Team Decision Making

Facilitators Guide

Overview

Target Audience: 2nd year nursing, speech pathology, social work and physiotherapy students, 3rd year medicine and physiotherapy students

Number of Participants: 30 students (6 per discipline)

Estimated pre-briefing time: 20 minutes

Estimated simulation time (Part A): 60 minutes

Estimated simulation time (Part B): 60 minutes

Estimated debriefing time: 40 minutes

Setting: acute outer metropolitan public hospital

Simulation method: simulated patient interviews, followed by immersive group scenario with students playing the role of health professional

Brief Summary of Scenario

In this scenario, students from nursing, speech pathology, social work, medicine and physiotherapy will come together to make difficult decisions about discharge. The setting is a general medical ward in an acute outer metropolitan public hospital. The hospital is currently at capacity with a large number of patients in the Emergency Department as well as several elective admissions without bed allocations. The Hospital Early Warning System (defined below) has been initiated and all attempts are being made to avert the need for progression to hospital bypass. Following morning handover, the Nurse Unit Manager, Kelly, identified several patients on the ward as having potential for discharge and informed the bed manager that 2 beds on the ward will be vacated this morning. Kelly had to leave work unexpectedly due to a family emergency. She has left a list of potential discharges but in the rush to attend to the emergency was unable to leave a detailed handover. The acting nurse in charge has called an impromptu meeting of staff involved in the patients' care to discuss the potential for discharge. The bed manager has requested that at least two beds on the ward be made vacant by lunchtime today to avoid the need for bypass.

"Hospital bypass is a period of time when a public hospital emergency can request that ambulances bypass it and take patients to other hospitals. However, even when a hospital is on bypass, urgent patients will be accepted. The Government has set a target for major metropolitan hospitals which requires them to spend no more than 3 per cent of operating time on bypass" (Source:

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http://performance.health.vic.gov.au/Home/Definitions-and-FAQs/FAQ.aspx?key=1). The hospital has currently exceeded that target.

The Hospital Early Warning System (HEWS) is an internal hospital response to increased pressure in an Emergency Department. It is instigated when occupancy and workload in the Emergency Department is at a level where there is a likelihood that bypass criteria will be reached within the next hour. The goal of HEWS is to better manage access for emergency patients by improving communication across and within both the hospital and the emergency system. The benefit of HEWS is derived from the internal escalation processes within hospitals that create additional capacity to deal with demand pressure. On receiving advice that an Emergency Department is on HEWS, Ambulance Victoria advises relevant crews of the change in status and seeks an alternative destination for non urgent patients, patients without a significant past history and patients not already in transit. (Source: http://performance.health.vic.gov.au/downloads/hospital-bypass-hews.pdf)

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Learning Objectives

Interprofessional

☐ **Interpersonal and Communication Skills**: Communicates sensitively in a responsive and responsible manner demonstrating the interpersonal skills necessary for interprofessional collaboration

☐ **Patient-Centred and/or Family-Focused Care**: Through working with others negotiates and provides optimal integrated care by being respectful of and responsive to patient/client and/or family perspectives, needs and values

☐ **Collaborative Decision Making**: Establishes and maintains effective and healthy working partnerships with other professionals whether or not a formalised team exists

☐ **Roles and Responsibilities:** Consults, seeks advice and confers with other team members based on an understanding of everyone's capabilities, expertise and culture

☐ **Team Functioning**: Uses team building skills to negotiate, manage conflict, mediate between different interests and facilitate building of partnerships within a formalised team setting

(Source: The British Columbia Competency Framework for Interprofessional Collaboration, 2008)

Pre-Briefing

☐ Welcome students
☐ Introduce members of staff involved in today's session
☐ Explain LinC-Sim project and purpose of funding
☐ Describe simulation and facilities available at MSHS for simulation
☐ Administer pre-simulation activity survey
☐ Outline learning objectives
☐ Explain format of session
☐ Reveal / explain group allocations
☐ Allow questions

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Part A

Part A

Part A of this scenario takes place in a simulated acute medical ward, where five patients have been identified as having potential for discharge from hospital. The five patients are:

Bed 1: Ana Galanis

Bed 2: Karina Wescott

Bed 3: Brenton Barker

Bed 4: Jack Lazar

Bed 5: Edith Lipski

Students will be provided with brief histories of each patient (as outlined in the patient stories) and a handover sheet. They will work in disciplinary groups (comprising up to 6 students) to conduct a brief interview and assessment with each patient. The aim of this activity is for students to determine if hospital discharge is appropriate for any patients on the ward. Each group of students will rotate around the ward and be allowed 10 minutes to conduct each of their assessments. After completing the assessments, students will be given a short period to debrief as a discipline and discuss their opinions regarding discharge.

