Implementation Manual

InCaD

(Interprofessional Case Discussion)

Version **2026 Edition**

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Implementation Manual

Julien Pöhner

Kathrin Seibert

Eva-Maria Regelmann

Henrikje Stanze

University of Applied Sciences Bremen

Am Brill 2-4

28195 Bremen

Germany

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Overview

This implementation manual supports the implementation and execution of the "**In**terprofessional **Ca**se **D**iscussion (**InCaD**)" in clinical practice.

The manual is aimed particularly at nurses, but can also be used by other stakeholders.

The manual is divided into four parts:

For implementing InCaD you will need the process flowchart, at least in digital form, or preferably as a paper version.

Before implementing InCaD or taking part in an InCaD for the first time:

Read the InCaD concept, familiarize yourself with it, and clarify any questions of understanding.

The following chapters provide an overview of the time course and phases of InCaD implementation. Materials for carrying out and documenting individual case discussions are included in the chapters.

It is recommended that the implementation process and its documentation are managed by an internal project lead.

Questions about this manual or InCaD implementation will be answered by:

Julien Pöhner, MSc., RN

Email: julien.poehner@hs-bremen.de

1 InCaD Process Flowchart

InCaD follows a defined process:

after all relevant patient documents have been reviewed (including advance directives, clinical progress documentation, etc.), the professional groups involved come together.

Patients, family members and close others are also considered an integral part of InCaD.

In four structured steps, problems are identified, action steps are derived, responsibilities are assigned, and a shared goals and care plan is documented [1].

All steps of the InCaD process flowchart depicted in Figure 1 are described in detail in the InCaD concept.

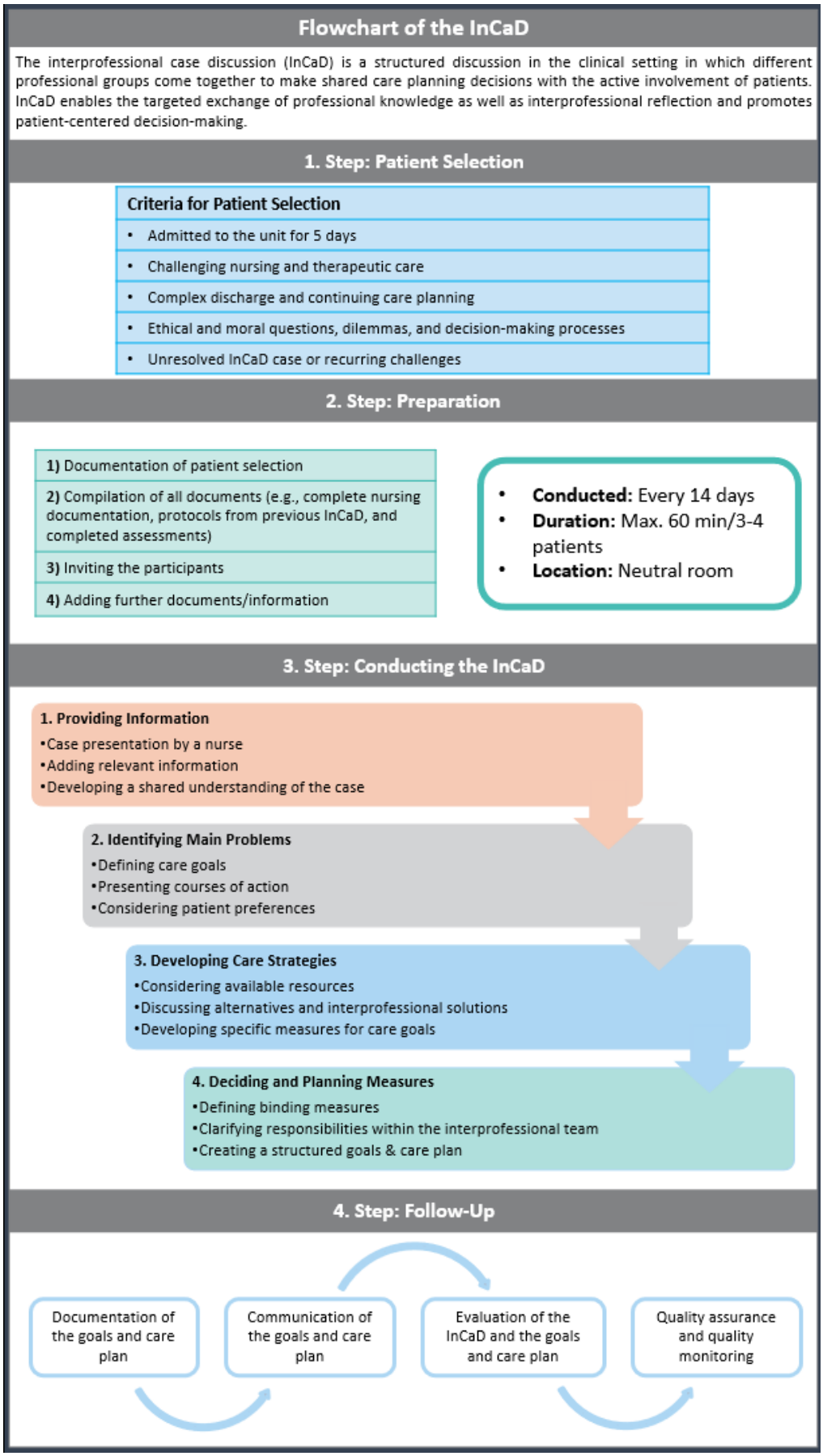

Figure 1: Overview: InCaD Process Flowchart.

2 Implementation Procedure

Implementation of InCaD takes place over six months and includes the following phases and work steps (Table 1):

Table 1: Overview: InCaD Implementation Procedure.

Duration of InCaD implementation: 6 months	
Phase	**Work step**
Preparation	Reading the InCaD concept and clarifying questions of understanding
Phase 1 **Kick-Off Workshop** (~ 1 week before first InCaD)	**Kick-Off workshop with all participating professional groups** ▪ Making setting-specific adaptations and decisions
Phase 2a **Introduction and application of InCaD** (6 months)	**Introduction and application of InCaD in routine clinical practice** ▪ InCaD routine operation: sessions every 14 days, 60 min each; 3-4 cases per session ▪ Active involvement of patients, family members or close others or follow-up discussion ≤ 24 h after InCaD ▪ Timely documentation in patient record; distribution of results protocol to participants (≤ 24 h)
Phase 2b **Evaluation of InCaD** (baseline assessment, post-session assessment)	**Data collection and evaluation, standardized questionnaire** ▪ Evaluation with standardizes questionnaires; baseline assessment (expectations) and post-session assessment (ratings, experiences) after InCaD with participating professional groups
Phase 3 **Kick-Down Workshop** (~ 1 week after last InCaD)	▪ Kick-Down workshop with all participating professional groups

Over a six-month period, phases of InCaD implementation can be divided as shown in Fig. 2. A start and end point for the implementation should be be defined.

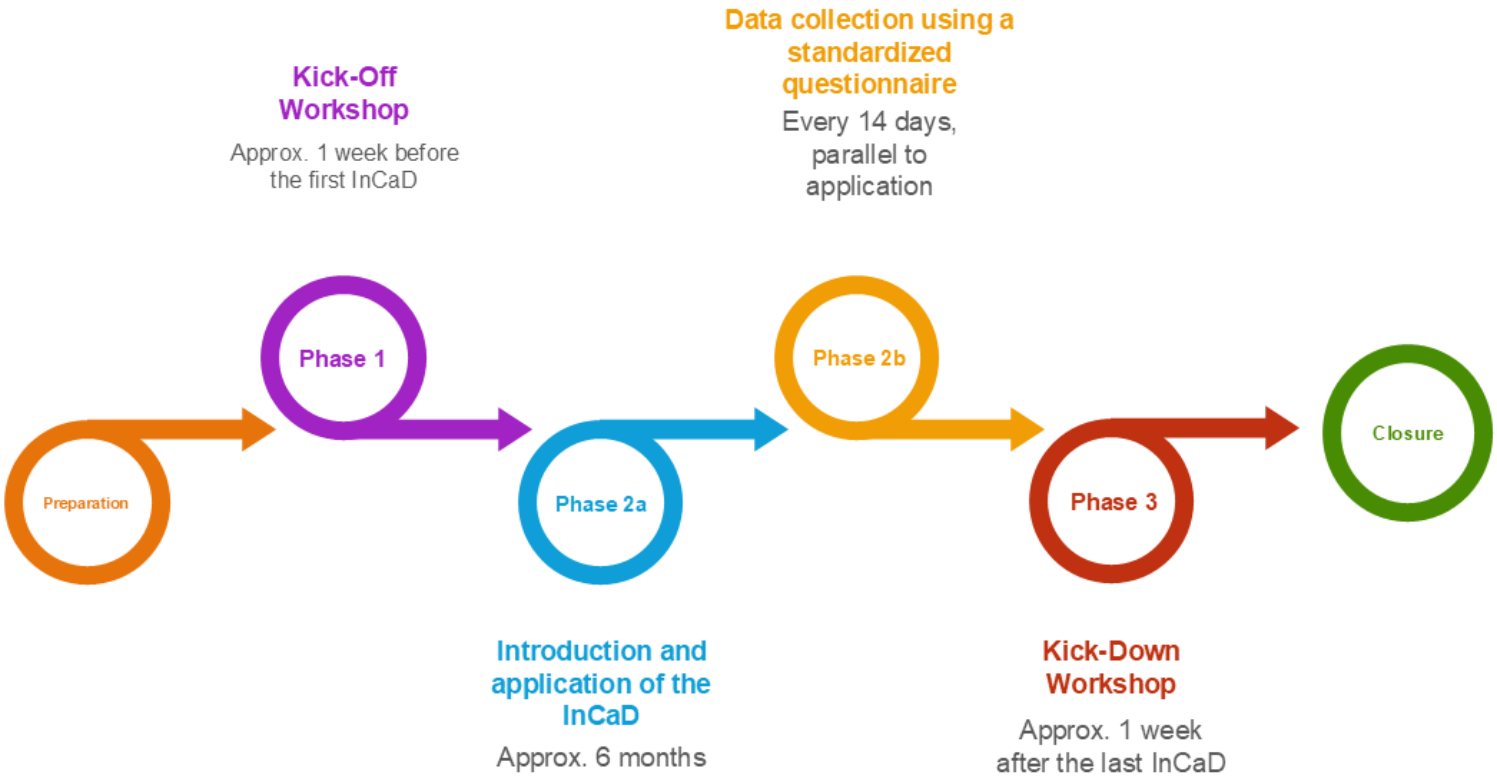

Figure 2: Overview: Phases of IncaD implementation.

