


Coordinating Client Care

One of the primary roles of nursing is the coordination and management of client care in collaboration with the health care team. In so doing, high-quality health care is provided as clients move through the health care system in a cost-effective and time-efficient manner. 

To effectively coordinate client care, a nurse must have an understanding of collaboration with the interprofessional team, principles of case management, continuity of care (including consultations, referrals, transfers, and discharge planning), and motivational principles to encourage and empower self, staff, colleagues, and other members of the interprofessional team.

COLLABORATION WITH THE INTERPROFESSIONAL TEAM

An interprofessional team is a group of health care professionals from various disciplines. Collaboration involves discussion of client care issues in making health care decisions, especially for clients who have multiple problems. The specialized knowledge and skills of each discipline are used in the development of an interprofessional plan of care that addresses multiple problems. Nurses should recognize that the collaborative efforts of the interprofessional team allow the achievement of results that a team member would be incapable of accomplishing alone.

- Nurse-provider collaboration should be fostered to create a climate of mutual respect and collaborative practice.
- Collaboration occurs among different levels of nurses and nurses with different areas of expertise.
- Collaboration should also occur between the interprofessional team, the client, and the client's family/significant others when an interprofessional plan of care is being developed.
- Collaboration is a form of conflict resolution that results in a win-win solution for both the client and health care team.

NURSE QUALITIES FOR EFFECTIVE COLLABORATION

- Good communication skills
- Assertiveness
- Conflict negotiation skills
- Leadership skills
- Professional presence
- Decision-making and critical thinking

THE NURSE'S ROLE

- Coordinate the interprofessional team.
- Have a holistic understanding of the client, the client's health care needs, and the health care system.
- Provide the opportunity for care to be provided with continuity over time and across disciplines.
- Provide the client with the opportunity to be a partner in the development of the plan of care.
- Provide information during rounds and interprofessional team meetings regarding the status of the client's health.
- Provide an avenue for the initiation of a consultation related to a specific health care issue.
- Provide a link to postdischarge resources that might need a referral.

VARIABLES THAT AFFECT COLLABORATION

Decision-making styles

The interprofessional team within a facility is challenged with making sound decisions about how client care is delivered. A variety of decision-making styles are available for use depending upon the needs of the situation. Often the group leader decides the decision-making style the team will use. Decision-making styles vary in regard to the amount of data collected and the number of options generated.

DECISIVE: The team uses a minimum amount of data and generates one option.

FLEXIBLE: The team uses a limited amount of data and generates several options.

HIERARCHICAL: The team uses a large amount of data and generates one option.

INTEGRATIVE: The team uses a large amount of data and generates several options.

Hierarchical influence on decision-making

Decision-making is also influenced by the facility hierarchy. In a centralized hierarchy, nurses at the top of the organizational chart make most of the decisions. In a decentralized hierarchy, staff nurses who provide direct client care are included in the decision-making process. Large organizations benefit from the use of decentralized decision-making because managers at the top of the hierarchy do not have firsthand knowledge of unit-level challenges or problems. Decentralized decision-making promotes job satisfaction among staff nurses.

Behavioral change strategies

Although bombarded with constant change, members of the interprofessional team can be resistant to change. Three strategies a manager can use to promote change are the rational-empirical, normative-reeducative and the power-coercive. Often the manager uses a combination of these strategies.

RATIONAL-EMPIRICAL: The manager provides factual information to support the change. Used when resistance to change is minimal.

NORMATIVE-REEDUCATIVE: The manager focuses on interpersonal relationships to promote change.

POWER-COERCIVE: The manager uses rewards to promote change. Used when individuals are highly resistant to change.

Stages of team formation

Teams typically work through a group formation process before reaching peak performance.

FORMING: Members of the team get to know each other. The leader defines tasks for the team and offers direction.

STORMING: Conflict arises, and team members begin to express polarized views. The team establishes rules, and members begin to take on various roles.

NORMING: The team establishes rules. Members show respect for one another and begin to accomplish some of the tasks.

PERFORMING: The team focuses on accomplishment of tasks.

