Northwell Health®

Faculty Advisory Council (FAC)

Interprofessional Practice/ Education Collaborative (IPEC) Subcommittee

IPEC Subcommittee

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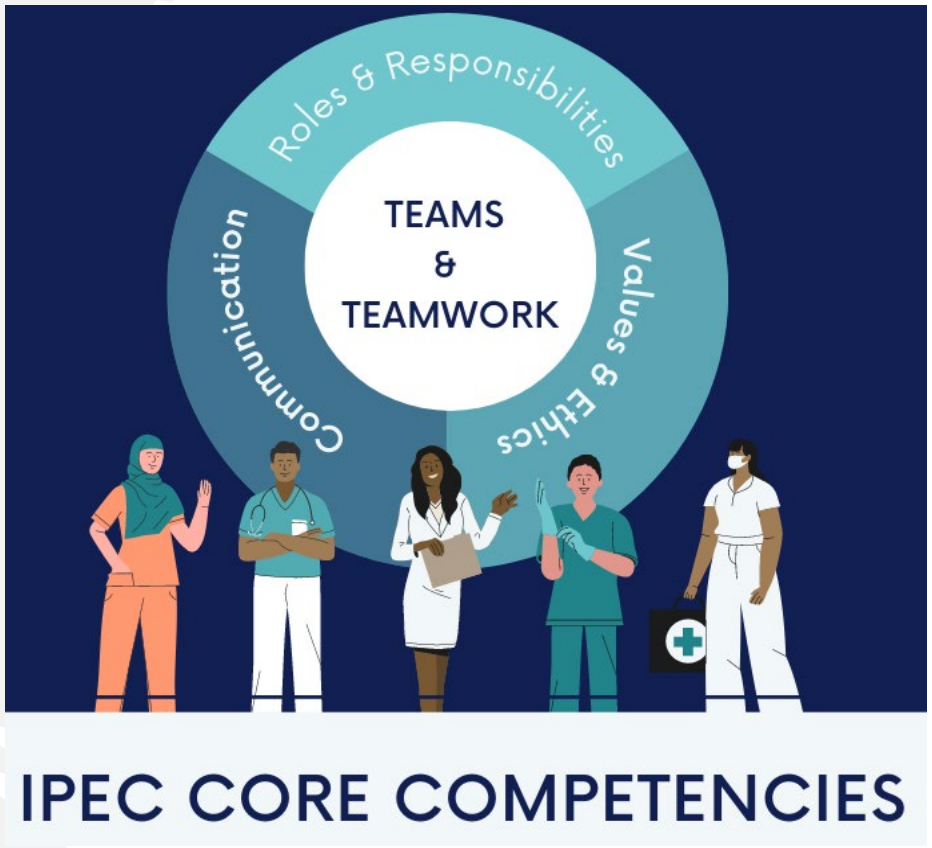

1.VALUES AND ETHICS

- Work with team members to maintain a climate of shared values, ethical conduct, and mutual respect

2. ROLES AND RESPONSIBILITIES

- Use the knowledge of one's own role and team members' expertise to address health outcomes

3. COMMUNICATION

- Communicate in a responsive, responsible, respectful, and compassionate manner with team members

4. TEAMS AND TEAMWORK

- Apply values and principles of team science to adapt one's own role in a variety of team settings

Source: https://www.ipecollaborative.org/ipec-core-competencies

IPEC Subcommittee

PRIORITY #4 – Interprofessional Care: *Despite its importance, inadequate modeling of interprofessional care remains an area of concern based on responses to anonymous ACGME surveys*

Goal: Educate leadership (program directors, training program administrators, nursing/SW/pharmacy directors and administrative directors) on the **expected interprofessional competencies** and how to share with their teams to increase cultural awareness of IPEC via this PowerPoint.