Equipment checklist

- ☐ 5x small whiteboards
- ☐ 5x obs charts
- ☐ Patient chairs x4
- ☐ Patient bedside tables x 5
- ☐ Walking belt
- ☐ IV bung x 2
- ☐ Diabetes monitoring kit
- ☐ Cigarette box and matches
- ☐ 4 wheeled frame
- ☐ Nasal prongs
- ☐ Extension tubing for oxygen
- ☐ SimMan 3G dressed as a female
- ☐ Biscuits, crackers and glasses of water

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☐ Monitoring equipment
☐ 30 copies of handover sheets to hand to students and staff
☐ 2 interview rooms with table and chairs to hold team meeting in

Preparation of simulation and environment

☐ Double simulation room, set up as a 5 bed ward.
☐ Names of each patient written on small noticeboard and placed above bedhead.
☐ Set up for each patient described below:
☐ Bed 1: Ana Galanis. Walking belt beside bed, bedside table with tub of custard on it, chair beside bed
☐ Bed 2: Karina Wescott. IV bung for IV AB administration, Diabetes monitoring kit, reading materials, glass of water and crackers on bedside table
☐ Bed 3: Brenton Barker. Cigarette box and matches, glass of water and crackers on bedside table
☐ Bed 4: Jack Lazar. 4 wheeled frame, nasal prongs, extension tubing for oxygen, glass of water and crackers on bedside table
☐ Bed 5: Edith Lipski. IV bung, SimMan 3G dressed as a female. Monitoring equipment

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Patient Story 1

Ana Galanis is a 44 year old female admitted three weeks ago following a fall from a ladder while attempting to repair an external shutter in her home. Ana suffered a traumatic brain injury in the fall with deficits including impulsive behaviour, ataxic gait and dysphagia. Following video fluoroscopy, Ana was declared an aspiration risk and was placed on a modified diet of thickened fluids/ pureed food. She is currently walking with close supervision, with staff using a walking belt to manage her ataxia. At present, she is not receiving any medical intervention and is awaiting a bed at a rehabilitation facility to optimise her recovery.

Ana lives in a two storey home with husband Angelo and two children Dean (aged 14) and Marcus (aged 11). She works part time in payroll for the family business - an automotive parts retail franchise. Her husband works 6 days a week managing the business with his brothers. Ana's family is very keen to take her home. Her 69 year old mother and 72 year old father are very supportive and wish to care for Ana and her children full time. However the family appears to be in denial about Ana's injuries and have little insight into how to best care for her. The physiotherapist has educated the family about how to use the walking belt, but they have refused to use it. Last week, Ana suffered a fall when trying to walk to the toilet while her room was crammed with family members visiting. The family have also been non compliant with her modified diet, bringing in soup for Ana to eat at mealtimes and giving her biscuits andcups of coffee. Ana has also been found in other patients' rooms looking for something to drink or eat.

Patient Story 2

Karina Wescott is a 41 year old female admitted 2 days ago for intravenous antibiotics following a diagnosis of community acquired pneumonia (streptococcus pneumoniae). Karina has been unwell for more than two weeks and was treated with 10 days of oral antibiotics prior to her admission. Her symptoms have included a fever, moist cough, malaise, loss of appetite and nausea. Karina also has Type 1 diabetes and has found that her blood sugar levels have been difficult to control. On the day of admission, her BSLs were 18.9mmol/L. After adjusting her insulin, her BSLs remained around 10 mmol/L yesterday. She is currently afebrile with a BSL of 9.9mmol/L.

Upon admission to hospital Karina was placed on intravenous benzyl penicillin and azithromycin. She will continue on these medications for 5 days and then move to oral antibiotics if her condition continues to improve. Karina has been referred for chest physiotherapy, but has not yet been reviewed by a physiotherapist. She is able to independently monitor her BSLs, but due to fatigue often falls asleep and forgets to check them. Karina reports losing 5 kilos over the last two weeks and did not have the energy to cook meals or go shopping.