Generational differences team members

Generational differences influence the value system of the members of an interprofessional team and can affect how members function within the team. Generational differences can be challenging for members of a team, but working with individuals from different generations also can bring strength to the team. **(2.1)**

MAGNET RECOGNITION PROGRAM

The interprofessional team is charged with maintaining continuous quality improvement. The nursing staff can choose to demonstrate quality nursing care by seeking Magnet Recognition.

- The American Nurses Credentialing Center awards Magnet Recognition to health care facilities that provide high-quality client care and attract and retain well-qualified nurses. The term magnet is used to recognize the facility's power to draw nurses to the facility and to retain them.
- Fourteen forces of magnetism provide the framework for the magnet review process. The first step for a facility that applies for magnet recognition is to complete a self-appraisal based on a set of established standards. It is important that all levels of nursing participate in the application process.
- After documentation that the standards have been met, an on-site appraisal is conducted. A facility that meets the standards is awarded magnet status for a four-year period.
- To maintain magnet status, the facility must maintain the established standards and submit an annual report.

2.1 Generational characteristics

	VETERAN	BABY BOOMER	GENERATION X	GENERATION Y
BIRTH YEAR	1925-1942	1943-1960	1961-1980	1981-2000
CHARACTERISTICS	Supports the status quo Accepts authority Appreciates hierarchy Loyal to employer	Accepts authority Workaholics Some struggle with new technology Loyal to employer	Adapts easily to change Personal life and family are important Proficient with technology Makes frequent job changes	Optimistic and self-confident Values achievement Technology is a way of life At ease with cultural diversity

CASE MANAGEMENT

Case management is the coordination of care provided by an interprofessional team from the time a client starts receiving care until she no longer receives services. **QTC**

PRINCIPLES OF CASE MANAGEMENT

- Case management focuses on managed care of the client through collaboration of the health care team in acute and postacute settings.
- The goal of case management is to avoid fragmentation of care and control cost.
- A case manager collaborates with the interprofessional health care team during the assessment of a client's needs and subsequent care planning, and follows up by monitoring the achievement of desired client outcomes within established time parameters.
- A case manager can be a nurse, social worker, or other designated health care professional. A case manager's role and knowledge expectations are extensive. Therefore, case managers are required to have advanced practice degrees or advanced training in this area.
- Case manager nurses do not usually provide direct client care.
- Case managers usually oversee a caseload of clients who have similar disorders or treatment regimens.
- Case managers in the community coordinate resources and services for clients whose care is based in a residential setting.
- A critical or clinical pathway or care map can be used to support the implementation of clinical guidelines and protocols. These tools are usually based on cost and length of stay parameters mandated by prospective payment systems such as Medicare and insurance companies.

NURSING ROLE IN CASE MANAGEMENT

- Coordinating care, particularly for clients who have complex health care needs
- Facilitating continuity of care
- Improving efficiency of care and utilization of resources
- Enhancing quality of care provided
- Limiting unnecessary costs and lengthy stays
- Advocating for the client and family

CONTINUITY OF CARE: CONSULTATIONS, REFERRALS, TRANSFERS, AND DISCHARGE PLANNING

Continuity of care refers to the consistency of care provided as clients move through the health care system. It enhances the quality of client care and facilitates the achievement of positive client outcomes. **Qecc**

- Continuity of care is desired as clients move from one:
 - Level of care to another, such as from the ICU to a medical unit
 - Facility to another, such as from an acute care facility to a skilled facility
 - Unit/department to another, such as from the PACU to the postsurgical unit
- Nurses are responsible for facilitating continuity of care and coordinating care through documentation, reporting, and collaboration.
- A formal, written plan of care enhances coordination of care between nurses, interprofessional team members, and providers.

NURSING ROLE IN CONTINUITY OF CARE

The nurse's role as coordinator of care includes the following.

- Facilitating the continuity of care provided by members of the health care team.
- Acting as a representative of the client and as a liaison when collaborating with the provider and other members of the health care team. When acting as a liaison, the nurse serves in the role of client advocate by protecting the rights of clients and ensuring that client needs are met.