Report of Implementation

Part of the Faculty Advisory Council Suggested 2023-24 Activities

- System-wide Grand Rounds on IPE 2-3 times annually with IPEC Team
- Repository of cases to use in teaching with IPEC teams

→ **Create Powtoons videos for IPE case scenarios**

→ **Share PPT at program orientation meetings with trainees and faculty**

→ **Add IPEC (Interprofessional Education Collaborative) competencies to MedHUB to make accessible**

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iLearn module on the IPEC Basics and Competencies (to come in 2024)

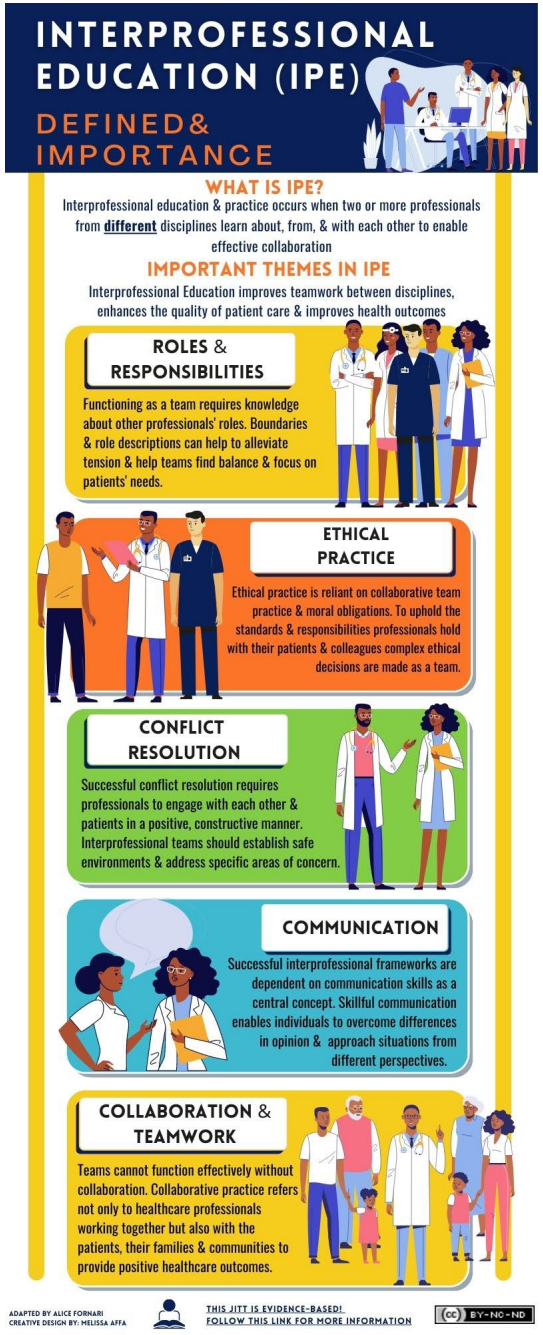
→ **Upload JiTTs with cases on MedHub for PDs and TPAs to access**

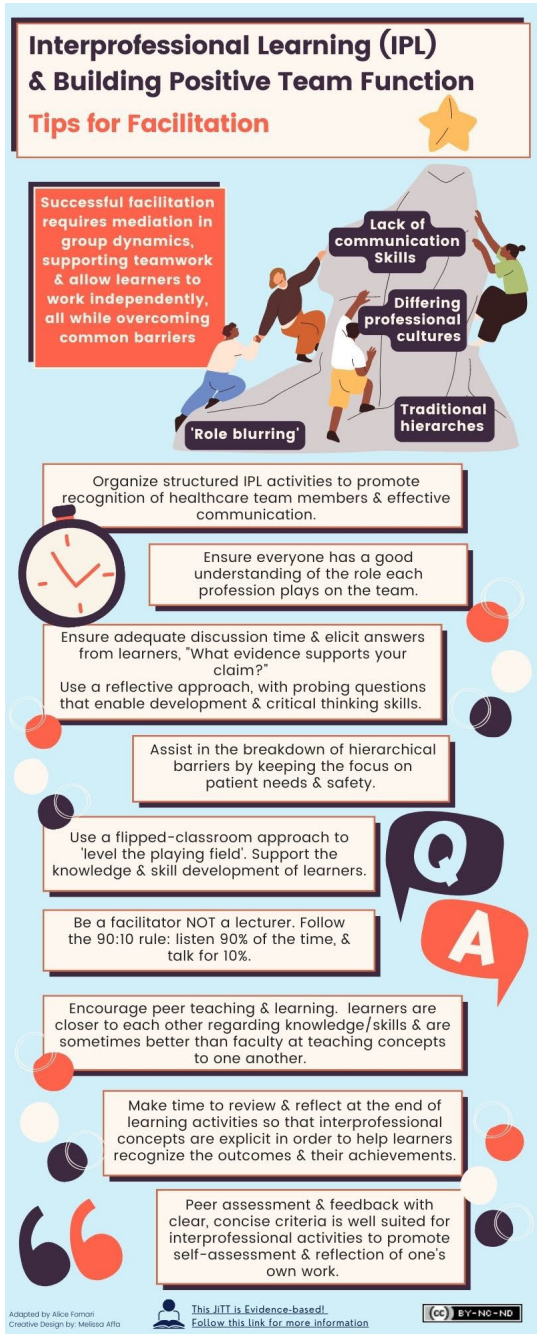
→ **Add 3 new IPE JiTTs (attached) to the JiTT App in Fall 2023 and MedHub by July 2023 with PPT and cases**

