – cellulites abscess RT arm; Hep C pos, HIV pos, MRSA pos
Treatment – antibiotics, wound care
Meds – Vancromycin IV q12h , Cipro PO q12h, Ativan SL PRN, Laxative PRN, Hydromorphone PO PRN
Current condition- needs some assistance with ADLs due to wound, difficulties with pain control

Mr. Franklin– 67 year old male

Diagnosis – Pulmonary embolism; hypertension, depression

Treatment – anticoagulants

Meds - Enoxepain SC daily, Diltiazem PO OD, Paroxetine HCl PO OD, Atorvastatin PO OD, Morphine IV PRN, Ativan SL PRN, laxative of choice

Mrs. Wrangel – 92 year old female

Diagnosis – pneumonia; CHF, dementia,

Treatment- oxygen, IV antibiotics

Meds – Ancef IV q8h, Digoxin IV OD, HCT PO OD, Furosemide PO OD, sliding scale insulin SC, Oxazepam PRN, Ventolin 2.5 mg nebs q4h

Current condition – total care, confused ++, SOB on exertion, on continuous oxygen via n/p

Ms. Green – 56 year old female

Diagnosis – cirrhosis – cause under investigation

Treatment – investigative testing, saline lock, fluid restriction (1L/day), ↑ protein in diet

Meds – Levothyroxine PO daily, Maalox PO PRN, Ranitidine PO daily, Cholestyramine PO TID, Multi-vitamin PO daily, Methotrexate PO, Aldactone PO daily

Current condition- independent for ADLs

Mr. Wright – 68 year old male

Diagnosis – Pulmonary embolism ? Left leg DVT; CA lung with liver mets, COPD, MI five days ago

Treatment – anticoagulation, pain control, on bed rest, comfort care

Meds – Heparin IV as per protocol, Hydromorphone CR PO BID, Hydromorphone PO PRN, Diltiazem PO OD, Ventolin 2.5mg puffer q4h PRN, Atrovent 500 mcg puffers q4h PRN, Laxative of choice

Current condition- difficulty with pain control, continuous oxygen, tachycardia, assistance for ADLs, psychosocial support for pt & family

Mrs. Rin – 31 year old female

Diagnosis – Abdominal pain

Treatment – investigative, TB testing, IV fluids

Meds – Morphine IV PRN, Maxeran IV PRN

Current condition- independent for ADLs , has limited English

Mr. Angus – 75 year old male

Diagnosis – Respiratory failure; COPD

Treatment – IV antibiotics, vented in ICU – now has trach, PICC line

Meds – Vancromycin IV, Cipro IV, Ventolin 2.5mg and , Atrovent 500 mcg nebs q4h, Pulmocort inhaler q4h, Ativan SL PRN, Laxative of choice

Current condition- total care, continuous oxygen, requires frequent trach suctioning, aphasic

Mrs. Crocker - 80 year old female

Diagnosis – GI bleed X 24 hours (now stopped); arthritis; diabetes
Treatment – blood transfusions, monitoring of Hgb, glucometer ac & qhs, IV
Meds – Sliding scale insulin QID, Multi-vit IV, Tylenol # 3 PO q4h PRN, blood transfusions as needed to keep Hgb above 90
Current condition- on bed rest, oxygen to keep O2 sat's above 90%, pain control

Mr. Fong – 62 year old male

Diagnosis – confusion; C4/5 incomplete quad since 1994
Treatment – investigative
Meds – Gabapentin PO OD, Haloperidol PO TID, Ativan S/L PRN, Laxative of choice
Current condition- total care, foley catheter, requires bowel care, lift for transfers

Ms. Fredericks- 27 year old female

Diagnosis – Sepsis; IVDU (Heroin), Lt arm cellulites, urinary retention
Treatment – antibiotics, PICC line, pain management, foley catheter,
Meds – Cipro IV QID, Flagyl IV BID, Methadone PO daily, Hydromorphone PO q4h PRN, Ativan S/L PRN, Tylenol PO q4h PRN, Laxative of choice
Current condition- demanding ++, challenges with pain control, referral to Chemical Dependency Team

Mrs. Wu – 32 year old female

Diagnosis- Gastroenteritis/ Septic Arthritis Lt. Knee
Treatment – PICC line, peripheral IV, antibiotics, NPO, pain management
Meds – Clindamycin q8h IV, Ancef q8h IV Morphine IV PRN, Gravol IV PRN
Current condition- reduced mobility due to Lt knee, requires some assistance with ADLs

Mrs. Lui – 52 year old female

Diagnosis – pancreatitis
Treatment – investigative, (R/O gall stones), NG tube, NPO and pain management, IV with KCL
Meds – Morphine IV PRN, Ativan S/L
Current condition- speaks limited English, independent with ADLs

Ms. Zaoski – 25 year old female

Diagnosis – Fever NYD
Treatment – investigative
Meds – Tylenol for fever over 38°C, Laxative of choice
Current condition- remains febrile with weakness, needs assistance with care, no family or friends known

Mrs. Booker – 70 year old female

Diagnosis – Sepsis NYD; Parkinsons, schizophrenia
Treatment – investigative, antibiotics, PICC line,
Meds – Flagyl IV BID, Ancef IV q8h IV, Levodopa PO daily, Cogentin PO daily, Clozapine PO TID. Ativan S/L PRN, Tylenol #3 PO q4h PRN, Laxative of choice
Current condition- high risk for falls, assistance with ADLs, supervision when up

Mr. Houssini - 71 year old male

Diagnosis – partial small bowel obstruction; CA lungs with mets to liver

Treatment – investigative, pain management, symptom relief, NPO (ice chips), IV with KCL

Meds – Hydromorphone SC q3-4h PRN, Ativan S/L PRN

Current condition- speaks no English, requires assistance with ADLs, unsteady on feet

Sample Assignment for Medical Unit

Possible assignments based on RN and LPN competencies. When making assignments don't forget to consider individual staff experience (new grad or casual vs. regular unit staff) as the assignment will look different for experienced regular unit staff than for new staff, recent graduates or casuals. For this exercise it is assumed all staff are experienced regular unit staff.

