Case Overview

Discharge Planning during Team Rounds: Structured Interprofessional Bedside Rounds (SIBR)

Part of the JHUSON Interprofessional Education and Simulation Online Program

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Brief Summary for Instructors

Learning Objectives

By the end of this simulation, the learner will be able to:

1. Observe team collaboration in preparing to discharge a patient.
2. Describe the role of each team member in preparing the patient for discharge.
3. Analyze how the patient's problems, needs and desire should be taken into consideration when planning for discharge.
4. Explain the importance of patient safety and strategies to address it when planning for discharge.
5. Describe how roles of team members overlap and how they are similar in discharge planning.
6. Differentiate teaching for the wife and teaching for the patient and explain the rationale for both approaches.
7. Explain how you might evaluate the effectiveness of your patient education.
8. Describe how you know that the goals of the team were met.
9. Discuss the following **Core Competencies for Interprofessional Collaborative Practice (2016)**

Core Competencies for Interprofessional Collaborative Practice (2016)

A. Values/Ethics sub-competencies

VE1. Place interests of patients and populations at center of interprofessional health care delivery and population health programs and policies, with the goal of promoting health and health equity across the life span.

VE3. Embrace the cultural diversity and individual differences that characterize patients, populations, and the health team.

VE6. Develop a trusting relationship with patients, families and other team members.

VE9. Act with honesty and integrity in relationships with patients, families, communities, and other team members.

VE10. Maintain competence in one's own profession appropriate to scope of practice.

B. Roles and Responsibilities sub-competencies

RR1. Communicate one's roles and responsibilities clearly to patients, families, community members, and other professionals.
RR2. Recognize one's limitations in skills, knowledge, and abilities.
RR3. Engage diverse professionals who complement one's own professional expertise, as well as associated resources, to develop strategies to meet specific health and healthcare needs of patients and populations.
RR4. Explain the roles and responsibilities of other providers and how the team works together to provide care, promote health, and prevent disease.
RR5. Use the full scope of knowledge, skills, and abilities of professionals from health and other fields to provide care that is safe, timely, efficient, effective, and equitable.
RR6. Communicate with team members to clarify each member's responsibility in executing components of a treatment plan or public health intervention.
RR9. Use unique and complementary abilities of all members of the team to optimize health and patient care.

C. Interprofessional Communication sub-competencies

CC2. Communicate information with patients, families, community members, and health team members in a form that is understandable, avoiding discipline-specific terminology when possible.
CC3. Express one's knowledge and opinions to team members involved in patient care and population health improvement with confidence, clarity and respect, working to ensure common understanding of information, treatment, care decisions, and population health programs and policies
CC4. Listen actively and encourage ideas and options of other team members.
CC8. Communicate the importance of teamwork in patient-centered care and population health programs and policies.

D. Teams and Teamwork sub-competencies

TT3. Engage health and other professionals in shared patient-centered and population-focused problem-solving.
TT4. Integrate the knowledge and experience of health and other professions to inform health and care decisions, while respecting patient and community values and priorities/preferences for care.
TT7. Share accountability with other professions, patients, and communities for outcomes relevant to prevention and health care.
TT8. Reflect on individual and team performance for individual, as well as team, performance improvement.
TT10. Use available evidence to inform effective teamwork and team-based practices.
TT11. Perform effectively on teams and in different team roles in a variety of settings.

Key teaching/debriefing points

In addition to interprofessional communication, teamwork, roles and responsibilities, and values/ethics included on the debriefing tool important discussions points include:

1. Discuss the importance of discharge planning
    a. Discuss the roles of the members of the team in the discharge planning process
    b. Discuss the patient's role and understanding of the discharge planning process

2. Compare the team discussion outside the room with the discussion inside the patient's room
3. Discuss how structured interprofessional rounds compare to what students have experienced in the hospital setting

Scenario overview

This simulation depicts discharge planning during structured interprofessional bedside rounds. The patient is Alex Taylor. Mr. Taylor is a 63-year-old male with Chronic Obstructive Pulmonary Disease (COPD), congestive heart failure (CHF), coronary artery disease (CAD), and hypertension (HTN) who presented to the Emergency Department last evening with a CHF exacerbation. Interventions included a chest xray, intravenous furosemide and oxygen. The interprofessional team will meet with him to discuss his present treatment plan and potential discharge.

Curricular Information

Educational Rationale and Need

Discharge planning is a very important part of ensuring a safe transition from the hospital to outpatient settings. Approximately 19% of patients discharged from the hospital suffer from adverse events within 3 weeks of discharge, and 66% of those events are medication related (Forster, 2003). Studies have shown an increased risk of rehospitalization when patients are inadequately prepared for discharge (Clancy, 2006). Interventional studies providing patients with comprehensive discharge planning and transition support have resulted in reduction of rehospitalization rates. (Braet, 2016; Leppin, 2014; Phillips 2004)

Recent changes in healthcare delivery, with trends towards shorter lengths of stay in the hospital, make addressing transitions of care even more important (Snow, 2009). An earlier discharge, in many circumstances, may necessitate a more complex discharge plan. Patients need to be educated on their diagnosis, treatment plan, medications, medication side effects, potential warning signs for deterioration of clinical conditions, and contingency plans. (Coleman, 2004) Adequate patient preparation at discharge requires input from various team members including physicians, nurses, pharmacists, social workers, and any others as needed. Patient with chronic diseases require particular attention at discharge time given their often complex medication regimens, the multiple self-management tasks that they need to master, and their frequently existing functional limitations. The latter may require additional attention at discharge time as further assessment and support services may be needed to ensure the patient's safety at home.

Hospitals across the US are increasingly expected to provide patient-centered services including a patient-centered discharge process. Patients' feedback about their discharge experience is collected as part of the HCAHPS (the Hospital Consumer Assessment of Healthcare Providers and Systems) survey (Goldstein, 2005). This survey is required by CMS (the Centers for Medicare and Medicaid Services), and the scores of individual hospitals on the survey's various domains (including 'communication with nurses' and 'discharge domains') are publicly reported (Hospital compare, 2019). Higher performance on HCAHPS is associated with higher quality of care, and reductions in pressure ulcers and rehospitalizations (Isaac 2010; Jha, 2008; Boulding, 2011; Price, 2014). Financial reimbursement from CMS is tied to hospitals' performance on the HCAHPS survey. Hospitals nation-wide have implemented multiple interventions to improve their performance on this survey (Aboumatar, 2015). Nurses are key players in the discharge process and nursing students need to become familiar with how patient-centered discharge services are provided.

Reference Materials

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