The Synergy Model in Practice

The Interdisciplinary Team Across the Continuum of Care

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This case study demonstrates how the patient-focused implementation of teamwork by the critical care interdisciplinary team, under the leadership of the critical care clinical nurse specialist, contributed to the positive outcomes of a complex patient. The success of the interdisciplinary team’s work is reflected in the tenets of the Synergy Model: (1) the patient’s characteristics, (2) the nurses’ competencies, and (3) the resulting outcomes of the patient. The 8 patient characteristics include resiliency, vulnerability, stability, complexity, resource availability, participation in care, participation in decision making, and predictability. The 8 nursing competencies include clinical judgment, clinical inquiry, facilitation of learning, collaboration, systems thinking, advocacy and moral agency, caring practices, and response to diversity.

Our facility is a 400-bed, nonprofit community hospital in the suburbs of Chicago, Ill. The critical care unit has 23 beds, with an adjoining 4-bed open-heart recovery unit. The critical care interdisciplinary team includes the clinical nurse specialist; primary nurse; social worker; quality resource manager; nutritionist; pastoral care; pharmacist; respiratory therapist; diabetic nurse practitioner; rehabilitation services representative; speech, physical, and occupational therapists; and wound care specialist.

THE PATIENT’S CHARACTERISTICS

S.S., a 45-year-old man, was admitted to our hospital the last week of December 2000 for shortness of breath, acute renal failure, and vague abdominal pain. He was morbidly obese, weighing more than 600 lb. Two weeks later, when S.S.’s condition deteriorated and he required intubation and mechanical ventilation, he was transferred to the critical care unit. The surgeons decided that the patient’s abdominal disease process required surgical intervention. A hemicolectomy for a perforated and necrotic bowel was performed. The wound was left open to heal.

The postoperative course was complex and challenging. S.S. developed sepsis resulting in hemodynamic instability, and required vasopressor support. His renal failure required hemodialysis. S.S. received total parenteral nutrition; later, he received enteral nutrition via tube feedings. He continued to be dependent on mechanical ventilation.

Because of his size, at least 6 staff members were needed for any major positioning, including assistance on and off the bedpan, which he requested at least twice a shift. During times of limited staffing, even our security personnel participated in moving S.S. A bariatric specialty bed was rented to provide skin protection, lateral rotation, and chest physiotherapy.

The family support system of S.S. included a supportive and loving mother, who was an active and youthful 81-year-old. S.S. was able to participate in decision making most of the time; if he was unable, his mother would make decisions for him. The patient’s participation in his care was limited to negotiating when and what care would be done. As time progressed and he stabilized, occupational therapists started working with him to improve his ability to participate in activities of daily living. The staff was challenged by S.S.’s desire to remain only in a supervisory role of his care. He would try to convince any new staff member that he or she needed to feed him.

S.S.’s resilience was amazing. After 8 weeks, his respiratory status had improved and he was stable.
enough to move out of critical care. The respiratory therapists, through explanations and encouragement, helped him tolerate the weaning process. With a speech therapist’s interventions and supervision, S.S. was able to safely take foods orally and vocalize with his tracheostomy.

S.S.’s renal function slowly improved and hemodialysis was discontinued, and his gastrointestinal tract began to normalize. His nutritional needs had continuously been monitored and regulated by the nutritionist. His albumin levels improved from a low of 14 to 32 g/L (1.4-3.2 g/dL). S.S. transitioned from total parenteral nutrition and tube feedings to oral feedings. The sepsis was resolved. His wound had healed to 75% granulation under the management of our wound specialist.

The occupational and physical therapists were able to help S.S. increase his activity and participate in rehabilitative exercises and activities of daily living. The nurses’ coordination of care, collaboration, communication, as well as the actual nursing care provided on the basis of physician orders and patient needs, supported the positive global outcome of progress toward wellness.

The need for S.S. to be placed in an acute rehabilitative facility or a specialty/subacute facility became apparent. We prepared him for transition out of the unit so that he could continue the healing process while adjusting to a different environment.

NURSING COMPETENCIES

Nursing maintained the leadership role in S.S.’s care, including the development, coordination, and facilitation of the plan of care. The smooth transition across the continuum of care was supported by the 8 nursing competencies of the Synergy Model.

Approaching the patient from a holistic framework and integrating many disciplines and strategies helped secure ongoing positive outcomes. The respect for each of the disciplines’ unique contributions was always present across the continuum of the patient’s care. Once a week the critical care interdisciplinary team would meet for case management rounds. The current plan of care and hospital course, as well as other issues, were reviewed and discussed. Adjustments in the plan of care and/or recommendations...
were made. Although the physicians were welcome and encouraged to attend the weekly rounds, they were not able to. We recognized the importance in communicating with the physicians and them being a part of case management rounds. Therefore, a written summary of the interdisciplinary rounds was placed in the physician progress notes as a permanent part of the medical record. The appropriate team members were assigned to follow up on the plan and recommendations.

For S.S., additional interdisciplinary rounds were arranged that included the primary care physicians and all medical specialty consults, as well as senior administration, because of the patient’s special bariatric needs. After several weeks, S.S. still weighed more than 500 lb. Because our facility did not have a bariatric unit, we had to review and accommodate special equipment and staffing needs. A specialty bariatric bed was rented, which had to be replaced a couple of times because of malfunctioning. Wound center staff helped us manage the bed. In the operating room, the biomedical engineer helped strap 2 tables together to allow for a large enough surface for S.S.’s surgeries.