Days

RN/LPN Team 1	RN/LPN Team 2	RN/LPN Team 3
Mrs. Smith	Mr. Singh	Ms. Best
Mr. Coorow	Mrs. Sarwecki	Mr. Samuels
Mr. Blythe	Mrs. Angelus	Mr. Sorbara
Mrs. Colins	Mr. Franklin	Mrs. Wrangel
Ms. Green	Mr. Wright	Mrs. Rin
Mr. Angus	Mrs. Crocker	Mr. Fong
Ms. Fredeericks	Mrs. Wu	Mrs. Lui
Ms. Zaoski	Mrs. Booker	Mr. Houssini

Assignment within RN/LPN Team

Option A.

LPN - Mrs. Smith, Mr. Coorow, Mr. Blythe, Ms. Green

RN – Mrs. Colins, Mr. Angus, Ms. Fredeericks, Ms. Zaoski

Option B.

LPN – Mrs. Smith, Mr. Blythe, Ms. Green, Mrs. Colins

RN – Mr. Coorow, Mr. Angus, Ms. Fredericks, Ms. Zaoski

Team 1

	LPN	Collaborative	RN
Mrs. Smith	Although the original diagnosis was query & NYD which would make the RN the most appropriate care giver, she now has a known diagnosis with care needs that fits within scope of LPN		
Mr. Coorow		If Mr. C has been in hospital for 48 hours or more most of his care needs fit within the scope of a LPN and his main care giver could be a LPN although the scale insulin which may require a RN to give (depending on work site). This collaboration could range from sharing the assignment to frequent communication with the LPN and discussing monitoring.	Note: If Mr. C. has been in hospital less than 48 hours or if Mr. C. experiences chest pain the RN would be the most appropriate caregiver.
Mr. Blythe		Provided he remains pain free Mr. B could have a LPN as his main caregiver with frequent communication with the RN.	If there were any concerns about his vital signs or if he was deemed to be at high risk for a 2 nd MI then he would need to have a RN as his primary care giver.
Mrs. Colins		Although much for Mrs. C.'s care needs fall within the scope of a LPN there would need to be frequent communication with the RN, provided there was a plan to address her pain control issues.	If there is not yet a plan to address Mrs. C.'s pain issues then a RN would be the most appropriate care giver due to the complexity of this patient's needs.

Ms. Green	Although the cause of Ms. G's cirrhosis is not known, there is an expected plan of care for the admitting condition and her care needs do fit within the scope of practice of a LPN.		
Mr. Angus		The RN & LPN could share the care of this patient with the RN as the main caregiver depending on the condition of other patients.	Due to the complexity of care for Mr. A the RN would be the most appropriate caregiver at this time.
Ms. Fredeericks		Although the RN & LPN could share the care of this patient due to her issues and challenges it would be best if she had one care provider consistently though out the shift.	Due to the complexity of Ms. F. care needs and the frequency of her IV meds the RN would be the most appropriate care provider.
Ms. Zaoski		Although much of Ms. Z's care fits within the scope of practice of a LPN due to the unknown cause of her fever (which unlike cirrhosis is a symptom not a condition) there would need to be frequent communication with the RN.	

Collaborative Nursing Practice – Surgical Case Study

Teaching and Learning Activity

Review the surgical patients below and consider an appropriate assignment for the RN and LPN. As an alternate activity, select typical patients from the list below and guide a care planning discussion.

Scenario

Hospital X is a regional hospital. The ward has **27 surgical beds plus 3 bed surgical step-down unit and 5 medical beds. Staffing** on days (12 hr) consists of a Unit Coordinator (M-F), six RNs & two LPNs and nights, five to six RNs plus one RN on step-down unit on all shifts. Type of unit-program: general surgery with some ENT and plastics, some medical beds, surgical step-down.

Typical patients on this unit

General Surgery Case Study

Mr. Dean 82 yrs

Diagnosis: Small Bowel Obstruction **Sx:** Hartman's colectomy (POD 2)

Treatment: Epidural pain control at 8mg/hr (Turned down from 10 over night due to low BP). Foley catheter. Snyder drain to abdomen. IV D5% & .45%NS @ 125. New colostomy. NG to low suction.

Meds: Citalopram po, Flagyl & Cipro IV, Ventolin nebs, Nystatin swish and swallow

Current condition: Required 2 to transfer preop. Dressing dry and intact. BP averaging 96/45. Output low. Pain 5/10.

Mr Kline 62 yrs

Diagnosis: Sacral ulcer **Sx:** debridement of ulcer and flap closure (POD 1)

Treatment: KCI bed. Foley catheter. Tegaderm to graft sites. VAC dressing to Lt. Hip. NSS BID to small open area on coccyx.

Meds: Heparin SC, Multivits po, clindamycin IV

Current condition: Paraplegic x 30 yrs. General high protein diet.

Ms Jones 50yrs

Diagnosis: Abdominal pain **Sx:** Lap. Appy (POD 1)

Treatment: IV .9NS @100. PCA pain control

Meds: Cefoxitin & Flagyl IV, Heparin SC

Current condition: Came back from PARR at 0230hrs. Temp 37.7. Has not voided yet. Has not dangled yet. Stab wounds x 4 dry and intact.