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Karina is single and lives alone in a one bedroom apartment. Her sister Michelle lives nearby, but is a busy single mother who works part time and Karina is reluctant to place additional strain on her. Karina works in a call centre for an insurance company. She has been on sick leave for the last two weeks.

Patient Story 3

Brenton Barker, a socially isolated 48 year-old man, was admitted to the ward three days ago for cardiac monitoring following an atenolol and diazepam overdose. Brenton has a history of alcohol and substance use disorder (SUD) as well as chronic lower back pain and hypertension.

Brenton is well known to Emergency Department staff through previous episodes of deliberate self-harm (overdoses of prescription medications and alcohol) at times of personal life crisis. Brenton reports drinking heavily since his father's sudden death a month ago, and has been "topping up" with diazepam to help him cope. As a result of intoxication at work, Brenton lost his job as a line supervisor at the plastics factory three days ago.

On the day of admission he described taking a handful of diazepam and atenolol to "ease the pain". Knowing that this may have serious consequences he contacted lifeline who then arranged the ambulance.

During his presentation in the Emergency Department, Brenton was assessed by the Crisis Assessment and Treatment Team (CATT) and determined to be at low risk (aggression, absconding), and moderate risk (deliberate self-harm). CATT recommended mental health treatment and assertive engagement in the community following medical stabilization of cardiac issues.

Brenton agreed to stay on the medical ward for monitoring - he is not recommended or sectioned under the Victorian Mental Health Act (1986). During his admission Brenton has complained of back pain, insomnia, anxiety, weakness and headaches. He spends most of his time in bed and feels his back pain is too severe for him to be able to go home. He remains highly anxious and has a widespread tremor at rest and with movement. At times he appears diaphoretic and he frequently asks staff and others' visitors for cigarettes.

Brenton lives in a rental property that he previously shared with his father. However, with his father's passing and his loss of employment he is no longer able to afford to pay the rent. His landlord has given Brenton three weeks to pay last months' rent; otherwise he will be evicted. When speaking with the Social Worker today he reported feeling depressed and said he often feels like "ending it all".

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Patient Story 4

Jack Lazar is a 65 year old male admitted to the ward five days ago with an exacerbation of COPD (emphysema). Upon admission he was found to be short of breath at rest with a RR of 28, SpO2 of 84% on room air and a moist cough productive of green sputum. He commenced treatment of 4 hourly (prn) inhaled salbutamol and ipratropium, oral prednisolone (40mg) and amoxycillin. Upon administration of 3L/min oxygen therapy via nasal prongs in the emergency department, his SpO_2 improved to 92%. Upon admission he had a temperature of 38.3°C; however he has remained afebrile for the past four days.

Jack has been reviewed by the Physiotherapist and commenced strategies to manage his breathlessness and secretions. He is currently walking 30 metres independently using a four wheeled frame, and is limited by shortness of breath. Prior to his admission Jack could walk around 100 metres before having to rest due to his breathlessness. Jack remains on oxygen therapy at 1L/min via nasal prongs and has been maintaining his SpO2 at 91%. He reports that the oxygen and frequent coughing have worsened his feelings of dryness in the mouth and lack of taste. He has struggled with these problems for the last 12 months and was very pleased to be reviewed by the ward Speech Pathologist who provided him with some strategies for managing this, including the use of oral balance gel.

Jack lives at home with his wife Norma. He retired from work as a truck driver 2 years ago following his diagnosis of COPD. He also ceased smoking 30 cigarettes a day at this time. Norma and Jack have 3 adult children and 2 grandchildren. This is Jack's second hospital admission due to COPD. He reports noticing that his breathlessness has become progressively worse over the last few months and that he often feels afraid to walk "further than the letterbox" in case he can't get back to the house. Jack has been compliant with intervention and eager to continue with assistance with managing his condition.

Patient Story 5

Edith Lipski is an 83 year old nursing home resident admitted overnight for management of a urinary tract infection. The nursing staff at the nursing home noticed that Edith's urine smelt offensive and that she expressed discomfort when passing urine. Her GP suggested that an ambulance should be called and that she should be transferred to the hospital for care as the GP is currently on leave and a replacement doctor would not be available until tomorrow.