As the coordinator of care, the nurse is responsible for:

- Admission, transfer, discharge, and postdischarge prescriptions.
- Initiation, revision, and evaluation of the plan of care.
- Reporting the client's status to other nurses and the provider.
- Coordinating the discharge plan.
- Facilitating referrals and the use of community resources.

DOCUMENTATION

Documentation to facilitate continuity of care includes the following.

- Graphic records that illustrate trending of assessment data such as vital signs
- Flow sheets that reflect routine care completed and other care-related data
- Nurses' notes that describe changes in client status or unusual circumstances
- Client care summaries that serve as quick references for client care information
- Nursing care plans that set the standard for care provided.
 - Standardized nursing care plans provide a starting point for the nurse responsible for care plan development.
 - Standardized plans must be individualized to each client.
 - All documentation should reflect the plan of care.

COMMUNICATION AND CONTINUITY OF CARE

Communication tools

- Poor communication can lead to adverse outcomes, including sentinel events (unexpected death or serious injury of a client).
- A number of communication hand-off tools are available to improve communication and promote client safety: I-SBAR, PACE, I PASS the BATON, Five P's **Qs**

Change-of-shift report

- Performed with the nurse who is assuming responsibility for the client's care.
- Describes the current health status of the client.
- Informs the next shift of pertinent client care information.
- Provides the oncoming nurse the opportunity to ask questions and clarify the plan of care.
- Should be given in a private area, such as a conference room or at the bedside, to protect client confidentiality.

Report to the provider **Qc**

- Assessment data integral to changes in client status
- Recommendations for changes in the plan of care
- Clarification of prescriptions

CONSULTATIONS

- A consultant is a professional who provides expert advice in a particular area. A consultation is requested to help determine what treatment/services the client requires. **Qecc**
- Consultants provide expertise for clients who require a specific type of knowledge or service (a cardiologist for a client who had a myocardial infarction, a psychiatrist for a client whose risk for suicide must be assessed).

The nurse's role regarding consultations

- Initiate necessary consults or notify the provider of the client's needs so the consult can be initiated.
- Provide the consultant with all pertinent information about the problem (information from the client/family, the client's medical records).
- Incorporate the consultant's recommendations into the client's plan of care.

REFERRALS

A referral is a formal request for a service by another care provider. It is made so that the client can access the care identified by the provider or the consultant. **Qecc**

- The care can be provided in the acute setting or outside the facility.
- Clients being discharged from health care facilities to their home can still require nursing care.
- Discharge referrals are based on client needs in relation to actual and potential problems and can be facilitated with the assistance of social services, especially if there is a need for:
 - Specialized equipment (cane, walker, wheelchair, grab bars in bathroom)
 - Specialized therapists (physical, occupational, speech)
 - Care providers (home health nurse, hospice nurse, home health aide)
- Knowledge of community and online resources is necessary to appropriately link the client with needed services.

The nurse's role regarding referrals

- Begin discharge planning upon the client's admission.
- Evaluate client/family competencies in relation to home care prior to discharge.
- Involve the client and family in care planning.
- Collaborate with other health care professionals to ensure all health care needs are met and necessary referrals are made.
- Complete referral forms to ensure proper reimbursement for prescribed services.

TRANSFERS

Clients can be transferred from one unit, department, or one facility to another. Continuity of care must be maintained as the client moves from one setting to another.

- The use of communication hand-off tools (I PASS the BATON, PACE) promotes continuity of care and client safety. **Qs**
- The nurse's role regarding transfers is to provide written and verbal report of the client's status and care needs.
 - Client medical diagnosis and care providers
 - Client demographic information
 - Overview of health status, plan of care, and recent progress
 - Alterations that can precipitate an immediate concern
 - Most recent vital signs and medications, including when a PRN was given
 - Notification of assessments or client care needed within the next few hours
 - Allergies
 - Diet and activity prescriptions
 - Presence of or need for specific equipment or adaptive devices (oxygen, suction, wheelchair)
 - Advance directives and whether a client is to be resuscitated in the event of cardiac or respiratory arrest
 - Family involvement in care and health care proxy, if applicable