Ms Peterson 72yrs

Diagnosis: Diarrhea **Sx:** Reanastomosis ileostomy

Treatment: PCA pain control. NSS to old stoma site BID. IV D5% & .45%NS + 20Meq KCL at 125/

Meds: Heparin SC, Cefoxitim & Flagyl IV, Tylenol #3 (ordered but not taking yet),

Current condition: Taking full fluids well. Wants to change to T#3s. Up to commode frequently (independently) for loose stools. Temp 38.5 at 0600

Mr Brown 80yrs

Diagnosis: Bowel obstruction/anorexia – awaiting surgery

Treatment: TPN. Foley catheter.

Meds: Lipitor, Metaprolol, Digoxin, Thyroxin, Lasix all PO.

Current condition: Hx of CHF. TPN held off until CHF under control. TPN has now be started. Also on a general diet. Up with one to assist. Occasional LLQ pain.

Mr Cloop 51yrs

Diagnosis: GI bleed secondary to cirrhosis, secondary to Hep C

Treatment: Has had 2 units of blood for continued lower GI bleeds. PICC line insitu. Snyder drain insitu.

Meds: Continuous Pantoloc & Sandostatin IV's, Lactulose, Cipro and Lasix PO

Current condition: Continues with decreasing GI bleeds on commode. Hb 81. Up independently. Abdomen large with ascites.

Mr Monroe 82

Diagnosis: Abdominal pain

Treatment: Must be fed.

Meds: Lasix, Flagyl, Slow K, Metaprolol all PO. Ventolin nebulizer

Current condition: ALC. Awaiting bed in residential care. Up with 2 and walker. Loose stools.

Ms. Kipp – 59 years

Diagnosis – Acute pancreatitis

Treatment – IV (2/3 Dextrose & 1/3 NS at 150/hr), TPN (aminosyn @ 88 cc/hr, Lipids 20% @ 18 cc/hr), blood sugars BID, Foley catheter

Meds – Morphine IM/SC PRN, Sliding Scale insulin ordered but not needed at this time)

Current condition – Will be starting on clear fluids today. Only requiring pain medication Q 6-8 hrs.

Collaborative Nursing Practice - Orthopedics/Gynecological Case Study

Teaching and Learning Activity

Review the information on patients in this regional hospital surgical unit below and consider an appropriate assignment for the RN and LPN. As an alternate activity, select typical patients from the list below and guide a care planning discussion.

Mr. Finch 99yrs

Dx: Rt. Hip fracture / Afib **Sx:** Rt. Omega hip pinning (POD 3)

Medications: LMWH sc; Prednisone, Digoxin, ECASA, Multivitamin, Ferrous Gluconate, Tylenol, Lasix, Eltroxin – all PO; eye drops at HS

Treatments: IV of RL at 100cc/hr. May saline lock when drinking well.

Current condition: General diet, voiding in urinal, bilateral leg edema. Very HOH.

Ms. Platt 75 yrs

Dx: Osteoarthritis (OA) Rt. hip **Sx:** Rt. Total hip arthroplasty (POD 5)

Medications: Ferrous Gluconate, Lipitor, L-thyroxine, Amiodarone, Spironalactone, Isordil, Digoxin, Pantoloc, ECASA – all PO

Treatments: Saline lock insitu. Has had blood x the last 3 days

Current condition: Cardiac general diet. Crackles and wheezes throughout lung fields. Up with walker. Dressing continues to ooze moderate sanguineous drainage.

Ms. Komler 79 yrs No Code

Dx: Rt. Hip fracture **Sx:** Rt Omega hip pinning (POD 6)

Medications: Metoprolol, Ferrous Gluconate, ECASA – all PO. Heparin SC

Current condition: Up with 2 with walker. Incontinent. On a general, cut up diet: only taking ~ 50% of tray. Decreased air entry both lower lobes of lungs. Groins reddened. For transfer to LTC facility today.

Ms. Morris 29yrs

Dx: Post hysterectomy infection / Rt pyelonephritis / R/O abscess **Sx:** Vag Hyst (POD5) - Readmission

Medications: Gentamycin, Ampicillin, Zophran & Gravol – all IV

Treatments: IV .9 @ 150 cc/hr. For abdominal/renal ultrasound today

Current condition: Up independently. Burning / pain on urination. WBCs 15.2

Mr. Kain 82yrs

Dx: OA Lt knee / diabetic **Sx:** Lt Total Knee Arthroplasty (POD 1)

Medications: Ferrous Gluconate, Ciprofloxacin, Warfarin (daily order), Pantoloc, Metforman, Lipitor, Oxycontin – all PO. Heparin & sliding scale Insulin SC. Ancef IV (x 1 more dose)

Treatments: Blood sugars QID. PCA. Intrathecal during OR. Newly diagnosed diabetic. Teaching initiated preop.

Current condition: Blood sugars running 7.9 – 11.0. General diet but nauseated.

Ms. Thomas 84yrs

Dx: Lt. Tib/fib fracture / presyncope NYD / Diabetic **Sx:** None

Medications: Scheduled dose of SC Insulin BID. Atacand, Pariet, ECASA Adalat, Calcium, Vitamin D, Remeron – all PO.

Treatments: Zimmer Splint

Current condition: Up with 2 and transfer belt. Unreliable on her feet.

