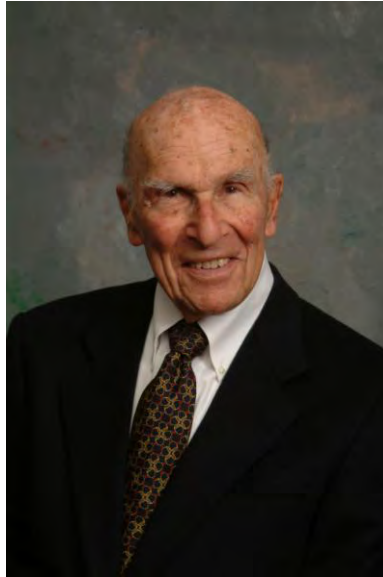# PATIENT-CENTERED CARE
Improvement Guide

Dedicated to Harvey Picker
A Pioneer of Patient-Centered Care
1915-2008

When Harvey Picker died in March 2008 at the age of 92, the world lost a tireless champion of patient-centered care. As founder of the Picker Institute, Harvey challenged the health care system to improve patient care by considering the totality of the experience through the eyes of the patient. He recognized that while science and technology were thriving in medicine, humanity and empathy were the antidotes needed to fix a broken system. To be truly healing and effective, Harvey understood that health care must be delivered in a way that is sensitive to patients' concerns and comfort, is responsive to their personal values and preferences, and actively involves patients and family members in shared decision making about their care.

Harvey Picker's vision for a health care system organized around the patient perspective was—and continues to be—the driving force of the Picker Institute. Days before he died, Harvey's request to all champions of patient-centered care was to "carry on." This appeal was the inspiration and guiding force for this guide. It is an honor and privilege to perpetuate his legacy.

PATIENT-CENTERED CARE IMPROVEMENT GUIDE

Susan Frampton, PhD
Sara Guastello
Carrie Brady
Maria Hale
Sheryl Horowitz, PhD
Susan Bennett Smith, MSN, RN, CNA-BC
Susan Stone, RN, PhD

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Picker Institute, Inc., based in Boston, Mass., with offices in Germany and Switzerland and a sister organization, Picker Institute Europe, in the UK, is an independent nonprofit organization dedicated to promoting the advancement of patient-centered care and the improvement of the patient's experience and interaction with healthcare providers.

Established in 1994, Picker Institute pioneered the use of scientifically valid nationwide surveys and databanks on patient-centered care to educate doctors and hospital staff how to improve services to patients from a patient's perspective. As a result, the patient's perspective is now a standard metric for measuring performance and used routinely by healthcare organizations worldwide.

Picker Institute has widened its focus to include a search for solutions as well as the measurement of the scope of the problem. Worldwide, Picker Institute promotes the advancement of patient-centered care through education programs, research grants, annual awards recognizing best practices, publications on patient-centered care topics, scientifically valid survey instruments and the maintenance of research databanks.

Education is a major component of the Picker Institute mission. The Picker Awards for Excellence in the Advancement of Patient-Centered Care were established in 2003 to honor people and organizations that have made significant contributions to advancing patient-centered care, and to highlight them as role models for others in the healthcare field.

Named after the tree under which Hippocrates, the Father of Medicine, taught his students in Ancient Greece, Planetree, Inc. is a not-for-profit organization that partners with hospitals and other health care organizations to transform organizational cultures and improve the patient experience. Planetree was founded in the late 1970s by Angelica Thieriot, a patient whose experiences with hospitals led her to envision a different type of healthcare experience where patients could receive quality care in a truly healing environment that would also provide them with access to the information needed to become active participants in their own care.

Based on focus groups with thousands of patients, family members and hospital staff members, Planetree has helped define what it means to be patient-centered by identifying core areas, elements and approaches, which are documented in the book *Putting Patients First*, the second edition of which was released in October 2008.

Today, Planetree is a growing global membership network of acute care hospitals, continuing care facilities, ambulatory centers, community health centers and health libraries, representing nearly one million annual hospital admissions, 15 million annual outpatient visits, 100,000 births, and more than 110,000 health care professionals. There are Planetree sites in 32 U.S. states, Canada and the Netherlands. A complete list of Planetree members is available at www.planetree.org.

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W e are deeply grateful to the Picker Institute for its invaluable support of this project. Beyond the financial backing to realize this Guide, we are most appreciative of the vote of confidence, the continued encouragement, and the collegial spirit of collaboration toward our shared mission of promoting and advancing the practice of patient-centered care on a broad scale.

Much work already has been done to define, implement, refine and evaluate patient-centered care by a number of organizations, including the Picker Institute, the Institute for Family-Centered Care, the Institute for Healthcare Improvement, Robert Wood Johnson Foundation, The Commonwealth Fund, the University HealthSystem Consortium and others. The work that predates this project has provided us a strong foundation from which to launch this Guide.

This Guide is robust with best practices and practical implementation tools thanks to the generosity of hospitals across the United States whose commitment to advancing patient-centered care trumped any inclination to keep their most effective practices to themselves.

We are most proud to call the hospital leaders and other health care experts who participated in the Patient-Centered Care Leadership Roundtable in March 2008 our partners. They are listed in Appendix B, and this Guide is definitively better for their input.

Though most of the patients and families who participated in the focus groups referenced in these pages will likely never see this Guide, the impression they have left on it is indelible. In the simple but powerful acts of telling their stories and sharing their ideas of how to improve health care, they are steering our industry toward change.

We would like to acknowledge the following sites and organizations for participating in the best practice gathering site visits and/or sharing the implementation tools that largely informed this Guide:

Alegent Health Bergan Mercy Medical Center (Omaha, Nebraska)
Alegent Health Lakeside Hospital (Omaha, Nebraska)
Alegent Health Mercy Hospital Council Bluffs (Council Bluffs, Iowa)
Alegent Health Midlands Hospital (Papillion, Nebraska)
Aurora BayCare Medical Center (Green Bay, Wisconsin)
Aurora Medical Center Oshkosh (Oshkosh, Wisconsin)
Cleveland Clinic (Cleveland, Ohio)
Delnor Hospital (Geneva, Illinois)
Enloe Medical Center (Chico, California)
Fauquier Health System (Warrenton, Virginia)
Griffin Hospital (Derby, Connecticut)
Hackensack University Medical Center (Hackensack, New Jersey)
Highline Medical Center (Burien, Washington)
Illinois Hospital Association
Loma Linda University Medical Center's East Campus (Loma Linda, California)
Mid-Columbia Medical Center (The Dalles, Oregon)
Northern Westchester Hospital (Mount Kisco, New York)
Sentara Virginia Beach General Hospital (Virginia Beach, Virginia)
Sentara Williamsburg Regional Medical Center (Williamsburg, Virginia)
Shands Jacksonville Medical Center (Jacksonville, Florida)
Sharp Coronado Hospital (Coronado, California)
South Carolina Hospital Association
Spectrum Health Reed City Hospital (Reed City, Michigan)
Stamford Hospital (Stamford, Connecticut)
University HealthSystem Consortium
University of North Carolina Children's Hospital (Chapel Hill, North Carolina)
University of Washington Medical Center (Seattle, Washington)
Valley View Hospital (Glenwood Springs, Colorado)
Waverly Health Center (Waverly, Iowa)
Windber Medical Center (Windber, Pennsylvania)