2.1 Preparation

These steps should be carried out to prepare InCaD implementation:

- Naming a person responsible for managing and handling the implementation
- Distributing the InCaD concept and process flowchart to participating professional groups
- Establishing a binding work-structure and plan time ressources
- Allocation of Personnel and Time Resources, Distribution of Tasks
- Reading the InCaD concept and clarifying questions of understanding
- Conducting a Kick-Off workshop on expectations and ideas of the participating professional groups

2.1.1 Distributing the InCaD concept and process flowchart to participating professional groups

Before the first InCaD is conducted, all participating professional groups or professionals should have the opportunity to familiarize themselves with the InCaD concept and the processflowchart. Distribute the InCaD process flowchart to all participating professionals 7 to 14 days **BEFORE** the Kick-Off workshop. The recommended professional groups can be derived from the InCaD concept.

These professional groups and professionals are suitable for participation in an InCaD:

- Nurses with an academic qualification,
- Nurses without an academic qualification,
- Nursing experts (e.g., wound care managers, pain nurses, ostomy therapists),
- Nursing assistants and support staff,

- Nursing scientists,
- Physicians,
- Care and case managers, discharge managers and
- Depending on the patient case:
    - Physical therapists ,
    - Speech and language therapists,
    - Occupational therapists ,
    - Dietitians,
    - Diabetes educators,
    - Chaplains or
    - other persons involved in care.

2.1.2 Establishing a Binding Work Structure and Planning Time Resources

Establish a binding work structure for implementing InCaD.

This includes agreements, decisions, and specifications regarding:

- regularity of InCaD and
- responsibilities for recording and communicating the status of work and results of the InCaD implementation (creating minutes, ensuring the flow of information).

2.1.3 Allocation of Personnel and Time Resources, Distribution of Tasks

A responsible person (implementation lead) must be designated to coordinate and manage the InCaD implementation. The implementation lead may allocate and distribute tasks. They define which tasks they will assume themselves and which tasks will be assumed by additional nurses (hereinafter referred to as the InCaD project group).

Experiences from InCaD pilot testing suggest that at least two further nurses next to the implementation lead should be involved in the InCaD project group.

These tasks and steps described in the following sections have to be coordinated and completed by the implementation lead, supported by the InCaD project group:

- Distribution of the InCaD concept
- Collection of open questions before the kick-off workshop,
- Planning, conducting, and documenting of the kick-off workshop,
- Planning, conducting, and documenting of InCaD sessions,
- Distrubution, collection, and analysis of evaluation questionnaires.

2.1.4 Reading the InCaD Concept and Clarifying Questions of Understanding

Collect open questions before the Kick-Off workshop. These questions are clarified during the Kick-Off workshop or recorded for later clarification.

Open questions - What needs to be clarified?

2.2 Kick-Off Workshop

- Plan and conduct a kick-off workshop for implementing InCaD.
- The InCaD kick-off workshop lasts 60 minutes and takes place BEFORE the introduction and application of InCaD in routine clinical care.
- The kick-off workshop introduces the InCaD concept and implementation procedure to as many professional groups as possible.

In the kick-off workshop, present:

- why the decision was made to introduce InCaD,
- what InCaD is about,
- what advantages implementation offers for
  a) patients,
  b) the interprofessional team, and
  c) interprofessional collaboration.

Additionally, use the kick-off workshop to elicit participants' expectations, possible patient cases, needs, and communication rules for implementing InCaD.

This needs to be planned and organized for the kick-off workshop:

- Set a location and time,
- invite and infom participants (which individuals and professional groups should participate?),
- prepare technical equipment (e.g., projector, laptop)
- prepare visualization (e.g., presentation slides, flipchart), and
- decide on a facilitatator.

These materials are helpful for the Kick-Off workshop:

- Flip chart or whiteboard,
- metaplan cards,
- flip chart or board markers, pens,
- facilitation cards,
- tape or pins,
- presentation slides and projector.

2.2.1 Content of Kick-Off Workshop and Copy Template for Agenda

Agenda: Kick-Off Workshop for InCaD Implementation (Duration 60 Minutes)

Facilitation notes:

- *Address the entire group when intervening*
- *Direct questions to the group rather than to individuals*
- *Avoid one-on-one discussion between individual participants and the facilitator*
- *Use Metaplan cards to record and visualize what has been said (role of facilitator or designated other person)*

Duration	Topic	Content, Comment	Material
	Preparation	Provide materials, create a welcoming working atmosphere (e.g., provide drinks, snacks)	
5 minutes	**Welcome**	Introduction, overview of workshop process, distribution of materials	
10 minutes	**Presentation of the InCaD concept**	Presentation of InCaD concept and process flowchart	Presentation slides, Handout: InCaD process flowchart
5 minutes	**Expectation query**	*"Please take 3 minutes and write on a card what you hope to gain from the InCaD. I will collect the cards."*	Metaplan cards, markers
30 minutes	**Opening the discussion**	*"We will now start the discussion. We have three guiding questions that we will work through together. The first question is: What are possible patient cases for an InCaD?"*	

Duration	Topic	Content, Comment	Material
	Question 1: What are possible patient cases for an InCaD?	Discussion on selecting patients for the InCaD **In-depth questions:** • What problems or challenges do these patients have? • Who proposes patient cases? • Who decides when which patient receives an InCaD? • What do we do if we do not have suitable patients? (Do we discuss cases retrospectively?) **Result: Unit-specific range of possible patient cases, challenges or problems, which can be adapted during the implementation process.**	**Metaplan board with prepared categories:** • *Challenging nursing, medical, and therapeutic needs* • *Complex discharge and continuing care planning* • *Ethical-moral questions, dilemmas, and decision-making processes* Metaplan cards, marker, tape, pinboard
	Question 2: What do we need for InCaD to succeed on our unit?	*"The second question is about what do we need for InCaD to succeed on our unit?"* **Discussion to identify resources, barriers, and support factors** **In-depth questions:** • What support or guidance would be helpful? • What risks or barriers do we see? • What information do we need about one another and from the patients for the InCaD? (Refer to existing assessment instruments if applicable) **Result:** ▪ Pinboard/flip chart with two columns: ○ *"This is essential"* ○ *"We need to pay attention to this"*	
	Question 3: How do we envision interprofessional communication and de-	*"The third second question is How do we envision interprofes-sional communication and decision-making in InCaD?"* **Discussion of shared communication and decision-making.** **In-depth questions:**	

Duration	Topic	Content, Comment	Material
	cision-making in In-CaD?	• What is important to you in communication during the InCaD? (addressed separately to individual professional groups) • *How do we handle differing opinions?* **Result: develop a shared understanding.**	
5 minutes	**Closing the discussion**	*“Against the background of today's discussion, which points are particularly important to you? Are there any open questions?”*	Metaplan cards, pens
	Scheduling a start date	*"At the end, I would like to set a start date for the first InCaD with you and then determine a 14-day schedule."*	Metaplan card with date
1 minute	**Closing**	*"Thank you very much for participating in this discussion. I look forward to the first InCaD here on our unit."*	
	Follow-up	Photo documentation of Metaplan or flip chart, brief documentation of the kick-off workshop	

2.2.2 Organization of Information Sharing

Topic-related information sharing during the implementation phases may be understood as on-going education. This may include peer exchange during

- team meetings,
- face-to-face trainings/in-depth discussion of content, or
- self-study by team members (reading specialist literature)

Consider which forms of information sharing are already used on your unit and which ones you want to expand or enable during implementation.

Already used	To be expanded/established

2.2.3 Readjusting Continuing Education Needs

At the beginning of implementation and also in later phases, a need for continuing education may arise and should be identified. This can be documented in the implementation protocol and subsequently addressed. Keep this in mind from the start of implementation.

Decide to what extent you already offer continuing education on specific topics and for which topics you would like to offer additional continuing education, for example on case discussions or interprofessional collaboration.

Continuing education can be offered not only during the first four weeks of implementation, but also in later implementation phases as needed.

2.3 Introduction and Application of InCaD

The following steps should be completed during this phase (phase duration approximately 6 months):

- Introduction and application of InCaD in everyday clinical practice
- Planning of the Kick-Down workshop

During the conduction of InCaD, the implementation lead and a designated member of the project group should be available as points of contact for face-to-face training, reassurance, and professional supervision.

Record your observations regarding questions, barriers, and success experiences during the application phase in the process documentation.

2.3.1 Application of InCaD follwong the InCaD concept

Application and conduct of InCaD are closely guided by the InCaD concept, which is appended to the end of this implementation manual. The InCaD concept forms the basis for implementing InCaD and may be adapted to organizational and content-related conditions of your unit or department.