Mr. Niles 77yrs

Dx: OA Lt. Hip / NIDDM **Sx:** Lt. Total hip arthroplasty (just returned from PARR)

Medications: Ferrous Gluconate, Oxycontin, Tylenol PO. Sliding scale insulin & LMWH SC. Vancomycin IV

Treatments: Intrathecal intraoperatively, PCA, continuous perineural block. Hemovac x 2. Blood sugars QID. IV D5 & .45% NS @ 100/hr, Foley. O2

Current condition: Dressing dry and intact. General diabetic diet.

Mr. Ort 79yrs

Dx: Dislocation Lt ankle / NIDDM **Sx:** ORIF Lt ankle (POD 2)

Medications: NTG & Fentanyl patch. Prednisone, Lasix, Sprinalactone, Metformin, Methotrexate, Venlafaxine SR. Gabapentin, Raberprazole, Tolterodine – all PO. Sliding scale insulin QID, Ancef IV x 1 more dose.

Treatments: IV D2/3 & 1/3 NS @ 100. Foley. O2

Current condition: Up with 2. Temp 37.8, Diaphoretic

Collaborative Nursing Practice – Acute Psychiatric Unit Case Study

Teaching and Learning Activity

Use the patient information provided below as a source for assigning patients for the whole unit or select a group of patients for the RPN and RN to self assign, taking into account professional and individual competencies. Nurses can also draw on selected patients below to discuss and develop a plan of care.

Scenario

Urban, regional hospital; Usual census – 25. **Staffing:**
Days: 2 RNs and 2 RPNs or 3 RNs and 1 RPN or 3 RPNs and 1 RN;
Nights: 3 RNs/RPNs

Typical patients

1. Mrs G, 84, Acute depression; hypertension – antidepressant meds just started, hs sedation, prn.
2. Mrs. D. 85, Bipolar disorder, manic episode, committed, close observation, Low stimulation program. meds are mood stabilizer, antipsychotic to decrease psychotic thinking and agitation, anti anxiety.
3. Mr. E. 41, schizophrenia, paranoid type, committed, meds: antipsychotic regular and prn's, multivite, hs sedation
4. Mr S. 55 - Chronic depression; alcoholism – just admitted, wants day pass, close observation for awol risk.
5. Ms Z. 28 - Drug overdose (antidepressants and analgesics); suicide precautions just admitted from ER; Awaiting medication/treatment orders.
6. Mrs. R. Chronic depression, alcoholism. Transfer from small community hospital. Needs admission history and doctor's orders.
7. Mr. F, 18, Psychosis, possible Schizophrenia, cannabis addiction, committed, close observation for awol risk and unpredictability. first hospitalization and very frightened.
8. Mrs. G. 46 Bipolar disorder-depression, hypothyroidism, meds. mood stabilizer. antidepressant, antipsychotic, antianxiety and hs sedation.
9. Miss. H. 42 Schizoaffective disorder, depressed, psychotic, borderline personality traits. Meds: anti psychotic, antianxiety, hs sedation
10. Mrs. I, 50 major depression, OD of mirtazapine(antidepressant) transfer

from ICU 3 days ago. Meds anti anxiety, estrogen, antidepressants will most likely be ordered in future. ECT has also been suggested to patient but husband refuses.

11. Mr. J, 35, cocaine, cannabis and alcohol abuse, suicidal ideation. On CIWA protocol., seroquel PRN for drug cravings.

12. Mr. K, 23, bipolar disorder- depressed, cocaine abuse, Mood stabilizer, antipsychotic, antidepressant, hs sedation.

13. Mr. L. 18, crystal meth psychosis, presently in seclusion for aggressive behaviour. clopixol as needed prn, antianxiety and antipsychotic.

14. Mr. M. 85, depression with psychotic features, Diabetes type 2, hypertension, close observation, PJ's, at risk for falls due to fragility and dehydration. admitted two days ago, vitals, push fluids, Meds: antidepressant, Glyburide and metformin for diabetes, antihypertensive, HS sedation

15. Mr. N 18, Psychosis, possibly drug induced admitted 1 day ago, agitated but easily directed. Meds; anti-psychotic and anti-anxiety medication.

16. Mr. O, 38, schizoaffective disorder bipolar type, manic episode, committed, Low stimulation program, Antianxiety, antipsychotic, mood stabilizer HS sedation.

17. Mr. P. 25, depression, suicide attempt (hanging), close observation for suicide risk, committed, Meds: antidepressants, antianxiety regular and PRN's, HS sedation.

18. Mrs. Q. 52, post traumatic stress disorder, Major depression, chronic pain, close observation for suicidal ideation, Meds: antidepressant, anti anxiety, antipsychotic for agitation, tylenol for pain and gabapentin, HS sedation

19. Mr. R. 78, major depression, mild CVA 8 months ago, diabetes type 2, meds: ASA, antidepressant, antianxiety, glyburide, HS sedation

20. Mr. S, 36, anxiety disorder-panic attacks, alcohol abuse, cannabis abuse. Waiting for residential alcohol and drug program

21. Miss T, 47, depression, suicide attempt by overdose and slashing of both wrists. borderline personality disorder. close observation, Meds. antidepressant, antipsychotic, antianxiety and HS sedation.

22. Mr. U, 22, drug induced psychosis, crystal meth addiction, hospitalized for 1 week. meds antipsychotic seroquel for cravings PRN, discharge to outpatient drug counselling program.

23. Mrs. V. 45 schizoaffective disorder, depressed with psychosis, committed, Meds: antipsychotic, antidepressant, anti anxiety, and HS sedation

24. Mrs. W. 77, major depression with agitation, close observation, receiving ECT, meds antidepressant and antianxiety

25. Mr. X. 68 delusional disorder, assessment for possible dementing process. close observation because of paranoia and risk for awol. anti anxiety for agitation. Psychneuro testing and functional testing by OT.