In addition to these sites, we would like to acknowledge the collective wisdom of the entire Planetree community of hospitals, continuing care organizations, ambulatory care centers and health resource libraries, each of which serves as a living laboratory where innovation in patient-centered care thrives, and whose focus groups informed the creation of this Guide.

"There is nothing more powerful than an idea whose time has come."
Victor Hugo

PATIENT-CENTERED CARE:
AN IDEA WHOSE TIME HAS COME

Organizing the delivery of health care around the needs of the patient may seem like a simple and obvious approach. In a system as complex as health care, however, little is simple. In fact, thirty years ago when the idea of "patient-centered care" first emerged as a return to the holistic roots of health care, it was swiftly dismissed by all but the most philosophically progressive providers as trivial, superficial, or unrealistic. Its defining characteristics of partnering with patients and families, of welcoming—even encouraging—their involvement, and of personalizing care to preserve patients' normal routines as much as possible, were widely seen as a threat to the conventions of health care where providers are the experts, family are visitors, and patients are body parts to be fixed. Indeed, for decades, the provision of consumer-focused health care information, opportunities for loved ones' involvement in patient care, a healing physical environment, food, spirituality, and so forth have largely been considered expendable when compared to the critical and far more pressing demands of quality and patient safety—not to mention maintaining a healthy operating margin.

How times have changed. This once radical concept has undeniably been pushed into the mainstream, in part by the Picker Institute's introduction of its scientific approach to identifying and understanding patients' varied needs and by the expansion of the Planetree membership network, comprised of health care organizations across North America and abroad all implementing a patient-centered approach to care. The Institute of Medicine's 2001 seminal report *Crossing the Quality of Chasm* identified patient-centeredness as an essential foundation for quality and patient safety—versus the conventional perspective of a patient-centered approach being a peripheral aim—effectively ushering in a reorientation of the health care delivery system: one in which the *way* care is delivered is considered equally as important as the care itself.

With the introduction of the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) patient experience of care survey, there now exists a standardized tool to evaluate the way care is provided from the patient perspective. The program's development has reinforced that, from the vantage point of patients, the health care experience encompasses much more than clinical capabilities, pharmaceuticals and technology. Whereas other nationally standardized and publicly reported outcomes, like CMS's core measures, evaluate hospitals on aspects of clinical quality that mean little to patients themselves and/or reflect outcomes that patients take for granted as minimum standards of care, HCAHPS examines those aspects of the health care experience that mean the most to patients, including communication with nurses and physicians, cleanliness and noise levels, pain control, and quality of discharge instructions and medication information. With individual hospitals' scores publicly available for the curiosity, scrutiny and comparability of health care consumers, HCAHPS has hastened the need for hospitals to examine the way care is delivered from the perspective of their patients. And with the advent of value-based purchasing, HCAHPS will likely become a basis for reimbursement, effectively advancing patient-centered care from the "right thing to do" to a business imperative.

DEFINING PATIENT-CENTERED CARE

The result is that, today, patient-centered care is in the consciousness of most every health care leader. Organizational mission statements reference it, special committees have been convened to address it, and considerable resources are expended to solicit patient feedback on it. Nevertheless, many organizations continue to struggle with what "it" is.

This ambiguity ultimately leaves many with vague or muddled expectations for what constitutes patient-centered care. Is it a surprise, then, that many leaders report feeling bewildered at how to go about becoming more patient-centered? Or that others, convinced that their approach is indeed a patient-centered one, are surprised to find data reflecting patient and/or staff discontent?

In the broadest terms, patient-centered care is care organized around the patient. It is a model in which providers partner with patients and families to identify and satisfy the full range of patient needs and preferences. Not to be overlooked in defining patient-centered care is its concurrent focus on staff. To succeed, a patient-centered approach must also address the staff experience, as staff's ability and inclination to effectively care for patients is unquestionably compromised if they do not feel cared for themselves.

Although patients may not always be able to accurately assess the clinical quality of their care, or whether safety processes are in place, patient safety and high clinical quality are fundamental to a patient-centered approach. Patient-centered care does not replace excellent medicine—it both complements clinical excellence and contributes to it through effective partnerships and communication. A wealth of resources exists to guide organizations in addressing clinical quality and patient safety, so for purposes of this Guide, we have narrowed our focus to discussing the patient and staff experience of care. We recognize, however, that it is essential for efforts to improve the patient experience to be grounded in and closely connected with quality and safety efforts.

REFLECTING THE VOICES OF PATIENTS, FAMILIES, STAFF AND LEADERSHIP

The Patient Voice
The CEO of a 200-bed hospital in California revered for delivering quality care suggests that the first step to becoming more patient-centered is the "recognition of mediocrity." She goes on to add, "…it's not until you recognize you are doing everything fine and that you're getting the quality and the clinical outcomes; you're getting what you need to stay in business—but you look really close and you realize you're mediocre when it comes to really dealing with the customer." Her comments underscore that while in principle patient-centered care may seem simple and obvious, it is anything but. The reality is that even in organizations that have made a leadership commitment to patient-centered care, at the bedside, many patients and families still feel disempowered, ignored, helpless and confused.

If the first step to adopting a patient-centered approach is to acknowledge that we are failing to adequately meet our patients' needs, we must next understand what those needs are and where the disconnects exist that impede our ability to satisfy them. For many organizations traveling the path toward patient-centeredness, this is accomplished through focus groups where patients

and their family members are asked to share what went well during a recent hospital experience and what could have been improved. Focus groups can be a very effective way to supplement patient satisfaction surveys as they provide the opportunity to more comprehensively explore individual patients' stories to get at the heart of why a particular experience was disappointing or what made another interaction memorable and meaningful in a positive way.