2.3.2 Moderation of InCaD

Moderation of InCaD is a core element in its application. It ensures that individual InCaD sessions are conducted in a structured, goal-oriented manner while maintaining respectful interprofessional exchange.

A nurse assumes the moderation role, leads the case discussion, structures the process, and ensures respectful communication.

The aim of moderation is to promote interprofessional communication, ensure the participation of all professional groups present, and support decision-making in the sense of shared care planning. Facilitation has a dual function: it provides structure (temporal, content-related, and methodological guidance of the case discussion) and safeguards the process (promoting participation, reflection, and consensus-building among participants).

Tasks and Responsibilities of the moderating nurse entail:

- adherence to the InCaD process,
- ensuring respectful and equitable communication,
- systematically working through all successive steps of InCaD,
- summarizing and documenting results, and
- communicating results to the team as well as to patients, family members, or other stakeholders involved.

Moderation is guided by methodological principles of participatory decision-making and by the steps of the case discussion defined in the InCaD concept description. These steps form the basis for the discussion process and ensure a consistent and transparent procedure.

2.3.3 Copy Template: InCaD Moderation *Cards*

The following copy template supports InCaD moderation. For each step, structured guidance for action and reflection, including objectives, guiding questions, and methodological notes is provided.

Welcome and Opening

- **Objective: Establish an appreciative and structured framework**
- **Facilitation:**
    - Welcome
    - Introduction of the facilitator and participants (name, function)
- **Establishing discussion rules:**
    - Respectful communication, no interruptions
    - Equal opportunities for all professional groups to speak
    - Focus on the patient's situation
- *Presentation of the process and time structure (max. 60 minutes, 3 to 4 cases)*

1. Step: Providing Information

Objective: Compile all relevant patient-related information interprofessionally to create a shared knowledge base.

Moderation tasks:

- Structured collection of information from all perspectives
- Ensuring that all professional groups are heard
- Documenting contradictions or gaps

Guiding questions for moderation:

- *"How does the patient's current situation appear from your perspective?"*
- *"Which nursing, medical, and therapeutic aspects are particularly relevant?"*
- *"Which psychosocial or organizational factors influence the case?"*
- If the patient/family member is not present: "What wishes or priorities has the patient or have the family members expressed?"

Moderation notes:

- Specifically address each professional group (nursing, medicine, therapy, social services, etc.)
- In case of ambiguity: ask follow-up questions ("Could you briefly explain that?")
- Record information gaps and, if necessary, assign responsible persons to clarify them

2. Step: Identifying Main Problems

Objective: Reflect on the information collected, weigh action options, and establish a basis for decision-making.

Moderation tasks:

- Guide the discussion of the identified main problems and action options
- Ensure that different perspectives are heard and weighed
- Refer to the four bioethical principles according to Beauchamp & Childress [2]: respect for autonomy, nonmaleficence, beneficence, and justice[1]

Guiding questions for Moderation:

- *"What action options emerge from the information gathered so far?"*
- *"From your perspective, what speaks for or against these options?"*
- *"How should the options be assessed in terms of benefits, risks, and ethical aspects?"*
- *"Which resources and limitations must we consider?"*

Moderation notes:

- Facilitate the discussion, do not direct its content
- Enable joint assessment ("How do the other professional groups view this?")
- Make conflicts or disagreements visible while keeping them constructive

[1] The four ethical principles form a fundamental ethical model for decision-making in healthcare. They serve as guidance in ethical dilemmas in nursing and medicine: respect for autonomy: the patient's right to decide for themselves about medical or nursing measures should be respected. Nonmaleficence: actions should not cause harm to patients. This includes avoiding and minimizing risks and refraining from unnecessary interventions. Beneficence: actions should serve the well-being of patients (for example, by alleviating suffering, promoting health, or protecting against harm). Justice: all patients should be treated fairly and equally, particularly with regard to access to resources, nursing services, and medical care.

3. Step: Developing Action Strategies

Objective: Develop feasible and realistic care and nursing planning. Interprofessional problem-solving while considering patient preferences, resources, and responsibilities.

Moderation tasks:

- Shape the transition from analysis to concrete solution development
- Ensure that all professional groups contribute their professional perspective to strategy development
- Guide a structured approach

Guiding questions for moderation:

- *"Which action strategies can be implemented realistically and in a resource-conscious manner?"*
- *"Which measures require cooperation among several professional groups?"*
- *"How can patients and family members be actively involved?"*
- *"Which steps should be implemented in the short term and which in the long term?"*
- *"Which risks or barriers do you see in implementation?"*

Moderation notes:

- Focus on solution orientation rather than further elaborating the problem
- Specify strategies with responsibilities, resources, and timelines
- Establish consensus on priority fields of action
- Prepare documentation of the strategies in the minutes

4. Step: Deciding and Planning Measures

Objective: Make shared decisions, define responsibilities, and ensure follow-up.

Moderation tasks:

- Summarize results
- Establish consensus (document if no consensus was reached)
- Define responsibilities, accountabilities, and deadlines
- Transfer agreed measures into the goals and care plan

Guiding questions for moderation:

- *"Which measure(s) will we implement?"*
- *"Who is responsible for implementation?"*
- *"By when should the measure be completed?"*
- *"How and when will we review the success of the measure?"*
- *"How will the patient/the family members be informed about the decision?"*

Moderation notes:

- Document results in the minutes
- Express thanks to all participants
- Ensure that the goals and care plan is forwarded within 24 hours

Closing and Follow-Up

Objective: Ensure transparency and traceability

Moderation tasks:

- Summarize results
- Refer to the minutes and follow-up discussion
- Thank all participants

Guiding questions for Moderation:

- *"Are there any open points or feedback?"*
- *"Are we planning another discussion (a follow-up) for this case?"*
- *"Documentation will be completed by [DATE/TOMORROW/...] at the latest, and the minutes will be sent to all participants."*

Closing:

- Thanks to all participants

2.3.4 Process Documentation

Process documentation is an important component of the implementation and application of InCaD. It supports transparency, traceability, and continuity of the case discussion process and provides a basis for follow-up, quality assurance, and evaluation.

The following two copy templates can be used for process documentation: **InCaD Case Discussion Protocol** and **InCaD Results Protocol**. At least one of these two protocols should be used for each InCaD session. For reasons of clarity and completeness, however, it is recommended to use both protocols. The InCaD Case Discussion Protocol enables detailed documentation of individual patient cases, including the case question, interprofessional assessment, patient perspective, goals, measures, and responsibilities. The InCaD Results Protocol provides a concise overview of all cases discussed in one session, including key decisions, responsibilities, deadlines, follow-up dates, and a brief check of the InCaD process.

2.3.5 Copy Template: InCaD Case Discussion Protocol

InCaD Case Discussion Protocol

InCaD No.: ____	
Date: _____ | Time: ___:___-___:___ | Duration: _____ minutes	
Department/unit/team: _____	
Location: _____	
Moderating: _____	
Participants	
Name	**Professional group**

1) Providing Information

Reason & question:

_____

_____

Medical history/diagnosis(es)	Living and care situation/resources

2) Identification of Main Problems

Compilation of various possible causes of the current situation

Professional group	Findings, observations, and additional information
Nursing	

Professional group	Findings, observations, and additional information
Medicine	
Therapeutic professions	
Other professional groups	

2.1) Patient Perspective

Involvement/representation: ☐ patient present ☐ family members represented

Preferences/goals (e.g., quality of life, autonomy, advance care planning):

_____

_____

_____

_____

2.2) Interprofessional Analysis & Development of Action Strategies (Proposed Solutions)

Idea collection/ brainstorming	

3) Deciding and Planning Measures (Goals & Responsibilities)

Our (main) problem is:		
Our goal is:		
Who	**... does what ...**	**... by when?**
Follow-up in: ____ days | Next InCaD: ____ / ____ / _____		

Open points:

_____

_____

Continuing education and training needs:

_____

_____

4) Micro-Reflection (max. 1 min)

What went well?
What will we change?

_____

Signature of InCaD Moderator

2.3.6 Copy Template: InCaD Results Protocol

InCaD Results Protocol

InCaD No.: ____	
Date: ____ / ____ / _____ | Time: __:__-__:__ | Duration: _____ minutes	
Team/unit: _____	
Location: _____	
Facilitator: _____	
Participants	
Name	**Professional group**

1) Cases Discussed

Case	Question (brief)	Decision (1-2 sentences)	Responsibility	Deadline	Follow-up date
					Yes ☐ No ☐ ____ / ____ / _____
					Yes ☐ No ☐ ____ / ____ / _____
					Yes ☐ No ☐ ____ / ____ / _____
					Yes ☐ No ☐ ____ / ____ / _____

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2) Follow-Up

- **Protocol sent to distribution list on: ____ / ____ / _____**
- **Reminder sent to responsible persons on: ____ / ____ / _____**
- **Next InCaD (date/time/room): _____**

3) Brief Check

	Score			Notes
	Yes	Partly	No	
Roles/rules clarified at the beginning	☐	☐	☐	
10-15 min per case adhered to	☐	☐	☐	
Measures documented	☐	☐	☐	
Brief reflection conducted	☐	☐	☐	

_____

Signature of InCaD Moderator

2.4 Evaluation of InCaD

In this phase, lasting approximately 6 months, different data are collected, using standardized ruestionnaires (Duration Approx. 6 Months). The project lead, supported by the project group members, review and evaluate the implementation of InCaD. Evaluation includes

- Baseline and pre-session assessment of expectations by the participating professional groups and
- Post-session assessment of participants' experiences and rating of InCaD.