Resources for Collaboration

Purpose

This section lists resources on collaboration that will be useful to nurse educators and managers. The first section includes print resources and the second is web based resources.

Print Resources for Collaborative Practice

Health Care Teamwork: Interdisciplinary Practice and Teaching by Drinka and Clark (2000) is included in the *CNP Resource Manual* as it offers an excellent resource on health care teams. Drinka and Clark share the benefits of effective interdisciplinary health care teams. They discuss ways to develop and support teams, team leadership, communication and conflict. They offer charts, key points, thoughtful discussion and case scenarios for discussion. Facilitators will find a multitude of helpful teaching and learning references in this book.

Collaborative Practice in the 21st Century by Schober and McKay (2004) is an excellent resource for nurses. They define and describe collaborative practice in health care. This reference was used extensively to develop the foundation document, *Collaborative Nursing Practice in BC Working Draft*.

Preparing RNs, RPNs and LPNs for Collaborative Practice in Nursing (BCNU, 2005) provides a literature review of collaborative nursing practice and the results of a survey investigating how nurses in BC were prepared for collaborative nursing practice. The paper was circulated to schools and health authorities. The paper provides the background to the project to prepare the *CNP Resource Manual*. It includes a number of important references in addition to the two cited above. Other references that may be useful to nurse educators/managers who are responsible for preparing nurses for collaborative nursing practice:

British Columbia Health Association, Registered Nurses Association of BC & Ministry of Health (Office of the Provincial Nurse Advisor). (1996). *Collaborative Practice Survey: Final Report*. North Vancouver, BC: The Young Group.

Canadian Medical Association & Canadian Nurses Association. (1996). *Working Together: A Joint CNA/CMA Collaborative Practice Project – HIV/AIDS Example*. Ottawa: CMA.

Conference Board of Canada. (2000). *Employability Skills*. Ottawa, ON: Conference Board of Canada. www.conferenceboard.ca

Curran, V. (2004). *Interprofessional Education for Collaborative Patient-Centered Practice Research Synthesis Paper*. Ottawa: Health Canada, Retrieved on 30/09/2004 from: http://www.hc-gc.gc.ca/english/hhr/research_synthesis.html

D'Amour, D. & Oandasan, I. (2004). *Interprofessional Education for Collaborative Patient-Centered Practice: An Evolving Framework*. Ottawa: Health Canada, Retrieved on 30/09/2004 from: <http://www.hc-sc.gc.ca/english/hhr/chapter10.html>

Henneman, e., Lee, J. & Cohen, J. (1995). Collaboration: A Concept Analysis. *Journal of Advanced Nursing*. 21, 103-109.

Hyrkas, K & Appelqvist-Schmidlechner. (2003). Team Supervision in Multiprofessional Teams: Team Members' Descriptions of the Effects as Highlighted by Group Interviews. *Journal of Clinical Nursing*. 12, 188-197.

Kenny, G. (2002). The Importance Of Nursing Values In Interprofessional Collaboration. *British Journal of Nursing* 11(1), 65-68.

Oandasan, I et al. (2004). *Interprofessional Education for Collaborative Patient-Centered Practice: Executive Summary*. Ottawa: Health Canada, Retrieved on 30/09/2004 from: http://www.hc-sc.gc.ca/english/hhr/exec_summ.html

Poulton, B., & West, M. (1999). The Determinants of Effectiveness in Primary Health Care Teams. *Journal of Interprofessional Care*. 13(1), 7 – 18.

Web Based Resources for Collaborative Practice

University of British Columbia (UBC) – College of Health Disciplines
www.health-disciplines.ubc.ca

The College of Health Disciplines at UBC offers courses, conferences and resources on its website. Check out “resources” and see a sample game used to teach inter-disciplinary practice.

Of the list of courses offered, *Health Care Team Development* IHHS will be very relevant to collaborative nursing practice. The course aims to assist learners to experience interactive, inter-professional teamwork, to prepare them to work collaboratively and to learn about a framework for teambuilding. The course includes an intensive two weeks of lectures, small group discussion, and team activities. Classes meet four hours per day, five days a week. Topics presented and discussed include: team structure and development; personal and professional components and variables; communication and team process; team health check; leadership and conflict resolution.

The College of Health Disciplines is also the home site of B.C.'s program of the national project on inter-professional practice (IECPCP). The various projects in B.C. are described and there are links to all of the associated documents and papers on inter-professional practice.

Vancouver Island Health Authority (VIHA) www.viha.ca

VIHA has developed a significant set of resources on the web page related to collaborative practice. To find their resources and tools, go to Professional Practice and look for LPN projects.

VIHA has also developed a web resource on conflict management. The web page includes a range of resources related to values, quizzes on your conflict style as well as an excellent list of other web resources. Go to http://www.viha.ca/conflict_management

Resource Web Pages - Tools and Techniques

In addition to “content” web pages, such as the UBC College of Health Disciplines, there are also web pages that offer tools and techniques for facilitators.

Collaboration Toolkit has been posted on the Enhancing Interdisciplinary Collaborative Practice (EICP) website: www.eicp-acis.ca. The EICP project has developed a toolkit that offers numerous web links on topics important to interdisciplinary practice. The web page is organized under the principles and elements of the EICP project and includes a wide array of resources. For example they address issues such as vision/strategic plans, communication, best practices and evaluation. These many rich resources are worth exploring.