In developing this Patient-Centered Care Improvement Guide, Planetree analyzed a stratified sample of more than ninety such anonymous focus groups (representing 35 hospitals and more than 645 patients) conducted over the past three years. The common themes that emerged about what, from the patient perspective, is *lacking* in today's health care experience have been the single most important source of data informing the Guide's development. After all, how could we credibly present strategies for better meeting the needs of patients and their families without first consulting patients and families themselves about just what those needs are? Throughout this Guide, their experiences—in their own words—will underscore what patients and families seek from their providers.

The Leadership Perspective
In addition to addressing the needs of patients, families and staff, any strategy recommended must also be practical from an operational standpoint. To ensure that the practices presented here meet these dual criteria, it was essential to solicit input not only from patients and families, but also from hospital leaders. In March 2008, a Patient-Centered Care Leadership Roundtable was convened to engage CEOs and other national health care experts in a dialogue about their experiences with patient-centered approaches to care. Incorporated throughout this Guide is the extensive input provided by Roundtable participants on the challenges they have faced, and most importantly, how they were able to overcome them to create and sustain a patient-centered culture.

The Staff Perspective
Perhaps the greatest influences on the patient experience are the individuals who comprise the hospital staff. Whether at the bedside or in the back office, in a patient-centered hospital, *every* staff member contributes to the overall patient experience. From ensuring linens are fresh and bathrooms are clean to following up on billing questions and compiling customized patient information packets, every interaction is an opportunity for caring, support and compassion. Patient input confirms that it is often the simple acts of caring that are most meaningful; conversely, the absence of caring attitudes and caring gestures can leave a lasting impression. The incredible demands that health care professionals contend with daily are challenging caregivers to find ways of delivering care that are efficient and effective without conceding the compassion that patients expect and deserve.

Clearly, the patient and staff experiences are inextricably intertwined. Consequently, to approach patient-centered care as exclusively about the patient and family is to overlook a critical piece of the puzzle. The insights of staff will be incorporated throughout the Guide to showcase these connections. In addition, specific strategies will be presented for leveraging staff's passion, creativity and caring attitudes to foster an environment that is nurturing not only for patients and families, but also for health care professionals.

RIGHT NOW. TODAY.

In as complex an industry as health care, the multitude of reasons for delaying action can be persuasive forces. But, in today's health care marketplace, there can no longer be any delay in adopting a patient-centered approach to care. Beyond the implications of publicly reported HCAHPS scores and value-based purchasing, delaying action means that our patients, their families and our staff are not being fully nurtured, supported and empowered in ways that meet their needs.

Of course every organization has a unique culture and its own set of circumstances. Communities served, bed size, governance structure, service lines, available resources, technological capability, reputation, and history vary greatly. Accordingly, to claim that every one of the strategies contained within this Guide will work for every organization would be the height of folly. Instead, the practices are presented as building blocks. Think about them, share them with others throughout the organization, consider ways to adapt them to make them yours, or perhaps use them as inspiration to develop a completely new and innovative way to address a similar patient or staff need. But most importantly, *do something*. *Right now. Today*.

This is not to say that becoming patient-centered can happen overnight—far from it. Securing buy-in from staff, boards, and medical staff takes time. Overcoming a well-ingrained resistance to opening ourselves up in full transparency to our patients—flaws and all—is a gradual process. And perhaps significant renovation or new construction will not happen until well into the future. But these are not reasons to hesitate taking those first steps toward becoming *more* patient-centered. Consider inviting members of your governing board to round with patients prior to their next meeting to set a different kind of context for leadership discussions. Look around and find areas in your physical environment where small changes could enhance the comfort or convenience of patients. Knowing that simple gestures of human kindness are often the most meaningful to patients and families, consider how you can tap into your volunteer force to spread smiles and helpful hands as needed. Review letters of both compliment and complaint that you have received. How can you address those areas of discontent so that other patients don't complain about the same thing, and how can you replicate what yielded praise?

We hope this Guide will be a useful resource in helping you to frame your organization-specific approach to implementing patient-centered care. In fact, though, the *most* powerful resources at your disposal to effect this change are right in front of you. They are your staff, your leadership team, your volunteers, your board members and medical staff, your patients and their families, and your collective commitment to providing the kind of care we would each want to receive if circumstances found us, or our loved ones, in the role of the patient.

> "*I think one of the things that is going to be very important is, through the stories and this work, to give somebody something that allows them to understand what the 'it' is...Imploring will never get us there. But if you make it through grounding processes...if you design it into the system, I think that's a huge contribution. Because people want to go there; they just need to know what 'it' is.*" (Jim Conway, Institute for Healthcare Improvement)

HOW TO USE THE PATIENT-CENTERED CARE IMPROVEMENT GUIDE

Funded by the Picker Institute, this Patient-Centered Care Improvement Guide is designed as a practical resource for organizations striving to become more patient-centered, yet perhaps struggling with how to do so. Wherever your organization is along the spectrum of patient-centered care implementation—whether just starting to contemplate opportunities for improvement, looking to revitalize a fading commitment or working to ensure that an established patient-centered culture is sustained over time—we are confident that you will find within these pages constructive strategies that will guide you on your way.

To help you navigate your way through the Guide most effectively, we begin with a Self-Assessment Tool on page 9 that you can use to identify and prioritize opportunities for introducing patient-centered approaches into your organization.

In Section IV (page 20), we then explore patient-centered care in the framework of organizational culture change, differentiating between a quick fix mentality and the deep-rooted, long-term commitment necessary to truly change the culture of an organization.

Next, we address head on some of the most frequently cited barriers to implementation of patient-centered care, among them resistance from the CFO or Board of Directors concerned about the cost to become more patient-centered, skepticism of staff wary of the next "flavor of the month," and the argument that providing patient-centered care means increasing staff ratios. In addition, the Guide addresses the questions of patient-centered care in the context of infection control, privacy laws, old physical plants and more. Read more about these myths of patient-centered care starting on page 23.

In Section VI (page 39) we lay the foundation for successful implementation, delving into the critical roles to be played by leadership, staff, medical staff, volunteers, and patients and families themselves. Strategies are presented for engaging all of these different stakeholders toward a collective vision.

Section VII (page 77) features tangible practices in place at high-performing patient-centered hospitals nationwide, many of which are straightforward improvements that can be implemented promptly and at little cost to the organization. The section is organized around important components of the health care experience, including communication (page 78), personalization of care (page 91), continuity of care (page 112), access to information (page 137), family involvement (page 145), the environment of care (page 170), spirituality (page 179), integrative medicine (page 185), caring for the community (page 192), and care for the caregiver (page 195). Considering that these strategies are structured around aspects of the patient experience identified by patients as most needing improvement, the potential for these practices to yield high impact results is significant.

