Role-play - Case 82-year-old Martha
Collaboration in interprofessional rehabilitation team

Short description

The aim of the task is to gather the client's interprofessional overall situation using from interprofessional perspective using the ICF framework and identify signs of limited health literacy.

Steps of the learning task:

1.) Each student first prepares independently by studying the case description and the ICF framework Interprofessional Collaboration Form, taking notes and completing the ICF form.
2.) Role play. Students share roles (see below preparation).
3.) Gathering information, shared decision-making notes and discussion. The whole group participates.

The coordinator leads the discussion and makes sure that everyone comments. ICF form to be filled in during the discussion.

First step: individual preparation
Each student becomes familiar with the content of different professional groups and the client's account.
Each student should topics for interview:
What should the health professional find out? How to recognize signals of limited health literacy?
What are the client`s needs for change?

Second step: teamwork (role play)
Students choose who acts as a client and different health professionals, as coordinator who leads the interview, and observers. After that the role-play can start.
(See role-play instructions from the preparation section and case description)

Third step: discussion
After the role play the whole group filles out notes in the Interprofessional Collaboration Form and shares the collected information.

Learning goals

You will show collaboration skills together with other health professionals and learn how to gather information using Interprofessional Collaboration Form and how to recognize the signals of limited health literacy (LHL)

a) Shared decision making using ICF-framework
b) Person- centered goal setting with collaboration in interprofessional team
c) Recognize and support clients LHL and self-management
d) How to use verbal conversation skills such as:
active listening, plain language, normalization and asking questions
e) GAS (Goal Attainment Scale) setting using SMART principle together with interprofessional team members.

Materials

Interprofessional Collaboration Form
Role Play descriptions.

LHL identification and additional course materials

Instructions

You will learn shared decision-making skills and how to set person-centered goals with the members of interprofessional team. You will learn how to identify the level of client health literacy.

Steps of the learning task:

1.) Each student first prepares independently by studying the case description and the ICF framework Interprofessional Collaboration Form, taking notes and completing the ICF form.
2.) Role-play: Students share roles (see below preparation).
3.) Gathering information and Shared decision making and discussion. The whole group participates.
The coordinator leads the discussion and ensures that everyone provides comments.
ICF form has to be filled in during the discussion.

Preparation

Make the groups of 8-10 students.

Agree on roles: client Martha, nurse, physiotherapist, occupational therapist, social worker, coordinator, who will lead interview, observers.

Read the role descriptions. Everyone prepares the role, how to gather the information, fill the Interprofessional Collaboration Form and recognize the signs of limited health literacy.

Pay attention to health literacy readiness, how the professionals could support the client.

Observes take notes: e.g., what was successful, what additional information is needed and what other options could be used.

Role Play Client Interview

The client prepares to state, what change does she like to have?

Each role plans what to find out and how to recognize signs of LHL.

Coordinator starts the interview by asking: How are you? What is your situation? What change do you like to have?

Coordinator leads the interview so that each role has the same time (about 5-10 minutes each).

Professionals listen carefully to what the client says and make observations related to health literacy. Observers make notes.

CASE DESCRIPTION

Reason for referral

The hospital's interprofessional team maps coping with everyday life and the need for support. The client is 82-year-old Martha, who lives alone in an apartment building and has been widowed for 20 years.

Social history

Relatives live in another locality. Due to the fear of falling, he is afraid to move outside alone. With the help of a neighbor, he has gone on errands and to the grocery store. The activity of the day is watching TV. Martha doesn't have a computer and can't access her own health records. A mobile phone that you use to stay in touch. Payment of invoices by direct debit. Martha has worked as a family daycare provider.

Health problems / health conditions / health status

Medical history Martha had type 2 diabetes for about 10 years, involving tablet medication. Recently, blood pressure has been fluctuating despite RR medication. This has resulted in dizziness and balance instability.

She has fallen and hit his head at home while going to the bathroom at night. She was taken to the department for observation. Memory problems have been identified in connection with the departmental period. Consulted an ophthalmologist and now also diagnosed with cataracts and elevated intraocular pressure. In connection with the ward period, it has been observed that the overall situation should be mapped out to determine how well you can cope at home.

Roles	
Client	
Consider: What would you like professionals to support and change to make everyday life go better. Professionals pay attention to signs of reduced health literacy (age, educational background, internet use, cognition). Your (Martha) own understanding of your condition and situation: "Sometimes I'm dizzy and I've stumbled at home, but there's nothing to worry about. I'll be fine when I get a rollator to support my outdoor activities. Medication: I take all the medications of the day at once, or take when I remember... I guess it's not that serious if I don't remember to take them as instructed" I don't really know why I have medication... RR and blood sugar are controlled at the health center every six months. Cooking: I go grocery shopping with a neighbor, at which point I buy the food for the week. I buy ready-made snacks that I heat. For breakfast, coffee and bread. In the evenings, tea and bread. Washing: the apartment has a shower where I wash myself in the evenings. Washing my hair has become more difficult as standing and keeping my eyes closed causes instability and I'm afraid I'm going to fall. It would be good to get some help with this. Movement: Inside, I move without taking support from the walls and furniture. When I get up from sitting to stand quickly or put on socks/shoes and lift my head, I feel dizzy easily. The dizziness goes away when I'm there. I live on the 3rd floor of an apartment building; the house has an elevator that allows me to get out. I'm afraid of going outside and falling over. It would be a good idea to have an assistive device to support outdoor exercise.	
Nurse	
General well-being is assessed: weight and weight monitoring (BMI 25, waist 85cm), diabetes (blood sugar, regular eating and medication), RR 175/95, dizziness, medication and regular intake, memory (Mini Mental 20/30p, mood, loneliness), vision monitoring (cataracts, eye pressure), reading, activities of daily living, medication (eye drops for eye pressure). Interventions: how to support understanding of medication, regular intake of medication (dosing), regular and varied nutrition and food intake (enough energy, weight monitoring, regular RR and blood sugar monitoring.	
Physiotherapist:	
Fall risk assessment (internal factors e.g. balance, lower limb muscle function, visual impact on mobility, external factors e.g. accessibility of the home carpets, furniture, thresholds, lighting), need for assistive devices, rehabilitation intervention (individual rehabilitation, group rehabilitation) Fall risk assessment Balance, muscle function, vision, assistive devices, home visit accessibility of the home.	
Occupational therapist:	

Evaluate how the client cooks, dresses, washes (cognition, executive function, initiative, attentiveness, vision, coping)? Are any aids needed? Functionality of the home (grab rails, thresholds, shower chair), accessibility, instructions for use of household appliances? activities of daily living, home visit.
Social worker:
Assess the need for home care and food service, whether cleaning assistance is needed, transport assistance, safety phone, interest in recreational activities e.g. memory group, peer support, singing, crafts, exercise, financial situation.
Observers
How client-oriented, shared decision-making was considered, signs of LHL, how it was supported (terminology, clear language, visualization, teaching).
Discussion **Interprofessional gathering of information. The whole group participates**
Professionals gather information in a multidisciplinary way and **fill the Interprofessional Collaboration Form.** **Discussion** after the role paly, where everyone tells the notes and experiences. **Coordinator leads the discussion.** First client tells how was client-centeredness achieved? After that other role continues, how was dialogue, shared expertise, notes of LHL etc.? **How was limited health literacy taken into account?** Summary: GAS Smart goal: client's own goal to improve everyday coping, identified with the support of professionals.