Relational Practice Module Exercises

Module 6: Relational Practice for Continuing Care

Exercise 6.1: Now that you understand the types of care in Canada, complete this exercise. Decide which an example of acute care is and which an example of community care is. Some of your answers may be the same.

<table>
<thead>
<tr>
<th>Care Type</th>
<th>Acute or Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health group home</td>
<td></td>
</tr>
<tr>
<td>Surgical unit</td>
<td></td>
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<tr>
<td>Palliative care facility</td>
<td></td>
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<tr>
<td>Obstetrics &amp; Gynecology unit</td>
<td></td>
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<tr>
<td>Walk-In Clinic</td>
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<tr>
<td>Dental Office</td>
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</table>

Exercise 6.2: Using the case study here, map out how continuity of care might occur. Use the template with the arrows. Identify who you will involve along the client’s journey to wellness. The blank lines are for you to identify who is contacted and which steps each takes. Use a big piece of paper to map this out. You are given an example to see how this works.

EXAMPLE: Kailey has multiple sclerosis (MS). She is living in her own apartment. She is ambulant but her gait is slow and shuffling. For distances she uses a motorized scooter. At home, she prefers to keep walking. While her muscles are less strong now, she is still able to do her ADLS, prepare her meals and do some simple cleaning around the house. She worries about falling and so receives some assistance from Home Support Services/Community Health to take a shower, help her with laundry and grocery shopping. Socially, she is an avid reader and belongs to a book club and volunteers at a local thrift store when she’s feeling strong enough. When there, she always uses her scooter. She also receives a visit from a Home Care LPN once per week to assess her physical status and needs. Today when the LPN visits Kailey in her home, she assesses fever, a slight cough and sniffled and the client reports a sense of not feeling well (general malaise).
The LPN calls her supervisor, the Community Health RN, because Kaleigh has signs of illness (a cold or respiratory infection) and (steps taken) the LPN and RN confer, deciding the next step is to call the physician because symptoms of MS can worsen with a cold (next step) the physician orders lab work and wants to see the client Community Health Nurse advises the LPN LPN tells client, who then calls Doctor’s office for appointment LPN and client know transportation needs to be arranged and LPN does so to ensure client sees physician and lab lab sends report to physician physician diagnoses and advises not only Kaleigh but also the Community Health Nurse who advises the LPN because the LPN will alter her focus of care dependent on the outcome of lab tests and physician diagnosis and Community Health Nurse assigns LPN to visit twice per week for now rather than once per week to make health assessments and Community Health Nurse advises Home Support Workers regarding Kaleigh’s health status because of need for more care daily until illness passes LPN and Community Health Nurse collaborate to provide progress note to Physician at the end of one week.

Now it’s your turn:

Bobby has Cerebral Palsy and lives in a privately-owned group home with 2 other residents who also have the disease. He has some difficulty breathing and mostly breathes through his mouth. He is non-ambulant, verbal (with some communication challenges) and is quite intelligent. He is currently working on a distance education course in first year university Sociology. You, the community health LPN visit him once per week to assess his health. The group home staff have called you today because they detect a change in Bobby’s breathing and note he has begun to cough occasionally. This concerns you. You go to see him today. You decide he may have a cold but you want to rule out any other type of respiratory infection since he is highly susceptible to infection. What do you do next and who do you involve?

Care home calls (who) ______________ because ____________ and steps taken_____________
→ Next person is ______________ and steps taken by that person ______________→ Next
person is ______________ because ______________ and steps taken by that person ______________
→ Next person is ______________ because ______________ and steps taken by that person.

*Add more steps if you like. Complete this map until Bobby is well again.*
**Exercise 6.3:** Look back now at your map. Where does Bobby appear in it? If you have used a relational practice approach, he had to be consulted and partnered with along the way. Answer this question honestly and then reflect on your answer for its meaning to your practice as an LPN.

- Did you or did you not consult with Bobby about your plans for his care at the beginning? Explain.
- Did you or did you not engage with him at various steps in this process to update him and involve him in planning for the next steps towards wellness? Explain.

**Exercise 6.4:** Answer the following questions based on this case study.

*Jagdeep, 33, lives in a private group home for mentally ill clients. He contracted pneumonia and was admitted to hospital on your medical unit. Now, 10 days later, he is being discharged back to the group home. You call the home to let them know and, you also tell them you will be sending a discharge summary outlining any care he needs to be continued.*

- The staff person at the group home asks:
  
  o If Jagdeep needs to still take antibiotics. You know the answer. Are you allowed to tell them? Whatever your answer is, write it down.

  o If Jagdeep’s girlfriend visited him in hospital and if so, was he sexually appropriate with her? She did visit but will you tell them? Whatever your answer is, write it down.

  o If Jagdeep’s parents visited him and gave him some money. You know that they did, but will you tell them? Whatever your answer is, write it down.

- Now, look back at your review the section on *Sharing across Care Sites*. Reconsider your answers to this exercise. Do you still believe you are correct in your answers or would you like to revise them? If so, do so now. (*See suggested answers to this case study at the end of this chapter.*)
Exercise 6.5: There are many examples of discharge summaries available on-line. Find at least 6 different versions of discharge summaries and study their formats. Do they look like anything that has been talked about here in Chapter 6? Explain. Write down your thoughts; your comparisons.

Exercise 6.6: Is it within the Scope of Practice for LPNs to write Discharge or Transfer Summaries? If you do not know the answer to this, you need to find out. Where will you find the answer? (Hint: Competency Profile for LPNs).

Reflections on Jagdeep Case Study

The client lives in a group home. It is appropriate and important to let them know about his medications. This information will also be included in discharge summary to them.

Whether or not Jagdeep had any visitors is not particularly confidential and you might say. However, whether or not he had sexual interaction of any sort with his visitors is inappropriate to disclose. To do so is a breach of confidentiality. If there is a concern the matter should be dealt with discreetly and sensitively among appropriate members of the healthcare team who are best suited to deal with the situation.

Whether or not Jagdeep got any money from his parents is also private and confidential unless there is some mechanism in place where he is to only have certain amounts of cash available. This will likely be identified on his care plan at the group home. It may have been established through the psychiatrist based on Jagdeep’s ability to manage money as well as perhaps legally through a trusteeship or Legal Guardianship where his money is taken care of for him. If you do not know this, you do not talk about this subject. It’s confidential. If you do know about it (perhaps through the admission report or the psychiatrist), you may only briefly provide this information. You are not to discuss it otherwise.