Meriting special attention are the challenges of providing patient-centered care despite the ever-more palpable intrusion of technology and performance data into the healing profession.

Fundamentally, patient-centered care is "low-tech and high-touch," but a number of hospitals have found ways to leverage the benefits of technology without compromising the importance of human to human interactions. Similarly, others have been able to curtail data fatigue by emphasizing the people, relationships and experiences behind the numbers. Section VIII (page 202) spotlights these practices for using data and technology in a way that is consistent with the values of patient-centered care.

We conclude in Section IX (page 211) with guidance for individuals interested in advancing patient-centered care within their own organizations, sharing personal strategies for enhancing one-on-one interactions with patients, families and colleagues.

In recognition of the heightened interest in HCAHPS, Appendix A delves into the HCAHPS tool, exploring what patients are looking for in their care experiences (as they relate to each of the HCAHPS composites), and identifying specific practices spotlighted in this Guide that may help to more effectively satisfy those expectations and preferences.

Also included throughout are sample policies, implementation tools and web resources. An annotated bibliography of published articles detailing research and evaluation projects related to essential aspects of patient-centered care will be available on the Planetree (planetree.org) and Picker Institute websites (pickerinstitute.org). Together, this Guide and the bibliography are designed to serve as an antidote to the ambiguity that has been a persistent barrier to the more widespread adoption of patient-centered care.

ADDITIONAL RESOURCES

In addition to the resources made available by Picker Institute (www.pickerinstitute.org) and Planetree (www.planetree.org), the following websites provide valuable information and further guidance for any organization working to introduce or enhance patient-centered practices:

Agency for Healthcare Research and Quality
www.ahrq.gov

American Hospital Association
www.aha.org

The Commonwealth Fund
www.commonwealthfund.org

Institute for Family-Centered Care
www.familycenteredcare.org

Institute for Healthcare Improvement
www.ihi.org

National Quality Forum
www.qualityforum.org

Robert Wood Johnson Foundation
www.rwjf.org

SELF-ASSESSMENT TOOL

The following self-assessment tool is provided as a resource to assist readers in navigating through this Patient-Centered Care Improvement Guide, particularly those struggling with the question of where to start. The assessment tool is organized around important aspects of a patient-centered culture, each of which is addressed in-depth in its own section of the Guide. Completing the self-assessment may help to identify important opportunities for improvement or to prioritize a list of initiatives your organization may be eager to undertake. You can then refer to the relevant section of the Guide to explore patient-centered approaches for enhancing those particular aspects of the patient and/or staff experience that emerged as priority focus areas.

The HCAHPS section of this self-assessment can be used in conjunction with Appendix A (which relates specific patient-centered practices to the HCAHPS survey) as you consider strategies for HCAHPS improvement that are consistent with and supportive of a culture of patient-centeredness.

No matter where the self-assessment tool directs you, it is suggested that you begin in the Setting the Stage, Strengthening the Foundation section (page 39) for strategies that will move your organization's journey toward patient-centeredness from a list of tasks to a commitment across the organization to a shared set of values, attitudes and behaviors that define how health care should be delivered.

INSTRUCTIONS:

1. Complete the table below by marking the box that most appropriately captures the current status of the described practice in your organization.
2. Tally up your score for each section, giving yourself:

   2 points for every practice that is **fully implemented**
   1 point for every practice that is **partially implemented**
   0 points for every practice where this is no activity or it is not applicable.

3. Calculate your organization's performance in each of the sections, and refer to the section of the Guide addressing those areas in which your percentage performance indicates the greatest opportunities for improvement.
4. Use the Prioritization Tool on Page 17 to prioritize implementation of initiatives.

	Fully Implemented Throughout Organization	*Partially Implemented (in progress or in place in some areas, but not all)*	*No activity*	*Not applicable*
SETTING THE STAGE, STRENGTHENING THE FOUNDATION, pg. 39				
The organization's commitment to patient-centered care is formally and consistently communicated with patients, families, staff, leadership, and medical staff (e.g. mission, core values).				
Expectations for what staff can expect in a patient-centered environment are clearly stated and proactively shared.				
Patients and family members have been invited to share their experiences with your hospital in focus groups.				
A patient and family advisory council meets regularly and actively provides input to hospital leadership on hospital operations.				
Patients and family members participate as members on hospital committees.				
The input provided by patients and families is used to guide the organization's strategic direction.				

	Fully Implemented Throughout Organization	Partially Implemented (in progress or in place in some areas, but not all)	No activity	Not applicable
Patient-centered behavior expectations are included in all job descriptions and performance evaluation tools.				
Staff at all levels, clinical and non-clinical, have the opportunity to voice their ideas and suggestions for improvement.				
Opportunities exist for both formal and informal interaction between leadership and staff, including staff working 2nd and 3rd shift.				
Opportunities exist for leadership to interact directly with patients and families.				
Managers are held accountable for "walking the talk" of patient-centered care.				
Physicians are held accountable for "walking the talk" of patient-centered care.				
Board members are provided opportunities to interact directly with patients and families.				
Total Score out of a Possible of 26		**Percent of Total:**		**%**
COMMUNICATING EFFECTIVELY WITH PATIENTS AND FAMILIES, pg. 78				
Patients are made aware of how to raise a concern related to patient safety and/or their care while they are hospitalized.				
Patients and families are encouraged to ask questions, and systems are in place to capture questions that arise when caregivers are not present to answer them.				
Systems are in place to assist patients and families in knowing who is providing their care, and what the role is of each person on the care team.				
Total Score out of a Possible of 6		**Percent of Total:**		**%**

	Fully Implemented Throughout Organization	Partially Implemented (in progress or in place in some areas, but not all)	No activity	Not applicable
PERSONALIZATION OF CARE pg. 91				
Patients are able to make requests for when meals will be served to accommodate their personal schedule and routine.				
Patients are able to make requests for when certain procedures will be performed to accommodate their personal schedule and routine.				
Resources are available to staff to educate them on different cultural beliefs/traditions related to health and healing.				
Food options are available to meet the preferences of different ethnic groups.				
Food is available for patients and families 24 hours a day.				
Total Score out of a Possible of 10		**Percent of Total:**	**%**	
CONTINUITY OF CARE pg. 112				
Patients and families are able to participate in rounds.				
Patients and families are able to participate in change of shift report.				
Plans of care are written in language that patients and families can understand.				
Opportunities exist for patients and families to meet with multiple members of their health care team (including the nurse and physician) at one time.				
Tools are provided to patients to help them manage their medications, medical appointments and other health care needs.				
Patients and families are encouraged to participate in discharge planning from the beginning of hospitalization.				
Processes are in place to reinforce and assess comprehension of information and instructions provided at discharge.				