The Fast Company web site offers numerous resources on leading a team, solving problems and specific techniques, including “Seven Secrets to Good Brainstorming”. The Brainstorming Secrets offers an excellent review. Go to: www.fastcompany.com

Langevin Learning Services boasts that it is the World’s largest train-the-trainer company. Go to: www.Langevinonline.com

They offer free training aids as well as other resources. The 59 Instructional Methods provides concise descriptions of teaching and learning methods from role playing, coaching, buzz groups, fish bowls to lectures and games. While brief, the descriptions can prompt ideas that you can use in your teaching.

Partnership

As partnership is integral to collaborative nursing practice, it is a topic worth exploring with nurses.

The following web pages offer ideas and case scenarios to explore. As with the tools and techniques resources, these web pages can trigger ideas for use in the particular context of practice of the nurses in your area and agency.

The Discipline of Collaboration by Russ Linden
www.pfdf.org/leaderbooks/L2L/summer2003/linden.html

The Goose Story
www.galtglobalreview.com/business/the_goose_story.html

A Guide to Partnerships
www.partnerships.org.uk/part

Appendix: Sample Guidelines for Assigning PCAs, LPNs and RNs in Acute Care, August, 2004, VCHA



Guidelines for assigning PCAs, LPNs and RNs in Acute Care August 2004*

Introduction

The following information is provided to help support decision making around assignments for PCAs, LPNs and RNs. This is meant to be guide only and is not meant to replace clinical decision making or judgements.

Whenever there is a decision to be made on what patient should be assigned to what category of caregiver there are several factors that must be taken into consideration:

The overall care requirements such as:

- the complexity of a patient's needs;
- the predictability of their progress;
- the knowledge and understanding required to provide the care; and
- the skills necessary to provided the care.

The circumstances around the care:

- the level of autonomy or independent decisions are required to provide the care;
- are there procedures and guidelines to direct the care being given;
- the clinical resources and supports available for consultation or intervention; and
- the frequency the care giver has at maintaining their skills with this (such as PIC line or CVC line care).

The environmental factors:

- the level of activity on the unit;
- the opportunity for staff to communicate frequently with each other around care of the patient and any changes that may occur; and
- the equipment is needed to provide care for this patient and who is familiar with it.

The category of care provider:

- does the care required fit within the scope of practice & employment for a PCA? LPN? RN?; and
- the experience level of the care giver with the patient and with similar patient populations.

** This appendix is offered as a sample from VCHA which may be modified for other sites*

Assumptions of care

1. A number of different factors and how they interconnect must be taken into consideration when determining which category of care provider can be assigned to which patient. This decision can not be based on the list of skills or tasks, but must also consider the previously listed factors and conditions as well.
2. The ability to perform a skill or a task can not be the sole deciding factor in who should provide patient care but rather the overall care needs of the patient must guide who is the most appropriate caregiver.
3. Regardless who is determined to be able to provide the care for a pt. the outcomes of best practices and safe care remain the same. The assignment of caregivers should not jeopardise a pt's safety and well being.
4. Assignment need to be based on who is the most appropriate caregiver not just what the scope of practice or scope of employment allows.

For the purposes of the following guides the terms are defined as set out below.

Accountability -	Ability to provide support for actions taken based on professional knowledge, skills judgement and attitude within guidelines of professional responsibility.
Acuity -	The nature of the onset and severity of a patient's health problems.
Assignment -	Designation of responsibilities for pt care within legal scope of practice, scope of employment and environment of practice.
Collaboration-	Members of the same health care team or members of a multidisciplinary team working together to deliver safe and effective patient care based on the values of mutual respect and open communication.
Competency -	Having specific knowledge, skill, judgement and attitude, along with critical thinking ability.
Complexity -	The range of variables that influence or characterize a patient's condition or circumstances such as multiple diagnosis, sudden changes in behaviour, challenging family dynamics.
Context -	The overall care environment such as the patient's care needs, the planned health outcomes, evaluation process for outcomes, clinical resources available, the number of other caregivers available to support the pt's care and the nature of the unit/ward at that time.
Evaluation -	The assessment process in place to look for the actual outcomes of care for comparison with the planned or expected health outcomes.

- Outcomes - The responses of the patient's condition (health status) and/or level of knowledge resulting from the therapeutic nursing interventions and actions provided. (International Classification for Nursing Practice, 1999).
- Predictable - The degree to which the progress of a patient can be determined based on observation, experience or scientific reason (Wolf, 1977).
- Responsibility - The obligation to provide for the care needs of patients, which are either implied or explicit in accordance with professional, legal and ethical standards of one's profession.

Competencies for the PCA Role

PCAs can be assigned to provide specific duties and tasks for specific patients by a RN. The most appropriate patients for the PCA to work with independently are patients with low acuity, low complexity and high predictability. For patients with high acuity and low predictability the PCA can work directly with a RN to provide care.

The experience of the PCA with the unit's patient population and familiarity with the unit must be taken into consideration when determining duties to be assigned for PCA.

Assessment

- Takes temperatures, pulse and respiration rates as directed by RN and reports findings.
- Observes and monitors patient progress, symptoms and behavioural changes and reports findings to designated RN.
- Observes and monitors patient discomfort and pain and reports to designated RN.

Planning

- Participates in development and evaluation of care plans by sharing information regarding patient's condition and response with other members of the health care team.
- Participates in unit discussions and in services by attending meetings and providing information to improve patient and family care and to efficiency and safety of the unit.