Critical Incident Report

- Solicit real/authentic scenarios from residents, fellows, attendings, nurses, social workers describing instances of interprofessional conflict and of effective teamwork affecting healthcare delivery and outcomes

- These scenarios would be used as a part of training (annual orientation/training/Grand Rounds and iLearn modules)





Note: to be added to JiTT App & MedHub

Authentic Video Cases to Apply JiTT Content for Interprofessional Education, Practice & Care (IPEC)

Setting: In patient medical-surgical floor

Instructions: Breakout into small groups of RNs and Residents (4-6 members); Consider the scenario provided

- ❑ Scenario: A 55 year-old woman is being discharged to home s/p total-knee replacement r/t degenerative osteoarthritis. She has a PMH of HTN, Anxiety, and CAD w/ a cardiac stent placed in 2021. Home medications include Amlodipine, Wellbutrin and Plavix. The RN and medical team need to collaborate and expedite a safe discharge for the patient.

ACTIVITY

- ❑ Teams are divided by discipline and each group has a whiteboard. They are given 5 minutes to list the tasks that they think must be completed by the *other* group to expedite the d/c process of this patient taking into account her discharge diagnosis, co-morbidities and medication history (ie RNs list tasks they believe Residents need to perform).
- ❑ Next, teams are asked to identify a barrier for each task listed that may cause a delay in d/c (ie RNs list "med reconciliation" with a barrier of "Residents need to get Attending approval before finalizing").
- ❑ The teams then go to the others' whiteboards and add any tasks that the other team did not include (ie Residents list tasks they must complete onto the list started by the RNs) along with any barrier(s).

BRAINSTORMING/GROUP DISCUSSION

- ❑ Reviewing one whiteboard/list at a time, there is a group discussion as to the validity of the tasks/barriers listed. Additional barriers for each task may be added to the list.
- ❑ After both lists are reviewed, the group brainstorms possible solutions for the barriers (This may uncover process issues that need to be addressed by the hospital).
- ❑ Takeaways from debrief can focus on stating an identified task/barrier for the other discipline not considered prior to this table-top simulation.

Submitted by Lisa Carolan| Domains: Competency 2 (Roles and Responsibilities) + Competency 4 (Teams and Teamwork)

Setting: In patient medical-surgical floor

Instructions: Breakout into small groups (4-6 members); Consider the scenario provided

Scenario: You are each called to the bedside of a patient. The primary nurse for the patient on the unit activated the "rapid response" team. Upon arrival, the patient's monitor displays the following vital signs: BP, 120/60 mmHg; HR, 70/min, sinus rhythm; R, 12/min; SpO_2, 99%; T: 37C (98.6F)

For brainstorming and group discussion:

- ❑ Is team member identification important in situations like these? Why or why not?
- ❑ What strategies and techniques would help small group members identify themselves to the primary nurse/one another upon arrival to the bedside?
- ❑ What strategies would the small group members suggest for efficiently identifying the reason(s) why the primary nurse activated the "rapid response" process?
- ❑ What are our implicit expectations about the team members' responsibilities: (a) who leads the group process? (b) who decides the actual care to be provided?