Total Score out of a Possible of 14			Percent of Total:	%
	Fully Implemented Throughout Organization	*Partially Implemented (in progress or in place in some areas, but not all)*	*No activity*	*Not applicable*
ACCESS TO INFORMATION, pg. 137				
A process is in place by which patients and family may request additional information on their diagnosis, treatment options, etc.				
Patients have access to their medical record while they are being treated, and are assisted in understanding the information contained within.				
Patients are made aware of the opportunity to review their medical record with the support of a health care professional.				
Patients are able to contribute their own progress notes in their medical record.				
Patient education materials appropriate for readers of varying literacy levels and for speakers of different native languages are readily available.				
Patients and families have access to a consumer health library.				
A process is in place to disclose unanticipated outcomes to patients (and family as appropriate).				
Total Score out of a Possible of 14			**Percent of Total:**	**%**
FAMILY INVOLVEMENT, pg. 145				
"Family" is defined by the patient.				
Visitation is flexible, 24-hour and patient-directed. (Exceptions may include behavioral health)				
Formalized training/education is available for a patient's loved one who may be providing routine care following discharge.				
A process is in place by which a family member or patient may initiate a rapid response team.				

	Fully Implemented Throughout Organization	Partially Implemented (in progress or in place in some areas, but not all)	No activity	Not applicable
Family members are able to remain with the patient during codes and resuscitation.				
Support is provided to patients and families involved in an adverse event.				
Comfortable spaces, equipped with a variety of positive diversions, are available throughout the facility for family use.				
Overnight accommodations are available to loved ones wishing to stay overnight with a patient.				
Support is provided to patients' informal caregivers.				
Total Score out of a Possible of 18		**Percent of Total:**	**%**	

ENVIRONMENT OF CARE, pg. 170

The following spaces create a first impression of "welcome," "comfort" and "healing:"				
• Main Lobby				
• Emergency Department Entrance				
• Parking Lots/Garage				
• Information Desk				
• Unit-based nurses' stations				
Patients are afforded privacy during check-in, changing and treatment.				
For hospitals with semi-private rooms, accommodations are available for patients to have a private conversation.				
Patients are able to adjust the lighting and temperature within their room on their own.				
Patient rooms have views to the outdoors				
Lounge areas are available in which patients and visitors may congregate.				

	Fully Implemented Throughout Organization	Partially Implemented (in progress or in place in some areas, but not all)	No activity	Not applicable
A range of diversionary activities, beyond the television, are available to patients and families.				
Overhead paging has been eliminated (with the exception of emergent needs).				
Pleasant smelling, non-toxic cleaning products are used.				
Signage reflects primary languages of populations served, and uses icons to aid in comprehension.				
Patients can easily find their way from the parking areas to their destination.				
Total Score out of a Possible of 30		**Percent of Total:**		**%**

SPIRITUALITY, pg. 179

Resources are available to staff to educate them on different religious beliefs/traditions related to health and healing.				
Spiritual assessments look beyond a patient's faith traditions to also capture what comforts and centers them.				
Space is available for both quiet contemplation and communal worship.				
Total Score out of a Possible of 6		**Percent of Total:**		**%**

INTEGRATIVE MEDICINE, pg. 185

Complementary and integrative therapies are available based on patient interest and community utilization patterns.				
Total Score out of a Possible of 2		**Percent of Total:**		**%**

CARING FOR THE COMMUNITY, pg. 192				
	Fully Implemented Throughout Organization	*Partially Implemented (in progress or in place in some areas, but not all)*	*No activity*	*Not applicable*
Space is made available within the facility for community groups to meet.				
Free health-related lectures, wellness clinics, health fairs, etc. are routinely offered to the public.				
Total Score out of a Possible of 4			**Percent of Total:**	**%**
CARE FOR THE CAREGIVER, pg. 195				
Staff's stress-reduction and wellness needs are addressed.				
Staff is routinely acknowledged for their good work by leadership, by peers and by patients and families.				
Staff have opportunities to provide input into ways to enhance the work environment.				
Space is available for staff to decompress between patients and/or cases.				
Support is provided to staff involved in an adverse event.				
Healthy food is available to all staff, including those who work on weekends and on nights.				
Total Score out of a Possible of 12			**Percent of Total:**	**%**

INITIATIVE PRIORITIZATION TOOL:

Instructions:

1. Complete with assessment items that you rated as either: "partially implemented" or "no activity."

2. Tally up the number of "Yes's" to identify top priority initiatives (greater number of Yes's=higher priority)

3. Refer to the sections of the Guide that correspond to your organization's lowest scoring areas for specific implementation strategies.

Assessment Item	Does this initiative satisfy an expressed patient, family and/or staff need?		Does this initiative support our organizational priorities?		Does this initiative present an opportunity for a high-impact "gain" in a short turnaround time?		Do our organizational resources allow for the implementation of this initiative?		Sum of Yes's
	Yes	No	Yes	No	Yes	No	Yes	No	
	Yes	No	Yes	No	Yes	No	Yes	No	
	Yes	No	Yes	No	Yes	No	Yes	No	
	Yes	No	Yes	No	Yes	No	Yes	No	
	Yes	No	Yes	No	Yes	No	Yes	No	
	Yes	No	Yes	No	Yes	No	Yes	No	
	Yes	No	Yes	No	Yes	No	Yes	No	
	Yes	No	Yes	No	Yes	No	Yes	No	
	Yes	No	Yes	No	Yes	No	Yes	No	
	Yes	No	Yes	No	Yes	No	Yes	No	
	Yes	No	Yes	No	Yes	No	Yes	No	

PATIENT SATISFACTION

1. Complete with aggregate data from your most recent four quarters of HCAHPS data:

2. Identify those domains in which either your organization's percent of "Always" responses is lower than the national average or your organization's percent of "Never" or "Sometimes" is higher than the national average.