The Baseline assessment takes place before holding the first InCaD session. Pre-session assessments during oingoing InCaD application can be used to gather expectations of new participants.

The ongoing post-session assessment takes place throughout the entire implementation period, immediately after the InCaD and before all participants leave. Ideally, the questionnaire is distributed and collected by the facilitating person.

You may also decide to use other questionnaires or include non-professional participants in the evaluation.

2.4.1 *Assessment of Participating Professional Groups' Expectations of InCaD*

Assess the expectations of the participating professional groups and professionals BEFORE the first InCaD is conducted or a new professional takes part in a session. These expectations provide indications of possible evaluation criteria and participants' assessment of InCaD at the end of the implementation phase. You may use this copy template to assess expectations:

A. Information on Person and Workplace

1. Age in years: _____

2. Years of professional experience (excluding training): _____

3. What is the highest professional qualification with which you currently work?

Nursing: nurse (3-year nursing training without degree)	☐ 1
Nursing: BA/BSc/MA/MSc Nursing/Nursing Management	☐ 2
Nursing: nursing assistant/support staff	☐ 3
Medicine	☐ 4
Physical therapy	☐ 5
Care and case management	☐ 6
Other, namely:	☐ 7

_____

4. Which gender do you identify with?

female ☐ 1 **male** ☐ 2 **diverse** ☐ 3 **no response** ☐ 4

5. Which option best corresponds to your employment level?

25% ☐ 1 **50%** ☐ 2 **75%** ☐ 3 **100%** ☐ 4

B. Previous Experience With Interprofessional Case Discussions

1. Have you ever ACTIVELY participated in a case discussion?
   Active means that you shared information about patients in a case discussion, discussed it with other professional groups, and expressed your assessment of needs, measures, or care planning.

No ☐ 1	Yes, fewer than 5 times ☐ 2	Yes, 5 to 10 times ☐ 3	Yes, more than 10 times ☐ 4

C. Expectations Regarding the Interprofessional Case Discussions on the NLU

We would like to learn about YOUR EXPECTATIONS of the interprofessional case discussion.

Please indicate the extent to which you agree with the following statements.

Please select only one answer each time.

If I participate in an interprofessional case discussion, I expect that

	Agree 1	**Somewhat agree** 2	**Somewhat disagree** 3	**Disagree** 4	**No response** 5
1. ... I can freely express my opinion, thoughts, and feelings	☐	☐	☐	☐	☐
2. ... I can clarify relevant questions and concerns	☐	☐	☐	☐	☐
3. ... I gain competence through my participation	☐	☐	☐	☐	☐
4. ... collaboration with other professional groups improves	☐	☐	☐	☐	☐
5. ... the perspectives of the other participants change my assessment of the situation	☐	☐	☐	☐	☐
6. ... work processes within the team become more efficient	☐	☐	☐	☐	☐

7. ... my job satisfaction improves	☐	☐	☐	☐	☐
8. ... quality of care improves	☐	☐	☐	☐	☐
9. ... patient care becomes more efficient	☐	☐	☐	☐	☐
10. ... shared decisions are made	☐	☐	☐	☐	☐
11. ... patient satisfaction improves	☐	☐	☐	☐	☐
12. ... discharge planning improves	☐	☐	☐	☐	☐

2.4.2 Copy Template: Post-session Questionnaire after conducting InCaD

A. General Information on the Interprofessional Case Discussion (InCaD)

Date of the InCaD: __.__.____

Location where the InCaD was conducted: _____

Duration of the InCaD: _____ minutes

Number of patient cases discussed? _____ patient cases

Were patients present? **Yes** ☐ 1 **No** ☐ 2

Were family members present? **Yes** ☐ 1 **No** ☐ 2

B. Information on Person and Workplace

1. Age in years: _____

2. Years of professional experience (excluding training): _____

3. For which professional group did you participate in the InCaD?

- ☐ 1 Nursing: nurse (3-year nursing training without degree)
- ☐ 2 Nursing: BA/BSc/MA/MSc Nursing/Nursing Management
- ☐ 3 Nursing: nursing assistant/support staff
- ☐ 4 Medicine
- ☐ 5 Physical therapy
- ☐ 6 Care and case management
- ☐ 7 Other, namely:

_____

4. Which gender do you identify with?

female ☐ 1 **male** ☐ 2 **diverse** ☐ 3 **no response** ☐ 4

5. Which option best corresponds to your employment level?

25% ☐ 1 **50%** ☐ 2 **75%** ☐ 3 **100%** ☐ 4

6. How did you participate in the InCaD?

Only listened ☐ 1 **Brought information** ☐ 2 **Shared information** ☐ 3 **Proposed measures** ☐ 4

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C. Experiences With Interprofessional Case Discussions

1. How often have you actively participated in the InCaD so far?

Active means that you shared information about patients in the case discussion, discussed it with other professional groups, and expressed your assessment of needs, measures, or care planning.

Once ☐ 1 | Fewer than 5 times ☐ 2 | 5 to 10 times ☐ 3 | More than 10 times ☐ 4

D. Experiences of the InCaD

We would like to learn how you experienced TODAY'S InCaD.

Please indicate the extent to which you agree with the following statements.

Please select only one answer each time.

	Agree 1	Somewhat agree 2	Somewhat disagree 3	Disagree 4	No response 5
1. The InCaD was helpful	☐	☐	☐	☐	☐
2. The InCaD process was feasible in everyday practice	☐	☐	☐	☐	☐
3. The benefit of the InCaD for patients justified the effort	☐	☐	☐	☐	☐
4. The benefit of the InCaD for the care team justified the effort	☐	☐	☐	☐	☐
5. The location where the InCaD was conducted was appropriate	☐	☐	☐	☐	☐
6. The duration of the InCaD was sufficient	☐	☐	☐	☐	☐
7. I was invited to the InCaD early enough	☐	☐	☐	☐	☐
8. Suitable patient cases were discussed in the InCaD	☐	☐	☐	☐	☐
9. The measures discussed in the InCaD will be feasible to implement	☐	☐	☐	☐	☐
10. A nurse led the InCaD	☐	☐	☐	☐	☐

HSB
Hochschule Bremen
City University of Applied Sciences

InCaD

	Agree 1	Somewhat agree 2	Somewhat disagree 3	Disagree 4	No response 5
11. The InCaD followed a clear process	☐	☐	☐	☐	☐
12. Sufficient information was provided in the InCaD	☐	☐	☐	☐	☐
13. A shared understanding of the case was developed in the InCaD	☐	☐	☐	☐	☐
14. Main problems were identified in the InCaD	☐	☐	☐	☐	☐
15. Care goals were defined in the InCaD	☐	☐	☐	☐	☐
16. Action strategies were developed in the InCaD	☐	☐	☐	☐	☐
17. Patients' resources were taken into account in the InCaD	☐	☐	☐	☐	☐
18. Shared decisions were made in the InCaD	☐	☐	☐	☐	☐
19. Measures to improve the nursing and care situation were planned in the InCaD	☐	☐	☐	☐	☐
20. The wishes and needs of patients and/or family members were considered in the InCaD	☐	☐	☐	☐	☐
21. Structured nursing and care plans were developed in the InCaD	☐	☐	☐	☐	☐

HSB
Hochschule Bremen
City University of Applied Sciences

InCaD

E. Rating of the InCaD

Please RATE today's InCaD.

Please indicate the extent to which you agree with the following statements.Please select only one answer each time.

In today's InCaD...

	Agree 1	Somewhat agree 2	Somewhat disagree 3	Disagree 4	No response 5
1. ... I was able to express my opinion, thoughts, and feelings freely	☐	☐	☐	☐	☐
2. ... I was able to clarify relevant questions and concerns	☐	☐	☐	☐	☐
3. ... I was able to gain competence through my participation	☐	☐	☐	☐	☐
4. ... collaboration with other professional groups improved	☐	☐	☐	☐	☐
5. ... the perspectives of the other participants changed my assessment of the situation	☐	☐	☐	☐	☐
6. ... work processes within the team became more efficient	☐	☐	☐	☐	☐
7. ... my job satisfaction improved	☐	☐	☐	☐	☐
8. ... quality of care improved	☐	☐	☐	☐	☐
9. ... patient care became more efficient	☐	☐	☐	☐	☐
10. ... shared decisions were made	☐	☐	☐	☐	☐
11. ... patient satisfaction improved	☐	☐	☐	☐	☐
12. ... discharge planning improved	☐	☐	☐	☐	☐

2.5 Kick-Down Workshop

- Plan a Kick-Down workshop as part of the implementation of the InCaD.
- The Kick-Down workshop takes place after completion of the InCaD implementation phase in routine clinical practice and lasts 60 minutes.
- Jointly evaluate experiences from the six-month implementation period.
- Visualize successes.
- Identify potential for improvement for future routine operation.

The aim of the Kick-Down workshop is to reflect, together with as many participating professional groups as possible, on the InCaD concept, its practical implementation, and your experiences during the implementation phase. Key findings from the evaluation should be presented and discussed jointly.

This phase serves as quality assurance and securing sustainability of InCaD on your unit or department. Through structured reflection, success factors and challenges are documented in order to integrate the InCaD into unit workflows over the long term and continuously refine it.

The Kick-Down workshop presents:

- initial results of the evaluation,
- central goals and content of conducted InCaD,
- experiences from practical implementation in routine clinical practice,
- perceived benefits of InCaD for

    a) patients,

    b) the interprofessional team, and

    c) interprofessional collaboration.

In addition, the Kick-Down workshop should systematically reflect on participants' experiences with InCaD. The focus is particularly on suitable patient cases, facilitating and hindering conditions for implementation, perceived effects, existing needs, and communication and decision-making processes within InCaD.