Basic Care and Safety

- Assists with ADLs of designated patients including bathing, grooming, dressing, oral hygiene, and toileting.
- Maintains a safe environment for patients by attaching call light/bells within a pt's reach, appropriate use of side-rails.
- Handles, stores and disposes of workplace hazardous materials in accordance with established protocols.
- Helps ensure hallways are uncluttered.
- Reports incidents and equipment problems to designated RN.

Mobility and Comfort

- Assist with the transport of patients using mechanical aides such as speciality beds, mobilizers, wheelchairs and stretchers.
- Assist with mobilization of pt. by positioning, lifting and/or transferring pt following prescribed safe techniques such as mechanical lifts or slide boards.
- Accompanies and provides assistance to patients as escort of transfers to other care areas as required.
- Helps to create a comfortable and pleasant environment for patients & families.

Elimination

- Assists with toileting as required.
- Administers suppositories and enemas as directed by RN and in accordance with well established protocols and established procedures.
- Empties urine bags.

Nutrition

- Assist patients with meals by serving meal trays, checking meals to ensure dietary restrictions are met and feeding patients. Directed.

Skin and Wound Care

- Observes and monitors skin and skin breakdown and notifies RN of any changes or areas of concern.
- Performs non-sterile dressings of for designated patients following established protocols and procedures.

Communication & Collaboration

- Reports all significant observations, changes in patients, and unusual incidents or accidents to designated RN.
- Establishes therapeutic relationships with patients and families and supports them through greeting them and orienting them to their room and the unit.
- Ensures confidentiality and respect for patient's rights and privacy is maintained at all times.
- Communicates with other members of the health care team in respectful and timely manner.
- Participates in team meetings as per unit routine.

Support

- Assist with maintaining supplies on unit by checking areas, identify items that need to be ordered, and notify appropriate person as per unit routine.
- Stocking and replenishing items and tidying supply & patient areas when required.
- Prepares room for discharge cleaning and assists with room set up with such things as stripping beds, remaking beds, sending soiled lined to laundry, emptying patient fridge's and removing extra supplies in accordance with established procedures and protocols.
- Performs related clerical duties such as answering telephones, providing information regarding unit, offering direction for patients, families and visitors & filing material as required.

Emergencies

- Responds to call bells and alarms by assisting the patient where appropriate or notifying other members of the health care team.
- Recognises emergency situations and takes appropriate action such as removing patients from eminent danger and calling appropriate code (Code Red, Code White, Code Blue, etc.).
- Performs CPR.
- Knows location of emergency carts and airway equipment.

Documentation

- Provides written documentation and records findings on appropriate forms as directed by unit policy and procedures.
- Signs or initials all appropriate documentation (such as MAR for administration of suppositories).

Other

- Performs unit specific skills and duties according to established standards and guidelines.

Competencies for the LPN Role

LPNs are responsible and accountable for their own practice. LPNs can work autonomously with patients with known health problems, moderate to low acuity, high level of predictability and low complexity. As the acuity and complexity increases and the predictability decreases the LPN works increasingly closer in collaboration with the RN and other members of the health care team. The experience of the LPN with the unit's patient population and familiarity with the unit must be taken into consideration when determining a patient assignment for a LPN. **LPNs can perform all the duties of a PCA along with the following duties, tasks and skills.**

Assessment

- Physical assessments: head to toe including chest and abdominal.
- Respiratory assessment; performs oral suctioning as needed.
- Vital signs including pulse oximetry, capillary blood glucose levels & neuro vitals including the Glasgow coma scale with interpretation of findings and taking appropriate responses.
- Pain assessment using rating scales and the corresponding responses.
- Understands laboratory values and diagnostic test results and implications for patient/ resident care.
- Psychosocial needs and influences.
- Interprets information from assessments, uses sound clinical decision making and takes appropriate action.

Planning

- Sets appropriate priorities for nursing care.
- Completes admission, transfer and discharge of patients/residents.
- Participates in developing and revising care plans for patient/resident.

Evaluation

- Evaluates nursing interventions for effectiveness and anticipated outcomes and revises plan of care accordingly.

Basic Care and Safety

- Provides a safe and clean environment including maintain asepsis and universal precautions, appropriate isolation techniques and protocols such as those for MRSE & VRE.
- Provides care of the body after death.

Mobility and Comfort

- Promotes activity, comfort and independence through encouraging activities as tolerated, appropriate use of positioning, walking devices, lifts and transfers, active & passive ROM and use of natural aids to promote comfort, relaxation and sleep.

Elimination

- Provides elimination care by assisting with toileting. Inserts and maintains straight and retention catheters for male and female patient/residents. Applies condom drainage and provides catheter care. Monitors and records intake & output. Provides bowel care as assessed in accordance with protocols, including giving of suppositories and enemas. Provides care of patient/resident with established ostomies.

Nutrition

- Provides nutritional care through assistance with appropriate feeding techniques & caring for patient/residents with feeding tubes &/or nasogastric tubes including checking placement, adding feeding solutions, flushing tube and bag, maintaining flow rate by gravity and using feeding pumps.

Skin and Wound Care

- Provides skin and wound care including processes that promote skin integrity, assessing skin condition, application of heat & cold, simple dressings, removal of sutures/staples.
- Follows established wound care protocols.