Edith became a nursing home resident following a stroke 2 years ago. The stroke let her with swallowing and mobility deficits. She requires a pureed diet and 2 people to assist with transfers. She is non ambulant. Edith has a mild cognitive impairment, causing her to forget names of people she met recently and remembering the flow of a conversation. She also requires a hearing aid and wears glasses; however these were not transferred with her to hospital. Over the last 48 hours Edith has become increasingly confused and has been unable to conduct a conversation. Overnight she has frequently wailed for help, which has disrupted other patients on the ward.

The medical staff commenced her on intravenous Trimethoprim and are happy for her care to be continued at the nursing home. In the short time Edith has been on the ward her condition has not

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changed. Overnight, Mrs Lipski's daughter Annabelle contacted the ward expressing her concerns regarding her mother's care at the nursing home. She was extremely distressed after seeing her mother confused and disoriented and has asked that she not return there. Annabelle feels that her mother has not been well looked after and will deteriorate if allowed to return to the same nursing home. A referral has been made to Social Work to assist with managing Annabelle's concerns.

Part B

Part B of this scenario comprises a mock team meeting to discuss potential discharges based on the information obtained in Part A. Students will be divided into multidisciplinary groups (with each group comprising at least 2 representatives from each discipline). The format and structure of the meeting can be decided by the group. Each group should nominate at least one person to run through the patient list and lead the group discussion.

Students should be encouraged to refer to the handover sheet when discussing each patient, considering the reasons for and against discharge. Each group will need to come to some consensus on which two patients on the ward would be most suitable for discharge (however, it is ok if the group agrees that more than two patients are suitable for discharge). The team should explore all options for discharge and ensure that decisions are patient-centred, appropriate and safe and that risk of readmission is minimised. At the conclusion of the meeting, the group should summarise their recommendations for each of the patients, including whether discharge would be appropriate and for what reasons this decision was made.

Following the conclusion of the team meeting (after approximately 30 minutes), all groups will reconvene in one room and share their decisions. The groups should discuss the rationale behind their decisions and the out of hospital supports available to facilitate discharge for each patient.

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Debriefing overview

Large Group Debriefing (30 minutes)

The primary aim of this activity is for students to gain an interprofessional learning experience, focussing on the following themes:

- Interpersonal and Communication Skills
- Patient-Centred and/or Family-Focused Care
- Collaborative Decision Making
- Understanding Roles and Responsibilities of health professionals
- Functioning as a Health care team

Where possible it is encouraged that group debriefing and feedback be steered towards these topics. An advocacy – inquiry model is the recommended format for group debriefing. Under this model, debriefing is conducted in three stages:

1. Reactions
2. Understanding
3. Summary

1. Reactions

This stage allows the students an opportunity to release some emotions so that they can focus on constructive discussion.

Ask a number of students who participated in the scenario "How did that feel?" This will guide you on what issues may need to be covered further in the debrief. Listen, but do not make many comments at this stage. This section will highlight any topics they may like to cover in the understandings stage. Then, review the clinical facts "Can you explain what happened during this scenario?" or "Can you explain what happened to the patient?" It is recommended that they report on the patient's problems, the assessment findings, any interventions provided, outcome measures used (if any) and how effective the intervention appeared. Let the students answer, then fill in the details if necessary.

2. Understanding

This stage allows exploration of the rationale for a student's behaviour or decision making. The observed action should be important to the individual and the group. It is recommended that an advocacy inquiry approach is used. "Student…. I observed X". "I was concerned that X occurred because….". "I am wondering why X happened" or "Help me understand why X happened?" Once an issue is exposed, generalise the discussion to the group. "Has this happened to/for anyone else?" "How did that feel?" Allow the group to discover solutions "How have you dealt with this problem in the past?" "Can anyone think of a strategy to overcome this problem in the future?"

It is also suggested that you focus on the positives from the scenario by asking the group "What went well?" Encourage the students to explore how they worked as a team and what they may have learnt about each other's roles.

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To help you with phrasing your questions, below are some examples:

Observation	Reasoning	Question
I noticed…	I liked that….	How do you see it?
I see/ saw that ….	I thought that was interesting	I was wondering, what are your thoughts?
I hear / heard you say…..	I was thinking….	What were you thinking at the time?
	I was worried / concerned…	Help me understand how you decided that?
	I had the impression that …	
	It seemed to me that ….	

3. Summary

In brief, review what was learnt throughout the session "Today we learned about…" You may wish to summarise the learning objectives. Ask each participant for their take home message from this scenario.

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