Based on the discussion, starting points for further development, adaptation, and possible continuation of InCaD in routine clinical practice should be identified jointly.

The following should be planned and organized for the Kick-Down workshop:

- Location and time,
- Invitation and information (which individuals and professional groups should participate?),
- Technical equipment,
- Visualization, and
- Moderation.

These materials are helpful for the Kick-Down workshop:

- Flip chart or whiteboard,
- flip chart or board markers, pens,
- Moderation cards,
- Tape or pins,
- presentation slides and projector.

2.5.1 Content of the Kick-Off Workshop and Copy Template for the Agenda

Agenda: Kick-Down Workshop for InCaD Implementation (60 Minutes)

Moderation notes

- *Refrain from making content-related statements*
- *Address the entire group when intervening*
- *Direct questions to the group rather than to individuals*
- *Avoid one-on-one communication between individual participants and the facilitator*

Duration	Topic	Content, Comment	Material
	Preparation	Provide materials, create a welcoming working atmosphere (e.g., provide drinks, snacks)	Flip chart, Metaplan, Moderation cards, markers, tape or pins, projector, ballpoint pens
5 minutes	**Welcome**	Briefly explain: The workshop is not intended to evaluate individual persons, but to jointly reflect on the InCaD implementation. *"Today, we would like to look back together: What worked in the implementation of the InCaD, what was challenging, which effects were perceived, and what is needed for the InCaD to be implemented permanently?"*	
10 minutes	**Presentation of the InCaD implementation results**	Present results for a maximum of 7 minutes, questions, buffer time	Presentation slides
5 minutes	**Opening question**	*"In a maximum of three sentences: What was your role in InCaD and how did you experience the implementation of the InCaD?*	Metaplan cards

Duration	Topic	Content, Comment	Material
		What is your most important insight from the implementation phase?"	
30 minutes	**Starting the discussion**	*"We will now start the joint reflection. I have brought guiding questions that build on the kick-off workshop. At that time, the focus was on expectations and prerequisites. Today, the focus is on what actually emerged during implementation and what we can learn from this for further developing the InCaD."* *The following question should guide this process: "Now that you have conducted the InCaD, for which patient cases do you think it is suitable?"*	
	Question 1: Which patient cases are particularly suitable for the InCaD?	**Discussion to reflect on and sharpen case selection** **Prepared Metaplan board with categories:** ▪ *"suitable cases"* ▪ *"less suitable cases"* ▪ *"need to adapt selection criteria"* **In-depth questions:** ▪ Which patient cases are particularly suitable? ▪ In which cases does a benefit become particularly visible? ▪ Were there cases that would have been suitable but were not presented? If yes, why? ▪ Were the InCaD selection criteria confirmed, or should they be adapted? ▪ Are there case constellations that should be discussed as a priority in the future? ▪ Should cases be considered retrospectively? **Result:** ▪ Pinboard/flip chart with three columns: ○ *"suitable cases"*	Metaplan cards, marker, tape, pinboard

Duration	Topic	Content, Comment	Material
		○ *"less suitable cases"* ○ *"need to adapt selection criteria"*	
	Question 2: What facilitated the conduct of the InCaD, and what made it more difficult?	**Discussion to identify facilitating factors, barriers, and necessary adaptations in the implementation process** **In-depth questions:** ▪ What worked well? ▪ Which conditions facilitated conduct? ▪ Which hurdles or barriers occurred? ▪ What proved useful regarding invitation, preparation, conduct, Moderation, documentation, and follow-up? ▪ What support was missing? ▪ Which adaptations were made or would be useful in the future? **Result:** ▪ Pinboard/flip chart with three columns: ○ *"facilitating factors"* ○ *"barriers"* ○ *"necessary adaptations"*	
	Question 3: Which changes were perceived as a result of the InCaD, and what is needed for continuation?	**Discussion of perceived effects on patients/family members, the team, and care processes, as well as conditions for continuation** **In-depth questions:** **Which changes were observed for:** ▪ patients ▪ family members or close others ▪ interprofessional team ▪ Has anything changed in care planning, discharge planning, quality of nursing care, or patient safety? ▪ Which effects were expected, and which were surprising?	

Duration	Topic	Content, Comment	Material
		▪ What should definitely be retained in the InCaD? ▪ What would need to be changed so that the InCaD can take place permanently? ▪ Who would need to assume responsibility for planning, Moderation, and follow-up in the future? **Result:** ▪ Pinboard/flip chart with two columns: ○ "perceived effects" ○ "prerequisites for continuation"/"necessary adaptations"	
5 minutes	**Prioritization**	**Brief final prioritization:** *"Which two points do you consider most important for the InCaD to be conducted in other clinics in the future?"* Each person receives two adhesive dots for the most important topics. **Result: prioritized key points for further development and continuation.**	Adhesive dots for Metaplan cards
	Open questions	*"Are there any remaining questions from your side?"*	
5 minutes	**Closing**	*"Thank you very much for the interesting discussion. The results will now be documented and incorporated into the evaluation of the InCaD implementation as well as into further development of the concept.*	
	Follow-up	Photo documentation of Metaplan/flip chart Brief documentation of the Kick-Down workshop	

3 Final Evaluation of InCaD

Conduct a final evaluation of InCaD at the end of the implementation phase. The final evaluation serves to provide a summary assessment of InCaD's implementation and to record key findings from the implementation process.

The final evaluation complements the Kick-Down workshop and the questionnaire data collected during the implementation phase. Its aim is to systematically integrate the experiences of the participating professional groups, the practical feasibility of the InCaD, and perceived effects on patient care, the interprofessional team, and collaboration.

The following data and materials may be used for the final evaluation:

- results of the expectation survey before the first InCaD,
- questionnaires immediately after each InCaD,
- case discussion protocols and results protocols,
- observations from the process documentation,
- feedback from the Kick-Off/Kick-Down workshop, and
- adaptations, barriers, and success experiences from the implementation process.

Analyze the results as simply and pragmatically as possible. The aim is not an extensive scientific analysis, but rather a clear summary of the central experiences and results. Present which aspects of InCaD could be implemented well, which conditions supported its conduct, and where there is a need for adaptation.

The following guiding questions may be used for the final evaluation:

- How often was the InCaD conducted during the implementation period?
- How many patient cases were discussed in total?
- Which professional groups participated in the InCaD?
- Which patient cases and questions were raised particularly frequently?
- How was the InCaD experienced by the participants?

- Which expectations of the InCaD were met?
- Which effects were perceived for patients, family members, the team, and interprofessional collaboration?
- Which organizational, structural, or communicative barriers occurred?
- Which adaptations were made during implementation?
- What prerequisites are necessary for the InCaD to be implemented permanently in routine clinical care?

Results of the final evaluation should be documented in a brief summary. This may be presented in tabular form or as bullet points and should include the most important findings for future routine operation.

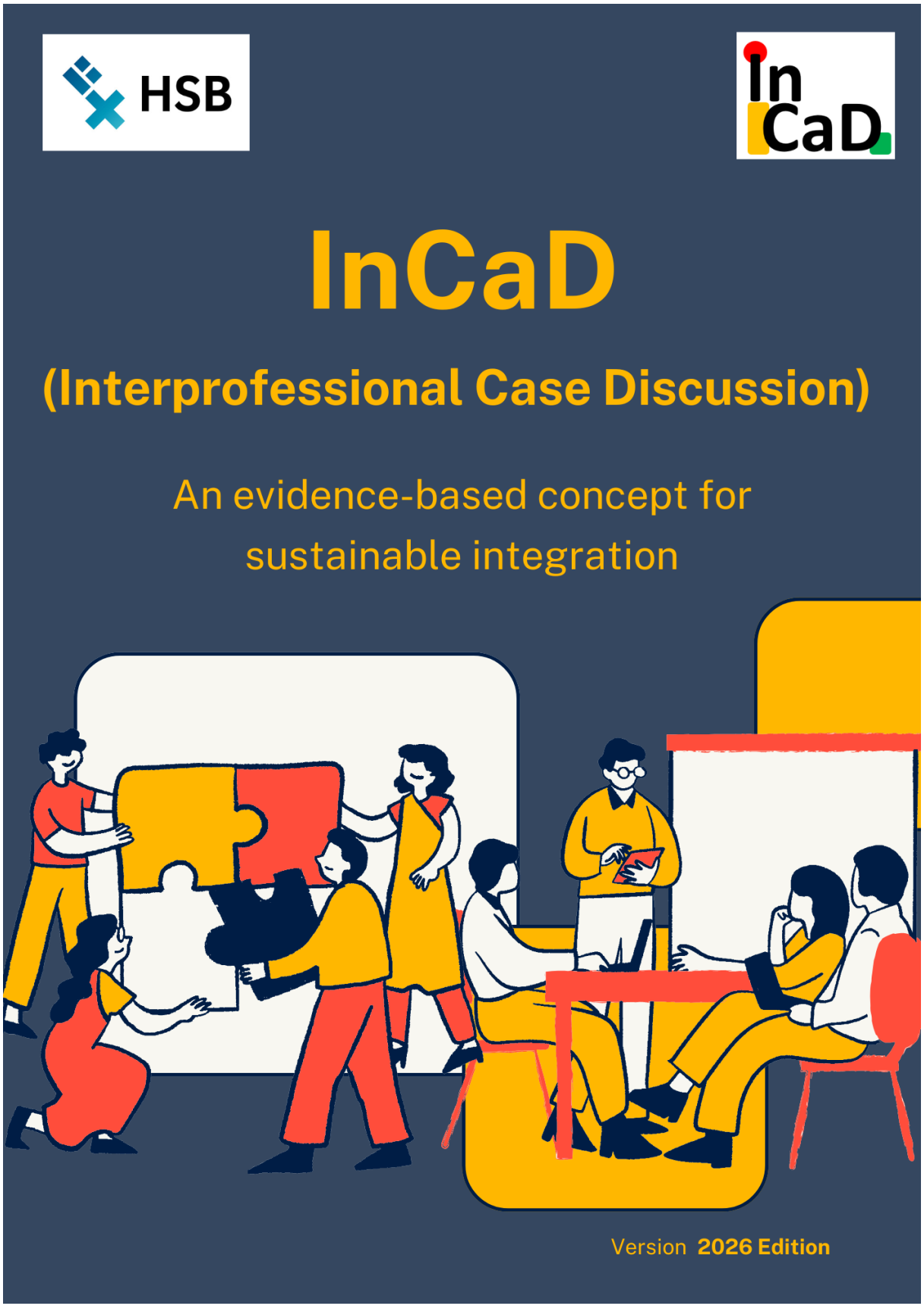
A presentation organized according to the following areas is recommended:

