Interprofessional Care EP5

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

In March 2019, Patient X determined in collaboration with Timothy Harris, MD that a total hip replacement was warranted. The patient and Harris decided to schedule the surgery for April 2019. Patient X's surgical process began with an appointment for Pre-Anesthesia Testing (PAT) in March 2019.

April Turner, MSN, RN BC, WakeMed Health & Hospitals, Raleigh Campus Orthopedic Spine Program Coordinator, is responsible for the coordination of care for the total joint replacement patient population and for collaborating with Dr. Harris and Mark Wood, MD, Medical Director of Orthopedics. Turner participates in daily huddles with the interdisciplinary team that includes the charge nurse, social worker, nurse case manager, physical therapist, occupational therapist, clinical nurse specialist and physician provider who ensure the coordination of care throughout hospitalization. (Evidence EP5-1, Turner Job Description)

Nurse Participation
Clinical Nurse Patricia Lee, BSN, RN-BC met with Patient X in March 2019 prior to surgery to conduct the Pre-Admission Testing (PAT) assessment, which consisted of a full review of Patient X’s medical history, past cardiac workups, PAT orders, electrocardiogram, lab work and screenings. Lee began the process of determining medical clearance by using the “Care Everywhere” application in Epic to review past medical information. Once Lee completed the health assessment and workup, an anesthesiologist reviewed with Patient X the information Lee had entered in Epic.

During the anesthesia clearance visit, the anesthesia providers request a physical exam, this was completed by Shawn Richard Kruse, MD, for any pertinent consultations. Lee completed the preoperative teaching with Patient X and reviewed the booklet, “Preparing for your Hip Replacement Surgery.” (Evidence EP5-2, Hip Replacement Booklet) Lee also played a brief video featuring herself, an orthopedic surgeon, social worker, and physical therapist collaboratively reviewing pre-op/post-op expectations. Lee used the algorithm provided by the physicians to order pre-op antibiotics for Patient X. Lee also monitored Patient X’s Microbiology Lab results to confirm a negative nasal swab for Methicillin-resistant Staphylococcus aureus (MRSA)/Methicillin-sensitive Staphylococcus aureus (MSSA), so antibiotic therapy prior to surgery was unnecessary.

Coordination of Care Across the Spectrum of Healthcare Services
Once the PAT assessment and appointment were completed, Lee generated a listing of upcoming surgeries that was disseminated to key players who would be essential in the care of Patient X. This group included Turner; 6B Orthopedics & Oncology Nurse
Manager Julia Russel, BSN, RN-BC; Post Anesthesia Care Unit (PACU) Nurse Manager Michele Sanders, BSN, RN, HACP; Surgical Services Operating Room (OR) Nurse Manager Jodi Donahue, BSN, RN, CNOR; Case Management, the social worker; Physical Therapy; Occupational Therapy; and clinical administrators for the Raleigh Campus.

This surgical list ensured members of the interprofessional team involved in the continuum of care were aware of Patient X’s upcoming surgery. Some team members reviewed the medical record for expected discharge disposition, insurance provider and durable medical equipment (DME) that would be needed postoperatively. Turner reviewed the surgical list as she does every week and then prepared the total joint data collection worksheet for Patient X by completing a review of the medical record. This worksheet pulls key pieces of information from the medical record to aid Turner in working with the interprofessional team to identify any care needs during hospitalization, ensure the preparation for surgery is complete and review discharge milestones during interdisciplinary rounds to ensure discharge needs are met. In Patient X’s case, Turner noted preoperative dental needs so she audited the chart to ensure that the dental records had been obtained and that the patient had completed all milestones prior to the date of surgery. This involved collaborating with the dental surgeon to obtain clearance for surgery.

Lee noted the need for further investigation of Patient X’s discharge plan. She emailed Turner and Lakeesha Fletcher, Medical Assistant, regarding the concern that there was no family member arranged to stay with Patient X after surgery. (Evidence EP5-3, Lee Email) A family member called Turner to tell her that Patient X had several limitations in the home that would make recovery from surgery less than ideal, and Turner emailed Harris to inform him of Patient X’s challenging home environment. (Evidence EP5-4, Turner Email to Harris) Turner also made Harris aware that Patient X was having dental work done only a couple days prior to surgery, which is contraindicated. Through this coordination of care, the team was able to confirm that Patient X did not have a root canal and was cleared for surgery.

Patient X arrived for surgery in April 2019. Turner met the patient and family immediately postoperatively on 6B Orthopedics to speak with them about care needs such as preferred discharge destination DME needs. Physical Therapist Timothy Ryan, PT and Social Worker Stephanie Boone, MSW were present during this conversation, and the preferred rehab destination was relayed to the patient and family at this time. With the patient going to rehab, DME did not need to be arranged during this visit. Patient X’s family member expressed relief that the discharge destination had been finalized prior to his arrival.

One key component of postoperative milestones is to ambulate on postoperative day zero. The Physical Therapy team coordinated with 6B Orthopedic clinical nurses to schedule a time to have Patient X ready for therapy. The coordination of pain management is a priority for recovery and was needed for Patient X’s comfort and ability to ambulate.
6B Clinical Nurse Jason Strother, BSN, RN completed the admission assessment and determined that Patient X had lost more than 10 pounds without trying to lose weight. Strother therefore entered a nutrition consult, which Registered Dietitian Tom Mellette, RD, completed in April 2019. (Evidence EP5-5, Nutrition Consult)

On day two, Turner confirmed with the patient’s brother that the plan was still for Patient X to discharge to a skilled nursing facility (SNF) for rehabilitation due to a challenging home environment. WakeMed Case Manager Michelle Strickland, MSN, RN and 6B Clinical Nurse Angelica Charles, MSN, RN gave nurse-to-nurse report of Patient X’s plan of care needs and discharge summary to the receiving facility on post-op day 3.

Patient X was discharged from 6B Orthopedics on post-op day 4 via WakeMed Health & Hospitals Mobile Care transport to an SNF for rehabilitation.