Submitted by Michael Cassara | Domains: Competency 2 (Roles and Responsibilities) + Competency 3 (Communication) | Introductions during critical situations

Setting: In patient medical-surgical floor

Instructions: Breakout into small groups (4-6 members); Consider the scenario provided

Scenario: A primary nurse activates the "rapid response" team for a patient on her unit. A clinical pharmacist, a second nurse, an internal medicine resident, and a physician assistant arrive. The patient's monitor displays the following vital signs: BP, 110/50 mmHg; HR, 180/min, atrial fibrillation rhythm; R, 12/min; SpO_2, 99%; T: 37C (98.6F). The physician assistant states that an antiarrhythmic medication needs to be given emergently.

For brainstorming and group discussion:

- ❑ Describe the conversation that should occur surrounding medication administration?
- ❑ Which provider(s) have responsibility for medication selection? For medication administration?
- ❑ What strategies and techniques would help all group members know when the medication has been administered?
- ❑ What strategies and techniques would group members use if they wanted to voice concerns regarding medication administration, e.g., choice of agent, safety of use, etc.?

Submitted by Michael Cassara | Domains: Competency 2 (Roles and Responsibilities) + Competency 3 (Communication) | Introductions during critical situations

Setting: Emergency department (ED)

Instructions: Breakout into small groups (4-6 members); Consider the scenario provided

Scenario: You are on rotation in the ED and have just evaluated a patient that has expressed suicidal ideation (thoughts + plan). You have been successful in collaborating next steps with the patient who agrees to an emergent evaluation by a psychiatrist. You are thinking about what to say before calling the on-call psychiatrist.

For brainstorming and group discussion:

- ❑ How would you structure this conversation? What are the best practices or evidence-supported models for framing conversations like these?
- ❑ Compare and contrast this conversation (e.g., phone dialogue with consultants of non-same professions/specialties) with conversations between providers of same profession/specialties (e.g., handoff during shift change). How are they similar? Different?
- ❑ What are the benefits of using a structured approach to conversations with healthcare team members of other professions/specialties? During periods of increased stress, patient acuity, or crisis?

Setting: Computer laboratory

Instructions: Breakout into small groups (4-6 members); Consider the scenario provided

Scenario: You are each enrolled in a session to learn about the key features of a new electronic health record (EHR) that the organization will be launching in the upcoming months. The instructor of the session – a team member trained to serve as a "super user" – has obvious expert competency with the EHR but is not within one of the patient-facing professions represented by the session's attendees.

For brainstorming and group discussion:

- ❑ Would this team member have credibility as an instructor of this content for learners like you and those within your profession? Why or why not?
- ❑ What value does this person provide as an instructor of this content for learners like you and those within your profession?
- ❑ Would you feel more comfortable with a same-profession instructor with less expertise than this instructor? Why or why not?

Submitted by Michael Cassara | Domains: Competency 1 (Values and ethics)

Setting: Administrative meeting room

Instructions: Breakout into small groups (4-6 members); Consider the scenario provided

Scenario: You are representatives of the collaborative care council of your unit. The team has assembled for a meeting to brainstorm on ways to reward the unit staff for exceeding quality and safety expectations over the past 6 months. The meeting's agenda allowed for 15 minutes of discussion, but after 20 minutes, the team is no closer to achieving consensus. Multiple sidebar discussions have started between different team members. The meeting is scheduled to end in 10 minutes; some participants are readying their items in anticipation of the meeting's end.

For brainstorming and group discussion:

- ❑ What strategies | techniques would be effective in resetting the agenda for this meeting?
- ❑ Who has responsibility for resetting the agenda for the meeting?
- ❑ Is scheduling a second meeting an effective solution?