DISCHARGE PLANNING

Discharge planning is an interprofessional process that is started by the nurse at the time of the client's admission. **Qtc**

- The nurse conducts discharge planning with both the client and client's family for optimal results.
- Discharge planning serves as a starting point for continuity of care. As client care needs are identified, measures can be taken to prepare for the provision of needed support.
- The need for additional services such as home health, physical therapy, and respite care can be addressed before the client is discharged so the service is in place when the client arrives home.
- A client who leaves a facility without a prescription for discharge from the provider is considered leaving against medical advice (AMA). A client who is legally competent has the legal right to leave the facility at any time. The nurse should immediately notify the provider. If the client is at risk for harm, it is imperative that the nurse explain the risk involved in leaving the facility. The individual should sign a form relinquishing responsibility for any complications that arise from discontinuing prescribed care. The nurse should document all communication, as well as the specific advice that was provided for the client. A nurse who tries to prevent the client from leaving the facility can face legal charges of assault, battery, and false imprisonment.

Discharge instructions

- Step-by-step instructions for procedures to be done at home. Clients should be given the opportunity to provide a return demonstration of these procedures to validate learning.
- Medication regimen instructions for home, including adverse effects and actions to take to minimize them.
- Precautions to take when performing procedures or administering medications.
- Indications of medication adverse effects or medical complications that the client should report to the provider.
- Names and numbers of providers and community services the client or family can contact.
- Plans for follow-up care and therapies.

The nurse's role with regard to discharge is to provide a written summary including:

- Type of discharge (prescribed by provider, AMA).
- Date and time of discharge, who accompanied the client, and how the client was transported (wheelchair to a private car, stretcher to an ambulance).
- Discharge destination (home, long-term care facility).
- A summary of the client's condition at discharge (gait, dietary intake, use of assistive devices, blood glucose).
- A description of any unresolved problems and plans for follow-up.
- Disposition of valuables, medications brought from home, and prescriptions.
- A copy of the client's discharge instructions.

2.2 Interfacility transfer form

INTERFACILITY TRANSFER FORM

Place label here

TRANSFER FROM: _____

Client Condition: _____ Stable _____ Unstable

Reason for transfer and Benefits and Risks of transfer:

- Client/responsible person's request
 Need for higher level of care not available at this facility
 Need for diagnostic equipment not available at this facility
 Transfer request by: _____, MD
 Other: _____

Benefits of Transfer:

Risks of Transfer:

- Death
 Vehicular accident
 Bleeding
 Pulmonary Decompensation
 Cardiac Decompensation
 Delivery in route
 Deterioration of medical condition:

 Additional delay in receiving appropriate treatment
 Other _____
 I certify that based upon the information available at the time of transfer, the medical benefits and treatment at the accepting facility, outweigh the increased risks to the client in the case of pregnancy, the unborn infant.
 After client assessment, I certify that I have discussed the risks and benefits to the client that were known to me at the time of transfer.
 Medical Diagnosis: _____

Provider's Name: _____

Signature: _____

Date: _____ Time: _____

I acknowledge by my signature that I agree to my transfer to the receiving facility and the transferring provider has discussed with me the risks and benefits of transfer.

Client Signature: _____

Client unable to sign, Signature of Responsible person: _____

Relationship: _____

Approval of Transfer

_____ The receiving facility has agreed to accept the client, provide appropriate medical treatment and has available and qualified personnel for the treatment of this client.

Name/title of transferring facility contact receiving above approval: _____

Name/title of receiving facility contact granting above approval: _____

Name of receiving facility: _____

Name of provider receiving client from transferring provider: _____

Name of transferring nursing personnel giving report: _____

Name of receiving nursing personnel receiving report: _____

Available space confirmed by: _____ Time: _____

Method of Transfer

Name of transferring facility: _____

Time of arrival: _____ Time of transfer: _____

Qualified personnel with appropriate medical equipment which will be able to use all necessary and appropriate life support measures will transfer the client:

_____ BLS _____ ALS _____ Air Transport

Other: _____

Treatment

_____ The transferring facility has within its capacity provided medical treatment to minimize the risk to the client's health (and in the case of pregnancy, the unborn infant).