3. Refer to Appendix A for suggestions of patient-centered approaches for improvement.

DOMAIN	% of respondents answering "Always"	U.S. National Average, "Always" (as reported on Hospital Compare)*	% of respondents answering "Never" or "Sometimes"	U.S. National Average, "Never" or "Sometimes" (as reported on Hospital Compare)*
Communication with Nurses		74%		6%
Communication with Physicians		80%		5%
Communication about Medications		59%		23%
Discharge Instructions		80%		20%
Responsiveness		63%		12%
Pain Management		68%		8%
Cleanliness		70%		10%
Quiet at Night		56%		13%
	% of respondents answering "Definitely Yes"	U.S. National Average, "Definitely Yes" (as reported on Hospital Compare)	% of respondents answering "Definitely or Probably No"	U.S. National Average, "Definitely or Probably No" (as reported on Hospital Compare)
Willingness to Recommend		68%		6%
	% of respondents answering with 9 or 10 rating	U.S. National Average (9 or 10) (as reported on Hospital Compare)	% of respondents answering with 0 to 6 rating	U.S. National Average (0 to 6) (as reported on Hospital Compare)
Overall Rating		64%		11%

National benchmarks are based on most recent Hospital Compare data (January 2007-December 2007)

IDEAS GENERATED BY THE SELF-ASSESSMENT:

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PATIENT-CENTERED CARE AS ORGANIZATIONAL CULTURE CHANGE

We would be remiss in producing an Improvement Guide full of specific practices in patient-centered care without making it abundantly clear that an organizational culture of patient-centered care is characterized <u>not</u> by discrete programs, but by the core values and attitudes behind the implementation of such programs. Patient-centered care is about engaging the hearts and minds of those you work with and those you care for. It is about reconnecting staff with their passion for serving others. It is about examining all aspects of the patient experience and considering them from the perspective of patients versus the convenience of providers. Ultimately, it is about a collective commitment to a set of beliefs about the way patients will be cared for, how family will be treated, how leadership will support staff, and how staff will nurture each other and themselves.

In the absence of such an overarching organizational vision, programs and policies, on their own, may effectively address specific objectives, but they will fall short of cultivating an authentically patient-centered organization. In a patient-centered culture, the core value of prioritizing the perspectives of patients and families may be manifested with, for instance, the development of a Patient and Family Advisory Council, with routine patient rounding to understand their perceptions of their care, or with regular focus groups. Without the conviction of the core values behind these practices—without a genuine recognition of the need to be responsive to the voice of health care consumers—such practices will be in vain. On the other hand, in an organization where a culture of patient-centeredness has taken root, these formal approaches are naturally complemented by the countless informal ways that staff—committed on a deep level to meeting the needs of those they care for—interact with patients, families, and even each other at the bedside, in the lobby, in the cafeteria, etc.

This difference between discrete patient-centered practices and comprehensive culture change is corroborated in conversations with leaders at a number of patient-centered hospitals that have performed well on the HCAHPS survey. These leaders confirm that, in their view, their survey success cannot be attributed to any precise or tangible actions or programs. Asked to identify the specific drivers for their HCAHPS success, many of them took a more nebulous approach, describing instead an organizational culture in which, of course, call bells are answered promptly, communication with nurses and physicians is open, and important information is reinforced—again, not because of a series of in-services or program roll-outs, but because that's the expectation throughout their hospital of how care is provided.

And therein lies the rub for many organizations striving to become more patient-centered. Patient-centeredness is not a check-list, a dashboard or an action plan. It is a cultural transformation. As such, it requires buy-in and engagement from all levels of the organization, it requires a long-term commitment, and a willingness to routinely challenge the "that's the way we've always done it" mentality.

What's more, patient-centeredness is not a goal to be achieved in order to move on to the next initiative. The true test of a culture of patient-centered care is its sustainability, and its ability to

endure even in the face of high census days, staffing shortages, demanding patients and leadership turnover. True to any profound organizational culture change, the gradual shift to patient-centeredness comes with a natural ebb and flow of momentum. Rather than a reason to abandon efforts to become more patient-centered, these ebbs represent opportunities for revitalization, celebration of past accomplishments and setting new goals; the "flows" are opportunities to push through barriers to further advance the culture.

So, it is with this caveat that this Patient-Centered Care Improvement Guide is presented: to be truly effective, the practices contained within must be implemented as part of a long-term and comprehensive vision of organizational culture change. That shift of mindset is a profound one with the power to unleash a swell of passion, enthusiasm and activity within your organization that will go far beyond the launching of a series of new initiatives. Indeed, with time, patience and ongoing attention, it could result in sweeping changes with far-reaching effects that will be felt for years to come by your patients, their families, and staff.

> **An important first step of this cultural transformation is articulating the core values of patient-centered care that will drive future changes. To assist you in this effort, we have included on page 22 a *Proclamation for Patient-Centered Care* that hospitals may use to publicly espouse to their patients, families and staff their basic beliefs about the way care should be delivered. Complimentary personalized copies are available from Planetree upon request.**
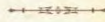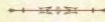
ORGANIZATION NAME

Proclamation for Patient-Centered Care

To Commemorate Patient-Centered Care Awareness Month we proclaim to our patients and community these truths, which we hold to be self-evident:
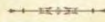
A patient is an individual to be cared for, not a medical condition to be treated.
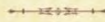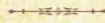
Each patient is a unique person, with diverse needs.

Each staff member is a caregiver, whose role is to meet the needs of each patient.

Our patients are our partners and have knowledge and expertise that is essential to their care.

Our patients' family and friends are also our partners and we welcome their involvement.

Access to understandable health information is essential to empower patients to participate in their care and it is our responsibility to provide access to that information.

The opportunity to make decisions is essential to the well-being of our patients. It is our responsibility to maximize patients' opportunities for choices and to respect those choices.
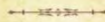
Our patients' well-being can be enhanced by an optimal healing environment, including access to music and the arts, satisfying food, and complementary therapies.

To effectively care for patients, we must also care for our staff members by supporting them in achieving their highest professional aspirations, as well as their personal goals.

Patient-centered care is the core of a high quality health care system and a necessary foundation for safe, effective, efficient, timely, and equitable care.

ORGANIZATION NAME

exists to serve our patients and our community. We are honored to be here for you.

THE MYTHS OF PATIENT-CENTERED CARE

For some, the concept of patient-centered care is self-evident, and simply put, the way they feel health care should be delivered. For others, the concept can evoke apprehension and/or skepticism—not because they object to the underlying philosophy of restoring empathy, humanity and patient-provider partnerships to health care, but because introducing changes to the standard operating procedures of most hospitals often requires a host of considerations, from cost and resource consumption to infection control and privacy protections. This is, after all, how health care earned its reputation as an industry disinclined toward change.

In this section of the Improvement Guide, we address some of the most commonly cited reasons why models of patient-centered care will not, or cannot, be effective, clarifying misconceptions and demonstrating once and for all why these persistent myths need no longer thwart the more widespread adoption of patient-centered care.

MYTH #1: PROVIDING PATIENT-CENTERED CARE IS TOO COSTLY.