Setting: Outpatient Clinic

Instructions: Breakout into small groups (4-6 members); Consider the scenario provided

Scenario: You are a clinic director and receive a complaint from an attending physician that a medical assistant is not preparing surgical trays appropriately for an outpatient clinic procedure. There have been two instances in the same week where one critical item was missing from the surgical tray. This was discovered near the end of the procedure, requiring the attending physician to deglove and step out of the room to ask for the item. The same medical assistant was involved in both incidents.

For brainstorming and group discussion:

- ❑ How would you begin to investigate this complaint? Who would you speak with?
- ❑ Who is responsible for ensuring all the items are on the surgical tray?

Additional prompts after discussion:

- A decision was made to create a protocol for surgical tray setup. How would you go about creating a protocol? Who should be involved in the discussion?
- Alternatively, it is determined that the attending physician is requesting a non-standard piece of equipment. The medical assistant was following the clinic protocol for surgical procedure setup. How would you discuss the results of your investigation with the attending physician?

Setting: Emergency Department

Instructions: Breakout into small groups and discuss the scenario

Scenario: You are each called to the workstation in a busy, teaching emergency department. Resident physicians have a graduated responsibility for initial evaluation and order placement for patients assigned to the care team. A nurse, who is new to the department, routinely addresses the supervising attending with questions regarding the patient care orders, even if the order was placed by the resident. The resident learns about this action and begins to become frustrated.

For brainstorming and group discussion:

- ❑ What strategies would help to identify and address the root of the resident's frustration? What is the role of the different team members in creating a positive work environment?
- ❑ What strategies and techniques would help team members identify themselves and their roles and responsibilities in patient care?
- ❑ What strategies would the small team members suggest for efficiently identifying barriers in communication in their roles on the team?
- ❑ What are our implicit expectations about the team members' responsibilities: (a) who decides the actual care to be provided (b) who is responsible for the orders placed (c) how do members of the team support each other to develop a shared clinical vision?

Submitted by Sanjey Gupta | Domains: Competency 1 Value and Ethics + Competency 2 Roles and Responsibility

Setting: Inpatient Medical Floor, Hospitalist Ward

- Instructions: Breakout into small groups (4-6 members); Consider the scenario provided
- Scenario: You are conducting team rounds in the morning. The Hospitalist Attending is overhead at the nursing station after coming out of a patient room. They complain about the patient's family member asking too many questions and having unrealistic expectations for outcome for their elderly parent stating, "you know how THEY are", referring to the patient's Asian culture.
- For brainstorming and group discussion:
  - ❑ What strategies would the small team members suggest for responding to this comment?
  - ❑ What are our expectations about the team members' responsibilities: (a) who should address this bias? (b) who is responsible for ensuring patient's and team members safety? (c) how do members of the team react and care for the patient's needs?

- Additional prompts after discussion:
  - ❑ Are team members (which) responsible to report this behavior?
  - ❑ How can the Attending's position in the team impact the other members' response to their actions?

Submitted by Julie Schwartzman-Morris | Domains: Competency 1 Value and Ethics + Competency 2 Roles and Responsibility

Consult Call Gone Wrong
What would you do as a Program Director?

CASE SCENARIO

You are the Program Director and you hear from the Site Director that one of the rotating residents was pushed by an Attending from another service (SICU). The resident has spoken to the Chair of your program and the Chair called the Medical Director to report the incident.

While the resident and the SICU attending are scheduled for a meeting with the Medical Director, you receive the following email from a SICU nurse.

How would you proceed with respect to talking to the resident and the nursing teams?

What aspects of this case provide learning opportunities for interprofessional care teams?

What IPEC competencies would you focus on teaching and implementing?

Submitted by Maja Srvakic, MD / Competency 2: Roles/Responsibilities OR Competency 4: Teams/Teamwork

Consult Call Gone Wrong (Cont.)