Treatment rendered included:

_____ IV: _____

_____ Medications: _____

_____ Oxygen: _____

_____ Procedures: _____

Vital signs at the time of transfer:

T _____ P _____ R _____ BP _____

Records sent with client:

_____ Laboratory findings: _____

_____ Radiographs: _____

_____ EKG _____ Valubles

_____ Medical record _____ To the family

Discharge client assessment: _____

Name of Transferring Nurse: _____

Date: _____ Signature: _____

2.3 Transfer report



Transfer Report

Name:		Birth date:	
Admission date:		Medical Record #:	
Transfer date:		Attending provider:	
Transfer from:		Address:	
Transfer to:		Phone:	
Contact:		Notify	<input type="checkbox"/> Yes
Address:			<input type="checkbox"/> No
Phone:			
Relationship:			

Reason for transfer	ADLs	No assistance needed	Assistance/supervision	Total care
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Vital signs: T _____ P _____ R _____ BP _____ WT _____	Walking			
Diagnosis:	Transfers			
Prognosis/rehab potential:	Bathing			
Allergies:	Eating			
Diet:	Oral hygiene			
Activity level:	Dressing			
Precautions:				

Medication:	Date/time of last dose:	Prosthesis:
Treatment:	date/time:	Hearing:
		Speech:
		Vision:
		Bowel/bladder:
		Mental status:
		Emotional status:
		Additional information:

Provider signature:		Nurse signature:	
Date:		Date:	

2.4 Discharge summary



Discharge Summary

Date:		
Medication	Route/schedule	Instructions/side effects
(include drug, route of administration, and instructions)		
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
Treatments/procedures:		
Activity:		
Problems to report to provider: (list signs/symptoms pertinent to client diagnosis)		
Diet:		
Follow-up:		
Referrals:		
Personal belongings given to:		
<input type="checkbox"/> Dentures <input type="checkbox"/> Hearing aid <input type="checkbox"/> Glasses/contacts		
Verbalizes understanding of present physical condition?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Verbalizes understanding of discharge instructions?		<input type="checkbox"/> Yes <input type="checkbox"/> No
The above discharge instructions have been explained and a copy has been provided to me		
Client/significant other		
Mode of transport:	Discharged via: <input type="checkbox"/> stretcher, <input type="checkbox"/> amb., <input type="checkbox"/> w/c	
Accompanied by:		
Destination:	With whom:	Departure time:
Nurse's signature:		

Application Exercises

1. A nurse is preparing to transfer an older adult client who is 72 hr postoperative to a long-term care facility. Which of the following information should the nurse include in the transfer report? (Select all that apply).
 - A. Type of anesthesia used
 - B. Advance directives status
 - C. Vital signs on day of admission
 - D. Medical diagnosis
 - E. Need for specific equipment
2. A nurse is participating in an interprofessional conference for a client who has a recent C6 spinal cord injury. The client worked as a construction worker prior to his injury. Which of the following members of the interprofessional team should participate in planning care for this client? (Select all that apply).
 - A. Physical therapist
 - B. Speech therapist
 - C. Occupational therapist
 - D. Psychologist
 - E. Vocational counselor
3. A nurse manager is working with a committee of nurses to update policies for new employee orientation. The nurse manager directs the team to collect as much data as possible and recommend several options. Which of the following decision-making styles is the nurse manager demonstrating?
 - A. Decisive
 - B. Flexible
 - C. Hierarchical
 - D. Integrative
4. A nurse who has just assumed the role of unit manager is examining her skills in interprofessional collaboration. Which of the following actions support the nurse's interprofessional collaboration? (Select all that apply.)
 - A. Use aggressive communication when addressing the team.
 - B. Recognize the knowledge and skills of each member of the team.
 - C. Ensure that a nurse is assigned to serve as the group facilitator for all interprofessional meetings.
 - D. Encourage the client and family to participate in the team meeting.
 - E. Support team member requests for referral.
5. A nurse on a telemetry unit is caring for a client who was admitted 2 hr ago and has chest pain. The client becomes angry and tells the nurse that there is nothing wrong with him and that he is going home immediately. Which of the following actions should the nurse take? (Select all that apply).
 - A. Notify the client's family of his intent to leave the facility. .
 - B. Document that the client left the facility against medical advice (AMA).
 - C. Explain to the client the risks involved if he chooses to leave.
 - D. Ask the client to sign a form relinquishing responsibility of the facility.
 - E. Prevent the client from leaving the facility until the provider arrives.