The misconception that providing patient-centered care requires a substantial infusion of financial resources overlooks a key point: that while certainly patient-centeredness can be enhanced with technology, renovations, and new equipment, fundamentally providing patient-centered care is about human interactions. It is about attitude, kindness, compassion and empathy, all of which are completely free! Providing compassionate and personalized care does not require hiring more staff, but rather *optimizing* interactions with patients and families at your current staffing levels.

A recent study demonstrated the operational benefits of providing patient-centered care.[1] A five-year comparison of two comparable hospital units (same types of patients, skill mix, and with standardized organizational pay rates, supply costs, policies, procedures, contracts, and regulatory compliance programs), one implementing the Planetree model of patient-centered care and the other not, found that the Planetree unit consistently demonstrated a shorter length of stay, lower cost per case, and a shift in use from higher-cost RN staff to lower-cost ancillary staff. In addition, the Planetree unit demonstrated higher average overall patient satisfaction for each of the five years studied.

This myth of the cost of providing patient-centered care has been perpetuated by another misguided line of thinking—that patient-centeredness requires significant investments in either renovations or new construction to ensure a striking and spacious physical facility within which these interactions can occur. This thinking fails to understand that a healing environment encompasses not only architecture and interior design, but the *atmosphere* of the space. Yes, the atmosphere can be improved by a number of low- to no-cost cosmetic improvements (including art work, soothing paint colors, plant life, and reorientation of furniture), but perhaps the most effective means of brightening up and demystifying an intimidating, institutional space is through

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[1] Stone, S. (2008). "A Retrospective Evaluation of the Impact of the Planetree Patient Centered Model of Care Program on Inpatient Quality Outcomes." <u>Health Environments Research and Design Journal</u>, 1(4):55-69.

the development of arts and entertainment programs, the presence of volunteer ambassadors in the lobby, by providing abundant information, and by establishing behavior expectations for staff that they acknowledge everyone they encounter. Even those hospitals that do undergo renovations need not spend more to create a patient-centered, healing environment. In fact, in the early 1990s when Griffin Hospital in Derby, Connecticut approached the state authority responsible for granting certificates of need with its plans for a patient care facility that would reflect its patient-centered philosophy, the plans were approved with one caveat: that the renovation must cost no more than a traditional renovation. The hospital met the challenge and the facility went on to be awarded all four of the top national health care design awards.

For many hospitals, volunteers have proven to be invaluable resources for advancing a culture of patient-centered care. By exploring new and creative ways that volunteers may enhance the environment of care and may support staff in their efforts to provide personalized care, these hospitals are not only better able to meet the needs of their patients and families, but they are also cultivating a more engaged, loyal cadre of volunteers who are ever-more willing and eager to donate their time and their talents to the hospital.

This is not to say that there are no expenses associated with the implementation of patient-centered care. For many hospitals, the most significant resource consumption is in making staff available for initial and ongoing education and training. But in the current landscape of the health care industry and the imposing forces of health care consumerism, these relatively small costs are wise investments, particularly as we consider the financial implications of substandard HCAHPS scores, of rising malpractice claims, and of the unrelenting challenges of the health professional staffing shortage. By making investments that set the stage for care to be delivered in a way that meets patients' needs, that treats them with dignity and respect, that fosters an environment of trust and transparency (even when things go wrong) and that inspires employee pride in the workplace, the costs of implementing patient-centered care are clearly dwarfed by the priceless potential benefits.

For a more comprehensive discussion of the business case for patient-centered care, refer to "Building the Business Case for Patient-Centered Care" by Patrick Charmel and Susan Frampton in the March 2008 edition of *HFM Magazine.*

MYTH #2: PATIENT-CENTERED CARE IS "NICE," BUT IT'S NOT IMPORTANT.

With the Institute of Medicine's identification of patient-centeredness as fundamental to quality care, one would think that this myth has been summarily debunked, but the perception of patient-centered care as all about cookie baking, pianos, and pet visits continues. There are some aspects of patient-centered care that perhaps are not essential to patient care, but they certainly do contribute to an outwardly more pleasant hospital experience. And just because something is "nice," does not mean it is not important. By strengthening partnerships between patients and caregivers and by actively promoting family involvement in patient care, patient-centered practices set the foundation for a characteristic of care that is of the utmost importance: that it be **safe**. Patient and family-initiated rapid response teams enable those closest and most familiar with the patient to initiate a rapid response team. Encouraging patients to review their medical

record not only promotes an atmosphere of trust and patient empowerment, it is a practice that can lead to patients averting what could have been costly medical errors by their identification of incorrect or missing information (such as an allergy). Involving patients and their loved ones in important aspects of care, including medication verification, prepares them to be discharged, well-equipped to manage their care at home. Responding promptly to call lights not only provides reassurance to patients, but it may also mean that a patient does not jeopardize their own safety by attempting to make it to the bathroom on his or her own. All of these practices are part of a comprehensive culture of patient-centered care, and while they all may be "nice," they are first and foremost, **important**. In its national patient safety goals, The Joint Commission has recognized the involvement of patients and families as a key patient safety strategy, stating:

> Communication with [patients] and families about all aspects of their care, treatment or services is an important characteristic of a culture of safety. When [patients] know what to expect, they are more aware of possible errors and choices. [Patients] can be an important source of information about potential adverse events and hazardous conditions.[2]

Providing consumer-responsive, patient-centered care is also increasingly important from a financial standpoint, and will become even more so if the Centers for Medicare and Medicaid Services introduces value-based purchasing, tying reimbursement to a number of measures, including performance on the HCAHPS patient perception of care survey.

MYTH #3: PROVIDING PATIENT-CENTERED CARE IS THE JOB OF NURSES.

This, in and of itself, is not a myth. What is a myth, however, is that providing patient-centered care is *exclusively* the job of nurses. On the contrary, implementation of patient-centered care is akin to a complete transformation of organizational culture and its success requires buy-in and involvement from every department, clinical and non-clinical, and every tier of the organization, from front-line staff to the medical staff and governing board.

In patient-centered hospitals, caring for patients is not just a function of nursing, it is a function of every staff member, whether they be a housekeeper changing linens, a billing specialist reviewing a patient's balance, a dietary aide delivering a patient tray, a librarian compiling a diagnosis-specific information packet, a maintenance person shoveling snow from the sidewalk, an infection control coordinator monitoring for hand hygiene, or a public relations specialist coordinating a community event. *Every* staff member in a patient-centered hospital is a caregiver, and accordingly every staff member is expected to be responsive to patient and family needs, which may mean personally escorting a visitor to their destination or alerting a nurse when a patient has a clinical concern.