Intravenous Therapy

- Provides care for patient/resident receiving peripheral IV therapy including assessing of site, monitoring for complications and performing appropriate interventions e.g. using infusion pumps, calculating and maintaining rates, recording accurate Intake & Outputs, changing IV bags that do not contain medication, discontinuing IVs and saline locks.
- Caring for patient/resident prior to and after receiving blood or blood products including recognising post transfusion reactions and the appropriate interventions. (The RN continues to have primary responsibility for care of the patient/resident during the transfusion including taking of vital signs.)
- Care of patient with CVC or PIC line, including recognising complications at insertion site

Medication Administration

- Administers medications with an understanding of the indications, side effects & related nursing actions via oral, subcutaneous, intramuscular, rectal, vaginal, topical routes and sc butterfly insertion. Instils ear, eyes & nose drops.
- Takes verbal orders in an emergency situation and receives telephone orders for medications. Following unit guidelines transcribes orders on to patient/resident's chart, MAR and Kardex, then faxes order to pharmacy.
- Remains aware of changes to patient/resident's medications throughout shift and follows hospital guidelines in keeping medication chart/drawer/bubble pack current.
- Participates in the regulation and control of narcotics including doing the narcotic count and solving discrepancies in the count should any exist.

- Participates in the care of patients receiving PCA or epidural pain control including recognition signs of complications, doing required assessments.

Communication and Collaboration

- Uses therapeutic communication skills with patients/residents and families.
- Communicates respectfully with other members of the health care team.
- Collaborates in professional manner with colleagues in the interest of optimal patient/resident care.
- Calls physicians for own patient/resident to discuss changes in status, communicates assessment findings or need for reordering medication. Processes physician's orders according to unit and organisational standards.
- Communicates with RN, Charge Nurse and Physician in response to abnormalities, unpredictable outcomes or challenging situations. Assists in restructuring assignments with RN &/or Charge Nurse when patient/residents conditions changes.

Support

- Provides care and teaching for patients receiving diagnostic tests and procedures including collecting specimens (i.e. stool, urine, and sputum) swabs for culture and straining urine. Understands selected diagnostic test results (e.g. laboratory values) and how they impact care and treatment.
- Participates in patient/resident teaching including orientation of patient/resident and their family to the unit on admission. Provides incidental teaching on activities of daily living, procedures, tests, medications and aspects of discharge planning. Assesses and supports patient/residents and their families in their adjustments to changes to health status, illness and death & dying.
- Mentors and acts as a preceptor for new staff and students.

Emergencies

- Responds, identifies and intervenes in Code Blue situations including providing CPR and knowledge of the equipment on the emergency carts and at the bedside (i.e. trach and chest tube emergency equipment).
- Responds to other emergencies such as choking, Codes White, Yellow, Orange etc.

Documentation

- Documents assessment, interventions and patient responses on appropriate forms. Completes appropriate flow sheets & clinical records e.g. MAR, IV therapy, pain management, wound care, behavioural monitoring. Reviews and updates Kardexes and Care Plans.

Other

- Performs unit specific skills and duties according to established standards and guidelines.

Competencies for the RN Role

RNs can practice autonomously regardless of the acuity, complexity or predictability of patients. When the acuity and complexity are high or increasing and the predictability is low or decreasing the RN is the most appropriate primary care giver.

The experience of the RN with the unit's patient population and familiarity with the unit must be taken into consideration when determining the assignment for a RN.

RNs can perform all the duties, tasks and skills listed for the PCA and LPN along with the following duties, tasks and skills.

Assessment

- Comprehensive assessments to identify the needs and health status of the patient.
- Interpretation of information through application and synthesis of scientific knowledge and nursing interventions leading (clinical decision making) and takes appropriate action.
- Advanced assessment and monitoring of patients receiving intervention such as APA.

Planning

- Develops plan of care for patients.
- Determines assignment of appropriate care provider (RN, LPN or PCA).

Evaluation

- Evaluates nursing interventions for effectiveness and anticipated outcomes and revises plan of care accordingly.

Basic Care and Safety

- As per PCA and LPN roles

Mobility and Comfort

- As per PCA and LPN roles

Elimination

- As per PCA and LPN roles

Nutrition

- As per PCA and LPN roles.
- Insertion of NG tubes.
- Care and monitoring of patients receiving TPN.

- Care and monitoring of patients with complex nutritional issues such as dysphasia and tolerance challenges with enteral feeding.

Skin and Wound Care

- Performs assessment and provides treatment of complex wounds.

Intravenous Therapy

- Initiates and maintains IV therapy as ordered by physician.
- Care of patient with PICC & CVC lines maintaining infusion and site dressing changes.
- Initiates and cares for patients receiving blood transfusions.

Medication Administration

- Administers medication via all routes including IV, epidural and entrachial (where applicable).

Communication and Collaboration

- Identifies issues and concerns in regards to patients and unit wide and uses critical thinking skills for problem solving.
- Role models respectful communication and conflict resolution skills for other health care team members.
- Involves other members of health care team in decision making and problem solving as appropriate.

Support

- Acts in Team Leader and Charge Nurses as per unit routines when assigned.
- Uses critical thinking and nursing judgement to problem solve unit and patient issues, and challenges.
- Promotes best evidence based practice.
- Provides clinical support and guidance to other staff.
- Mentors and acts as preceptor for new staff and students.

Emergencies

- Responds, identifies and intervenes in Code Blue situations including providing CPR and knowledge of the equipment on the emergency carts at the bedside (i.e. trach and chest tube emergency equipment).
- Assist Code Blue team as required including accepting role of Code Recorder as directed.
- Responds to other emergencies such as choking, Codes White, Yellow, Orange etc.

Documentation

- Documents assessment, interventions and patient responses on appropriate forms. Completes appropriate flow sheets & clinical records e.g. MAR, IV therapy, pain management, wound care, behavioural monitoring. Reviews and updates Kardexes and Care Plans.

Other

- Performs unit specific skills and duties to established standards and guidelines.

References

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College of Nurses of Ontario. A Decision Guide: Determining the Appropriate Category of Care Provider. 2000

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