	Key results	**Implication for routine operation**
Conduct of the InCaD		
Participating professional groups		
Patient cases discussed		
Participants' experiences		
Patient and family member perspective		
Interprofessional collaboration		
Organization and feasibility		
Need for adaptation		
Continuation		

At the end of the evaluation, next steps should be defined. These include, in particular, decisions regarding the future frequency of InCaD, responsible moderation, selection of suitable patient cases, documentation of results, and communication of relevant information to the interprofessional team.

The final evaluation thus provides the basis for further development and possible continuation of InCaD in routine clinical care. It supports the unit in maintaining successful structures, making necessary adaptations, and securing InCaD over the long term as an instrument of patient-centered and interprofessional care.

4 Appendix: InCaD Concept



InCaD

(Interprofessional Case Discussion)

An evidence-based concept for sustainable integration

Julien Pöhner

Kathrin Seibert

Eva-Maria Regelmann

Henrikje Stanze

University of Applied Sciences Bremen

Am Brill 2-4

28195 Bremen

Germany

Funded by the German Federal Ministry of Research, Technology, and Space.

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The increasing complexity of patient care in acute care hospitals requires close interprofessional collaboration to ensure high-quality and patient-centered care [3]. An interprofessional case discussion (InCaD) provides an established method for this purpose, characterized by structured communication, shared participatory decision-making processes, and the promotion of shared responsibility [1, 4, 5].

Previous scientific studies show that InCaD can not only improve the quality of clinical decisions but also increase the satisfaction of the professional groups involved [4, 6].

One problem in implementing InCaD is insufficient standardization and a lack of theoretical foundations of concepts, which make sustainable integration into everyday clinical practice more difficult [3]. The present concept aims to address this problem. Through the systematic implementation of InCaD based on evidence-based program logic, flexible adaptation to specific clinical contexts is enabled and sustainable integration within the hospital organization is supported.

The InCaD concept helps to plan, conduct, and evaluate InCaD in a clinic-specific manner. InCaD aims to improve the quality of nursing and care, continuity of nursing and care, and patient safety, optimize communication processes, and sustainably strengthen interprofessional collaboration.

InCaD is conceptualized as a participatory decision-making process [7] that also provides fixed structures for patient involvement as well as the involvement of their families, friends, and caregivers. Within the framework of shared decision-making [8], it is ensured that preferences are systematically considered in InCaD. This not only strengthens their autonomy but also improves the acceptance and implementation of the jointly developed goal and care plans. In addition, advance care planning (ACP) is integrated into InCaD as a guiding framework [7, 9] to support goal and care decisions. ACP enables patients to formulate their wishes and align them with the interprofessional team as well as with their families, friends, and caregivers [9]. As a concept, InCaD is clearly distinct from an ethical case discussion [10]; nevertheless, ethical reflection in complex care decisions is also a central element and should therefore be systematically oriented in InCaD, for example, toward the four ethical principles according to Beauchamp & Childress [2]. These principles support

the interprofessional team in making patient-centered, reflective, and balanced decisions. In InCaD, however, it is also ensured that existing advance directives are considered, goal and care plans are continuously reviewed, and treatment decisions are made in accordance with individual preferences.

The insights gained and care strategies developed within InCaD serve not only to optimize the nursing and care process as well as the quality of nursing and care in individual patient cases, but through their systematic reflection and derivation of generally applicable actions and procedures, they also contribute to sustainably improving care and process design for patients beyond InCaD.

4.1.1 What is InCaD?

Definition: The interprofessional case discussion (InCaD) is a structured discussion in the clinical setting in which different professional groups come together to make shared care planning and decisions with active patient involvement. InCaD enables a targeted exchange of expertise as well as interprofessional reflection and promotes patient-centered decision-making [3, 4].

4.1.2 What organizational form does InCaD have?

InCaD is organized and moderated according to a nurse-led approach. Trained nurses assume central responsibility for preparing, conducting, and following up on InCaD. Interprofessional collaboration is an integral component; however, leadership is deliberately assigned to nursing because nurses, from their perspective, usually have a continuous and comprehensive view of patients' nursing and care processes.

Establishing the nurse-led approach strengthens the role of nursing in clinical decision-making and contributes to improving interprofessional communication. The nurse-led approach promotes more efficient use of resources and improves the coordination of patient care [11].

4.1.3 What are the objectives of InCaD?

The objective of InCaD is the systematic integration of interprofessional collaboration into everyday clinical practice to improve nursing and care quality and work processes. This includes:

- Promoting interprofessional reflection and decision-making
- Improving nursing and care quality and patient safety
- Strengthening team cohesion and communication
- Promoting active patient involvement in care planning
- Supporting sustainable implementation through structured procedures
- Considering risk and resource assessments
- Improving discharge planning and patients' continuing care

In addition, InCaD can also stimulate discussion at the organizational level that extends beyond the individual patient case. Ethical, legal, or economic aspects may become the focus:

- Identification of critical care trajectories
- Recognition of structural and process-related weaknesses within the institution
- Optimization of interprofessional collaboration to improve communication within the institution
- Implementation of new processes and adaptation of existing processes to ensure more efficient and patient-centered care
- Development and establishment of guidelines or care standards to promote standardized and quality-assured procedures within the organization

4.1.4 What effects can be expected from conducting InCaD at the level of patients, families, friends, and caregivers?

- Individual nursing and care plans
- Consistency in quality and improved quality in nursing and care
- Organized follow-up care for patients
- Planned discharges
- Planning security for families, friends, and caregivers
- Increased satisfaction among families, friends, and caregivers
- Increased patient satisfaction
- Shorter hospital stays
- Avoidance of readmissions (revolving-door effect)

4.1.5 What effects can be expected from conducting InCaD at the level of the interprofessional team?

- More efficient nursing and care processes
- Enhanced interprofessional teamwork
- Enhanced interprofessional communication
- More efficient workflows and work processes
- Increased job satisfaction
- Improved interprofessional collaboration
- Shared interprofessional decision-making
- Interprofessional exchange on equal footing
- Increased efficiency and quality in nursing

4.1.6 Which professional groups or disciplines can participate in InCaD?

Participation in InCaD is intended for the following professional groups or disciplines:

- Nurses with an academic qualification
- Nurses without an academic qualification
- Nursing experts (e.g., wound managers, urotherapists, pain nurses, ostomy therapists)
- Nursing assistants and support staff
- Nursing scientists
- Physicians
- Care and case managers
- As needed and depending on the patient case:
    - Physical therapists
    - Speech therapists
    - Occupational therapists
    - Discharge managers
    - Dietitians
    - Diabetes educators
    - Chaplains
    - Others

4.1.7 How often and where is InCaD conducted?

- Frequency: InCaD should be conducted every 2 weeks. During implementation, individual patient cases may also be included in InCaD repeatedly.
- Duration of InCaD: A maximum duration of 60 minutes is planned for 3-4 patients per InCaD. However, the number may also be reduced depending on the complexity of the patient cases. If a need is identified in advance indicating that 60 minutes will not be sufficient, this is communicated in the invitation so that there is no unrest during InCaD due to possible subsequent appointments and no differences in the time required for individual patient cases.

- Location: A neutral room is selected, either on the unit or in the immediate vicinity, so that patients with physical or mobility limitations can reach it easily and families, friends, and caregivers do not have to search for it. If it is not possible to use a neutral room, for example due to structural conditions, the choice of room can also be adapted individually.

4.1.8 What organizational framework does InCaD have?

- Organizational preparation: All necessary documents must be prepared during the organizational preparation of InCaD. These include complete nursing documentation, protocols from previous InCaD sessions, and completed assessments. Each participating professional group or discipline is responsible for compiling its own documents.
- Invitation to InCaD: The nurse leading InCaD invites the participants in writing. In principle, two invitation letters are provided for this purpose and can be sent by email:
  1. Invitation to all participating professional groups or disciplines,
  2. Invitation to families, friends, and caregivers or legal guardians.

  The invitation is sent at an appropriate interval before InCaD so that families, friends, and caregivers or legal guardians can arrange active participation in InCaD whenever possible. Patients must, of course, also be informed. This may also be done verbally and should be recorded in the documentation. When a patient is invited should be decided individually. If the patient has expressed that they would like to be informed as early as possible, this should be taken into account.
- Documentation of InCaD: InCaD is documented in a protocol. It should be noted that all participants receive a protocol afterward. This ensures that the goal and care plan defined in the protocol can be reviewed at any time and that the agreed and provided nursing and care can be evaluated against it.
- Consideration of InCaD in patient documentation: Participation, whether in person or not, is documented in the patient record. The selection for InCaD must already be documented, followed by participation including the agreed goal and care plan. Finally, it is documented that

this plan was communicated to the patients and to their families, friends, and caregivers and that they agreed to it. If objections, concerns, or further wishes are expressed, this must also be recorded in the patient documentation.