We started planning for S.S.’s transition from critical care 2 weeks before the estimated transfer time. A meeting was organized to plan what unit S.S. would go to and what resources that unit would need. It was extremely important that the resources be in place for the needs of the patient, his family, the staff, and the physicians. We identified a specific process that had to take place in order to transport S.S. in and out of his new room in a safe and timely manner. An evacuation plan was outlined and added to the plan of care.

As the discharge planning team began looking at placement, we discovered that the specialty/subacute rehabilitation facilities in the area would refuse to take him because of his size. Social services worked with great intensity to find a facility that would meet his needs and be close enough for his mother to be able to visit.

Caring practices, clinical judgment and reasoning, and clinical inquiry were ongoing and intertwined in S.S.’s care. We coordinated the timing of activities with the many disciplines to provide optimum response to therapies and some “free time,” which also gave him ownership of when his activities were due and stressed the outcome goal of independence. Each of the disciplines brought evidence-based practice to his care. Diversional activities such as live music and card playing were incorporated into his schedule. When we realized that S.S. had a dog that he was close to, the concept of pet therapy motivated us to arrange for his dog to visit. S.S. declined the offer, but knew he could change his mind at any time if he wanted to see his canine friend.

Because the patient’s lack of participation in activities was considered to be a symptom of depression, a psychiatric consult was asked for. The right combination of medication contributed to a positive change in his behavior. Pastoral care was a constant source of support and comfort for him and his mother.

Occupational and physical therapists became frustrated at S.S.’s lack of continuing the simple exercise assignments he was to be doing between scheduled therapy sessions. As the facilitator of learning, nursing recommended that the therapists create a visual reminder with instructions for the patient. The patient’s input was solicited. The therapists created large posters that were placed in his room where he could see them. The posters were well done with drawings and simple directions in large print, and encouraged participation of the patient, the nursing staff, and S.S.’s mother.

The advocacy and moral agency was prominent in the transition from the acute care setting to the subacute facility. A facility that would meet the patient’s needs was found and agreed upon. To ensure continued progress across this phase of the continuum, several steps were taken. Nursing staff from the subacute facility participated in the wound care process. The facility arranged for the necessary bariatric equipment. Arrangements were made with the medical transport system to ensure that their equipment, transport personnel, and vehicle would provide safe transportation for the patient. S.S. was successfully transferred on April 2, 2001. Occupational therapy, physical
therapy, and nursing made arrangements to go to the facility after a couple of days to meet with our counterparts to maintain continuity by reinforcing the patient’s abilities and optimal positioning.

S.S. adapted well. He was happy with his room, liked the food, and was joking. He was sat up in a chair for the first time. The facility had a hoeyer lift that would accommodate his size. His mother was there and was glad to see that we cared enough to follow up. Over the next few weeks, S.S. progressed to being off the ventilator. He was able to get into a wheelchair and go outside on nice spring days.

THE READMISSION

S.S. was readmitted to our hospital and critical care unit on April 28, 2001, with an abdominal abscess that required surgical intervention. The team members knew what to do on the basis of our previous experience with him. He progressed well after surgery. His stay in the critical care unit was less than a week. The physicians felt comfortable transferring him to the telemetry unit he had been on before. All arrangements were once again in place—even the evacuation plan. S.S.’s return to the subacute facility was planned within a couple weeks.

S.S. then developed signs of respiratory failure. He was transferred back to the critical care unit. He developed acute respiratory distress syndrome. Despite aggressive therapy, it was clear that his compensatory mechanisms would no longer sustain his life. All available resources were used, but he did not improve. His mother became the decision maker on his behalf, and death was predicted.

THE NURSING COMPETENCIES

From the clinical inquiry to the caring practices, the staff included the patient and his mother as the central focus when treating his body, mind, and spirit. The nursing staff read articles on managing a patient with acute respiratory distress syndrome, and found that these articles supported the treatment techniques used in S.S.’s care. We were aware of Kathleen Vollman’s prone positioning research, but even if we could convince the pulmonologists of this concept, his size would have prevented this option. Nursing incorporated the literature that recommended the periodic decreasing of propofol to allow him to wake up briefly. We realized that we were not going to impact the length of intubation or length of stay in the critical care unit, instead we wanted S.S. to respond to his mother and hear the reassurances from the different disciplines that still came to see him. Pastoral care would continue to offer prayer as she had done during the previous admission.

When it was evident that death was near, the staff supported S.S.’s mother through the difficult decision to agree to a do-not-resuscitate status when his heart would fail.

Advocacy and moral agency was identified when we informed the director of the local funeral home of S.S.’s anticipated death so that he could prepare his resources. The director was grateful for this advance call. When his death was imminent, the nursing staff made sure S.S.’s mother did not leave the hospital and that she had someone with her—a niece whom she was close to. S.S. died on June 14, 2001, peacefully, with his mother at the bedside. The transition to the funeral home went smoothly and quickly.

The expected outcomes for this patient had changed from his first admission. Death with dignity and the smooth transition to the funeral home are difficult to perceive as positive outcomes. The positive outcomes achieved during this readmission focused on the validation that the interdisciplinary planning and the competencies of the Synergy Model impacted the patient’s outcomes and improve the transition of a complex patient across the continuum of care.

References