PRACTICE Active Learning Scenario

A nurse is explaining her role as case manager to a newly licensed nurse. What should the case manager include in her discussion? Use the ATI Active Learning Template: Basic Concept to complete this item.

UNDERLYING PRINCIPLES: Identify three roles of a case manager.

Application Exercises Key

1. A. The nurse should include only information that is pertinent to the transfer. The receiving nurse and facility do not need to know the type of anesthesia used in order to provide care or address the client's current needs.
B. **CORRECT:** The receiving nurse and facility need to know advance directive status in order to provide care and address the client's current needs.
C. The receiving nurse and facility do not need to know admission vital signs in order to provide care or address the client's current needs. However, the nurse should provide the most recent set of vital signs in the report.
D. **CORRECT:** The receiving nurse and facility need to know the client's medical diagnosis in order to provide care and address the client's current needs.
E. **CORRECT:** The receiving nurse and facility need to know the client's need for specific equipment in order to provide care and address the client's current needs.
N NCLEX® Connection: Management of Care, Continuity of Care
2. A. **CORRECT:** The client will need the assistance of a physical therapist to assist with mobility skills and maintain muscle strength.
B. A speech therapist assists a client who has speech and swallowing problems, which are not anticipated for this client.
C. **CORRECT:** The client will need the assistance of an occupational therapist to learn how to perform activities of daily living.
D. **CORRECT:** The client will need the assistance of a psychologist to adapt to the psychosocial impact of the injury.
E. **CORRECT:** The client will need the assistance of a vocational counselor to explore options for re-employment.
N NCLEX® Connection: Management of Care, Collaboration with Interdisciplinary Team
3. A. When the decisive decision-making style is used, the team uses a minimum amount of data and generates one option.
B. When the flexible decision-making style is used, the team uses a limited amount of data and generates several options.
C. When the hierarchical decision-making style is used, the team uses a large amount of data and generates one option.
D. **CORRECT:** When the integrative decision-making style is used, the team uses a large amount of data and generates several options.
N NCLEX® Connection: Management of Care, Concepts of Management
4. A. The nurse should use assertive skills when communicating with the interprofessional team.
B. **CORRECT:** The nurse should recognize that each member of the team has specific skills to contribute to the collaboration process.
C. A nurse can serve as the facilitator. However, this role can be assumed by any member of the team.
D. **CORRECT:** Collaboration should occur among the client, family, and interprofessional team.
E. **CORRECT:** The nurse should support suggestions for referrals to link clients to appropriate resources.
N NCLEX® Connection: Management of Care, Collaboration with Interdisciplinary Team
5. A. The client has the legal right to leave the hospital against medical advice. Notifying the client's family without the client's permission violates the client's right to confidentiality.
B. **CORRECT:** When documenting a discharge, the nurse should document the type of discharge, including an AMA discharge.
C. **CORRECT:** The nurse is legally responsible to warn the client of the risks involved in leaving the hospital against medical advice.
D. **CORRECT:** Clients who leave the hospital prior to a prescribed discharge are asked to sign a form to provide legal protection for the hospital.
E. A nurse who tries to prevent a client from leaving the hospital by any action, such as threatening him or refusing to give him his clothes, can be charged with assault, battery, and false imprisonment.
N NCLEX® Connection: Management of Care, Client Rights

PRACTICE Answer

Using ATI Active Learning Template: Basic Concept

UNDERLYING PRINCIPLES: Roles of a case manager

- Coordinating care of clients who have complex health care needs
- Facilitating continuity of care
- Improving efficiency of care
- Enhancing quality of care provided
- Limiting cost and lengthy stays
- Advocating for the client and family

N NCLEX® Connection: Management of Care, Concepts of Management