4.1.9 What is important when planning the conduct of an InCaD?

Various aspects must be considered when planning InCaD so that the expected effects can also be achieved:

- InCaD must follow a structured process (see chapter "planned procedure")
- InCaD must follow a systematic approach, and patient selection must be based on the checklist
- A protocol is kept during InCaD
- Patients and their families, friends, and caregivers are integrated into InCaD; their wishes can be expressed, and shared decision-making is conducted with them
- Additional assessment instruments may be used by the respective professional groups in preparation for InCaD. These must be selected individually for the respective situation
- An interprofessional reflection must take place after InCaD
- InCaD must be evaluated at regular intervals

Through the active involvement of patients and their families, friends, and caregivers, their individual wishes regarding nursing and medical[2] and therapeutic care can be identified and defined in individual nursing and care plans using interprofessional expertise.

The use of protocols and checklists in patient selection and in the conduct of InCaD ensures the systematic approach and provides for interprofessional exchange and shared decision-making that are not shaped by individual opinions.

[2] The differentiation between nursing and medical care emphasizes their specific responsibilities within the discipline of medicine, taking into account possible reserved tasks and delegation.

Through reflection and regular evaluation, individual and shared perspectives can be discussed, and by increasing the effectiveness and sustainability of InCaD, the care and nursing process can be designed more effectively and interprofessional collaboration can be strengthened.

4.1.10 For which patients is InCaD suitable?

In principle, all patients are eligible for InCaD. However, to ensure that sufficient information is available to discuss the case as effectively as possible and identify the best solutions, patients should have been admitted to the unit for at least 5 days.

In addition, patients are selected according to specific criteria defined by the unit. The following criteria can help select patients for InCaD:

- Challenging nursing, medical, and therapeutic needs:
  - Patients with increased or specialized nursing needs (e.g., wound management, trache-ostomy, enteral nutrition)
  - High need for coordination and definition of rehabilitation and care goals
  - High symptom burden (e.g., supportive or palliative care needs)
  - High need for education, guidance, and counseling
  - High need for assistive devices or adaptation of the care situation
- Complex discharge and continuing-care planning:
  - Complex discharge situations, particularly when home care options are limited or follow-up care capacities are unavailable
  - Need for early involvement of social services, transitional care, or families, friends, and caregivers
  - High risk of repeated hospital admissions due to inadequate continuing care and unmet need for specialized care

- Ethical-moral questions, dilemmas, and decision-making[3]:
    - Uncertainty about the nursing and medical appropriateness of further measures, taking into account the principles of nonmaleficence and beneficence
    - Discrepancies between patient wishes, family opinions, and nursing, medical, or therapeutic assessment, taking into account the principles of respect for autonomy and nonmaleficence
    - Need to clarify advance directives or treatment goals and measures, taking into account the principles of autonomy and beneficence

A basis must be defined for selecting patients on which the decision to include a case in InCaD is made. This decision must be made by the respective unit and the interprofessional team and can be guided by the points listed or expanded to include additional setting-specific characteristics derived, for example, from nursing documentation (e.g., risk of falls, risk of delirium, challenging discharge situations).

[3] Decision-making should, for example, be guided by the ethical principles of Beauchamp & Childress as an established model for ethical decision-making in health care 7. Stanze H, Nauck F. Advance Care Planning bei Patienten mit onkologischen Erkrankungen. Der Onkologe 2020; 26: 763-770. doi:10.1007/s00761-020-00796-5

4.1.11 What is the planned procedure for InCaD?

Figures 1-3 show the planned InCaD procedure.

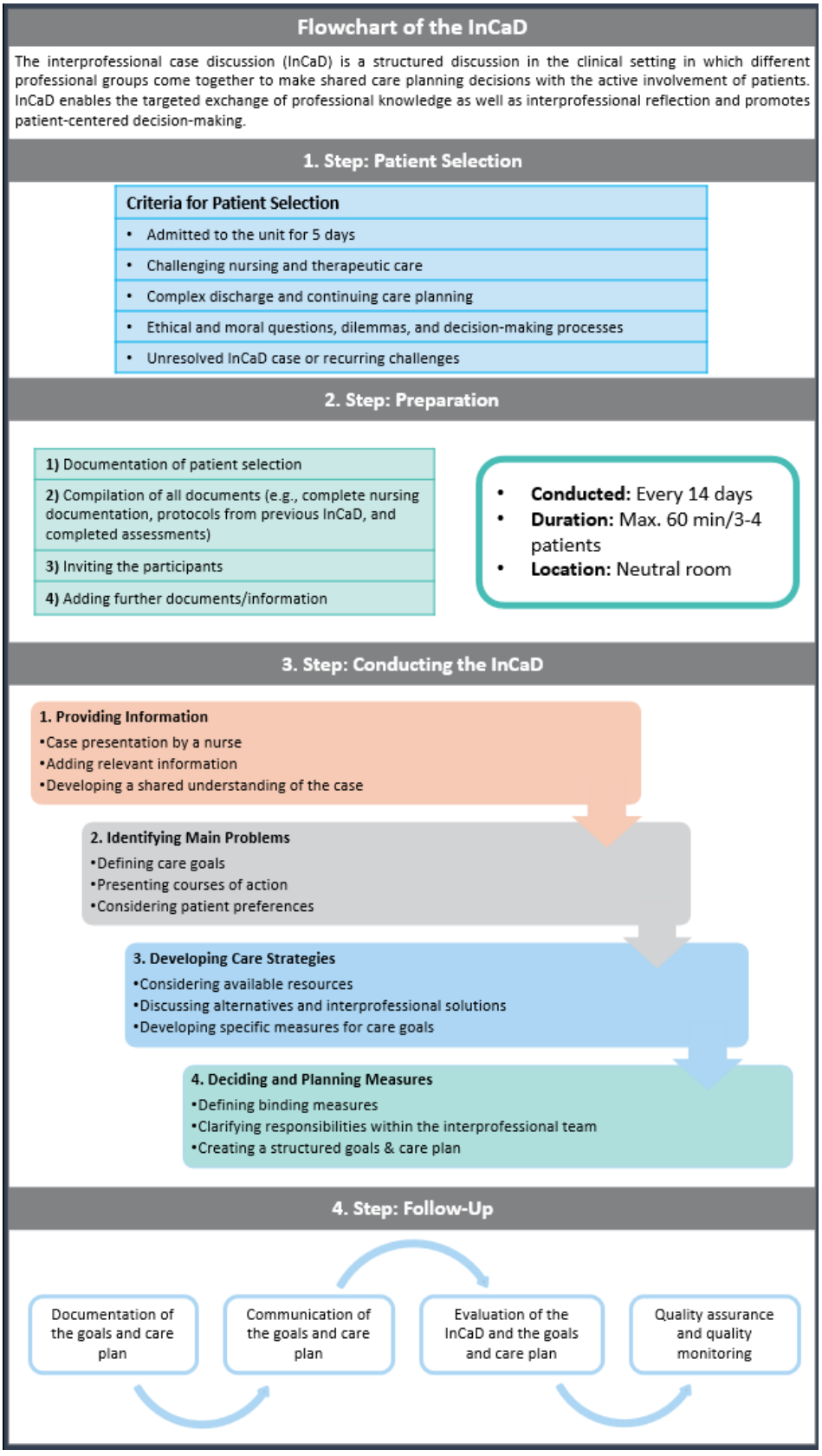

Figure 1:Overall InCaD Procedure [1]