To whom it may concern,

- I want to escalate an incident that happened in the Surgical ICU over the weekend on Saturday April 22nd. ENT resident came to the SICU for a bedside procedure on an intubated patient assessing for a foreign object stuck in a patients trachea. I was the primary RN taking care of this patient. The resident started the procedure without introducing himself and completely dismissed some concerns I had about the procedure regarding patient safety. To specify, the endotracheal tube was not properly being secured while he had the scope in the patient's mouth and he completely disregarded me voicing my concern in this matter. This patient was deemed a critical airway and intubated for possible airway edema. As an ENT resident, one would assume he would know how important this patients airway is. Secondly, I also informed him that he should roll a towel and place it under the patients neck to give him better access to the airway. He made no comment and continued with the procedure while disregarding me again. I felt dismissed and belittled by this doctor.
- The SICU attending on for the weekend was also at the bedside during the procedure. At one point he was trying to direct and help the ENT resident not to injury the patients teeth and he became angry and quick to respond to the attending yelling: “I am not on the teeth”. His attitude towards the nursing staff, his fellow residents, and the SICU attending was uncalled for & inappropriate. When the procedure ended and the attending walked out of the room, the ENT resident grew angrier and stated out loud “next time don’t call us- do it yourselves” as he walked out and left all of the dirty equipment used on top of the patient without cleaning up after the procedure. He then sat at the computer outside the room on his phone.
- After the procedure, the ICU attending approached him to debrief the situation and the ENT resident then screamed at him saying “Don’t you ever talk to me like that again” causing a loud scene in the middle of the busy unit.
- I have never in my career as an ICU RN of 6 years witness such behavior. I felt as it needed to be escalated that as a second year resident should never be disrespectful or aggressive towards his coworkers. This resident was not open to any feedback, suggestions, and demands from nursing or the attending which is unsafe and not how we practice in the Northwell family. If you have any questions or concerns please feel free to reach out to myself or my coworkers present for the situation.

Submitted by Maja Srvakic, MD / Competency 2: Roles/Responsibilities OR Competency 4: Teams/Teamwork

Resources

- https://www.ipecollaborative.org/ipec-core-competencies

- longitudinal FD to improve communication with IPE.pdf

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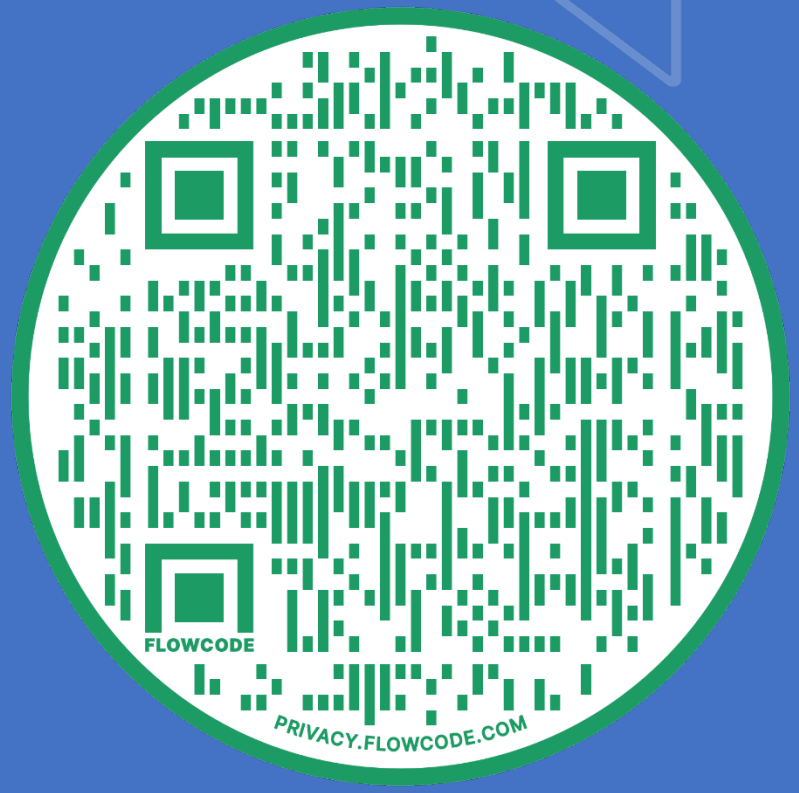

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