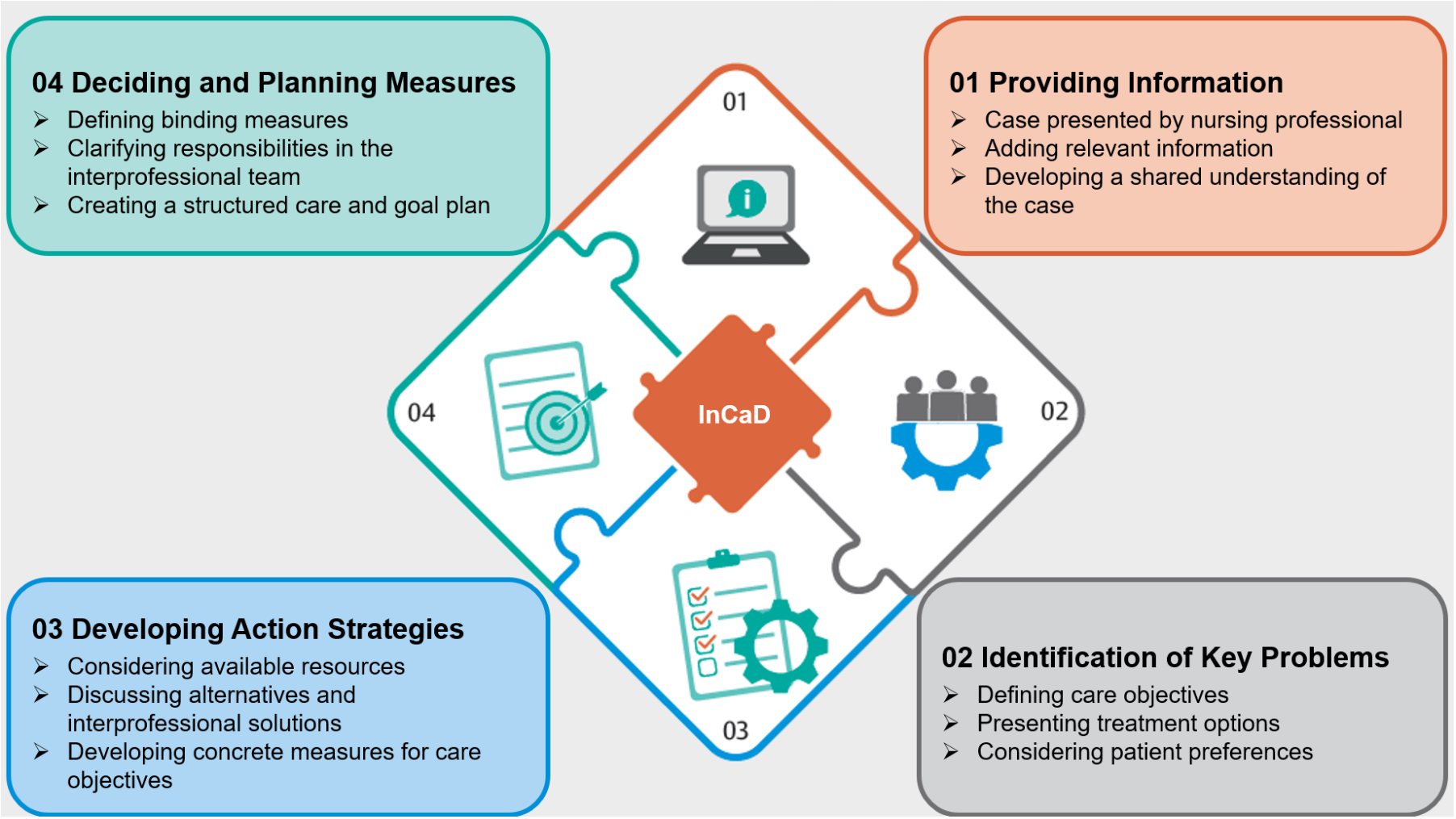

Figure 2:InCaD Flowchart [1]

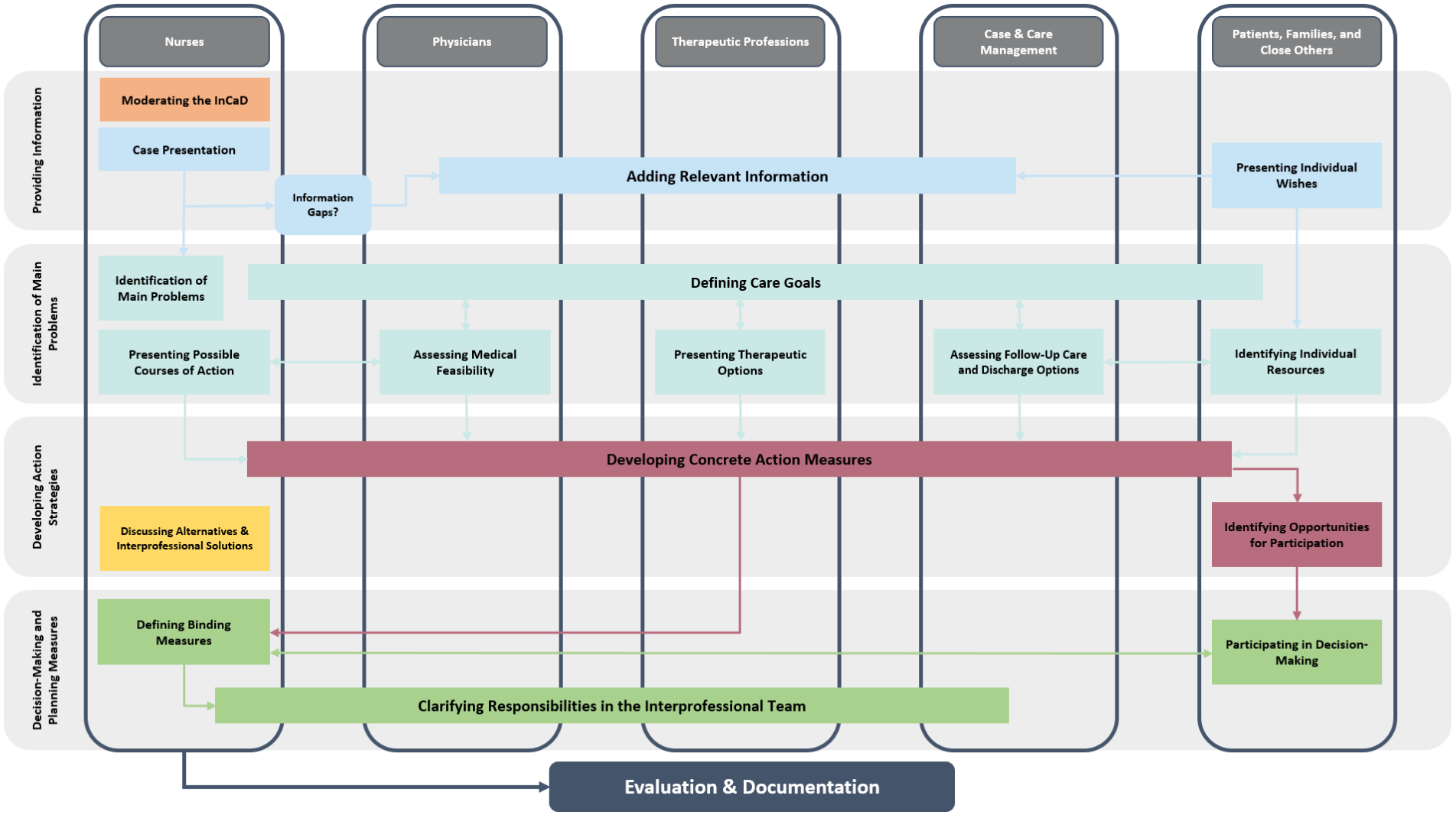

Figure 3:Procedure and activities of the participating groups in InCaD

4.1.12 What special aspects must be considered in InCaD?

- Additional measures, goal and care plan: If patients and their families, friends, and caregivers are unable to participate in InCaD, the goal and care plan is discussed with the persons concerned no later than 24 hours after InCaD. In addition to the specific individual goal agreements, daily or weekly goals and the associated care are agreed upon, recorded, and evaluated. The goal and care plan may include all or selected focal points of nurse-led care. Supportive measures are agreed upon and documented with families, friends, and caregivers no later than 24 hours after InCaD.
- Recurring patient cases: If individual patient cases are so complex that they cannot be fully discussed in a single InCaD, or if it is determined that the measures within the goal and care plan cannot be implemented, the patient case can be included in InCaD again at any time.
- Quality assurance: Measures to ensure and develop the nursing and care quality of InCaD include the standard procedures used in the hospital. In addition, specific measures are determined by nursing leadership and department leadership in consultation with nursing staff and the nursing science support. Furthermore, regular evaluations (every 3 months) establish interprofessional quality assurance to ensure continuous improvement of InCaD from various professional perspectives (see Evaluation of InCaD). This interprofessional perspective ensures a comprehensive evaluation of InCaD and contributes to the sustainable improvement of clinical processes.
- Quality monitoring: Indicators for monitoring the nursing and care quality of InCaD include the standard indicators used in the hospital. In addition, specific indicators are determined by nursing leadership and department leadership in consultation with nursing staff and the nursing science support.

4.1.13 How is an InCaD moderated?

Moderation plays a central role in the InCaD process. It is led by a nurse who acts as a neutral moderator, guides the process, and enables a focused discussion. Moderation comprises several phases, which for the concept are oriented toward the steps of InCaD:

1. Welcome and opening
    - Introduction of the participants and the moderator.
    - Establishment of discussion rules (e.g., respectful communication, equal participation of all participants).
2. Clarification of reason and question
    - The nurse describes the central question and the context.
    - Other participants add open points or relevant aspects.
    - The moderator supports the clarification of problems.
3. Collection of facts
    - Systematic collection of all relevant information about the case.
    - Each professional group, as well as the patients and their families, friends, and care-givers, contributes its perspective.
    - Identification of information gaps that may need to be closed before interprofessional decision-making.
4. Assessment of the facts
    - Discussion of the different care options.
    - Assessment based on principles such as benefit for the patient, feasibility, and ethical aspects.
    - If contradictions or differing perspectives exist, they are juxtaposed without making premature decisions.
5. Outcome and recommendation

- Interprofessional consensus-building on the best care options.
- Definition of next steps and responsibilities.
- If uncertainties remain, another InCaD can be scheduled.

6. Closing and follow-up
   - Summary of results, documentation, and protocol keeping.
   - Thanks to all participants.
   - Ensuring that the discussed measures are included in the goal and care plan.

4.1.14 How is InCaD evaluated?

InCaD should be evaluated at regular intervals. For this purpose, an initial start-up phase of 3 months is recommended. After this period, the first evaluation of InCaD should take place and be repeated at 3-month intervals in order to respond to existing inconsistencies in the process or concept as quickly and effectively as possible.

An evaluation must also be conducted for patients, families, friends, and caregivers. It is possible to include this as a separate question in the clinic's existing evaluation forms. Alternatively, existing clinic questionnaires can be adapted and used for this evaluation.

In individual consultation with the implementing clinic, additional effects of InCaD that are not included in the described levels of effect can also be evaluated. These must also be determined in close consultation with the implementing clinic and are recommended in accordance with DIN EN ISO 9001:2015 to ensure sustainable process optimization and quality assurance. This may include measuring the average length of stay, reducing unplanned readmissions, optimizing the discharge process, reducing ineffective care, or using clinical guidelines and standards more effectively before and after the introduction of InCaD.

For precise evaluation, the implementation manual can be followed.

5 References

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