Recognizing that every person on staff contributes in some way to the overall patient experience reinforces that patient care is a team effort. If a patient is met by a cold or disinterested admitting clerk upon arrival, for instance, it will not matter how kind and compassionate the nursing staff is; the impression has already been made. On the other hand, in patient-centered

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[2] (The) Joint Commission (2008). <u>2008 National Patient Safety Goals Manual Chapter</u> Chicago : The Joint Commission. Accessed August 21, 2008, from [http://www.jointcommission.org/NR/rdonlyres/71E4800A-8C31-46D9-B6C8-E8BD0818B3E1/0/08_DSC_NPSGs_Master.pdf].

hospitals, staff of all disciplines leave positive and lasting impressions because they are empowered as caregivers to go above and beyond their basic job description to enhance the patient experience in whatever ways they can. *"Is there anything more that you need?"* is a question asked not only by nurses, but by any staff member who interacts with a patient and/or their family.

Because providing patient-centered care is a universal responsibility within the hospital, the implementation of patient-centered care needs to be inclusive of staff from all areas of the hospital, with representation on patient-centered care committees from nursing, administrative personnel, ancillary departments, and the medical staff. It is only with this broad base of input and engagement that the complete patient experience can be considered—from arrival in the parking lot through discharge and care transitions. This also reinforces that responsibility for patient-centered care does not fall on the shoulders of one, but on many, and cultivates a wellspring of patient-centered care champions throughout the organization.

Strategies for engaging leadership, staff, physicians, volunteers, and patients and families will be described in Section VI.

MYTH #4: TO PROVIDE PATIENT-CENTERED CARE, WE WILL HAVE TO INCREASE OUR STAFFING RATIOS.

Somewhere in between the notions that patient-centered care requires an infusion of money and resources, and that patient-centered care is all about nurses, is the myth that hospitals will have to increase their staffing ratios to accommodate the additional time staff will be administering to patients. This reasoning is based on the assumption that nursing staff in patient-centered hospitals devote more time meeting the needs of patients, which increases their workload. The experiences of several hospitals implementing models of patient-centered care demonstrate that this assumption is erroneous, and in fact, the converse may be true: that nursing time is actually decreased. For example, open medical records are a hallmark of the patient-centered approach to care. Patients are informed about having access to their record and staff set aside time to go over and explain those sections of interest to the patient. In hospitals implementing this policy, nurses find that rather than increasing their work, they save time by fielding questions all at once, cutting back on time spent responding to multiple calls and questions spaced throughout the day.

That patient-centered care does not necessitate an increased amount of resources for bed-side care is also borne out by data. In a discussion with four hospitals that have successfully implemented patient-centered care for more than five years, each found that both their RN staffing ratios and hours per patient day had not changed after their adoption of a patient-centered care approach. In fact, their data from surgical, medical, step down and maternity units all fell within the range of similar hospitals published in the Annual Survey of Hours Benchmark Report.[3]

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[3] Suby, C. (2008). "2007 Survey of Hours Report. Direct and Total Hours Per Patient Day (HPPD) By Patient Care Units." <u>Perspectives on Staffing and Scheduling</u>. Bloomington, MN.

Additional confirmation comes from recent research that compared a hospital that had adopted a patient-centered approach to other hospitals within the same system. Over the course of the patient-centered care implementation (a five year period), the patient-centered care unit was able to reduce the higher cost RN hours by using more lower cost clerical and aide/LVN hours, compared to an increase in these higher cost RN hours by the other hospital units.[4]

MYTH #5: PATIENT-CENTERED CARE CAN ONLY BE TRULY EFFECTIVE IN A SMALL, INDEPENDENT HOSPITAL.

With its emphasis on personalized care, patient-centered care may seem impractical, or even impossible, in a large institution or an integrated health system. Today, though, even some of the country's largest hospitals and systems are recognizing the need to complement clinical excellence with a superior patient experience.

To overcome the challenges presented by organizational size and scope, many of these larger institutions and systems opt to use a phased approach. Aurora Health Care, a fourteen-hospital, 120+-clinic system out of Milwaukee, Wisconsin, has developed a standardized four-phase process for implementation that focuses on leadership engagement, patient and staff input and identification of areas for improvement, staff engagement and continuing innovation. While every system entity will ultimately go through each phase of implementation, the process leaves ample room for customization to meet the specific and expressed needs of a particular site's key stakeholders. Each site's culture change endeavors are guided by the system, but ultimately it is the leadership at each site that is accountable for their outcomes. Among these individual entities, though, it has been important to also emphasize the collective, system-wide commitment to patient-centered care, which has meant sharing both best practices and struggles among sites, communicating consistently (both internally and externally) about patient-centered care, and setting common behavioral expectations. The Aurora system has made system implementation of the Planetree model of patient-centered care part of its ten-year long term strategy.

At the Cleveland Clinic, the system-wide *Patients First* initiative is being spearheaded by a new division, the Office of Patient Experience, created exclusively to focus on the patient experience. Led by the Chief Experience Officer, physician and nurse Experience Officers are also appointed in every institute within the system and within every regional hospital in the system. In addition, a Patient Experience, Quality and Safety Committee of the Board of Trustees has been formed to bring even greater support and visibility to this effort enterprise-wide.

The University HealthSystem Consortium (UHC), an alliance of academic medical centers, their affiliated hospitals and associated faculty practice groups, recently conducted a benchmarking study with 26 of its members aimed at identifying common strengths and opportunities as they relate to patient-centered care in the academic medical center setting. This benchmarking study was followed-up by an implementation collaborative to address the opportunities for improvement identified. *The Executive Summary of UHC's Patient- and Family-Centered Care 2007 Benchmarking Project is included as a tool at the end of this section, along with a Strategy*

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[4] Stone, S. (2008). "A Retrospective Evaluation of the Impact of the Planetree Patient Centered Model of Care Program on Inpatient Quality Outcomes." <u>Health Environments Research and Design Journal</u>, 1(4):55-69.

Map that outlines approaches organizations can use to transform their organizational culture to be more patient-centered. See page 34-38.

The Illinois Hospital Association also conducted a collaborative designed to help member hospitals enhance patient-centered care in 2007, which included both large and small hospitals and health systems.

MYTH #6: WE MAY THINK PATIENT-CENTERED CARE IS AN EFFECTIVE MODEL FOR CARE DELIVERY, BUT THERE IS NO EVIDENCE TO PROVE IT.

In an industry where evidence-based practice is the standard, systematic and rigorous study of the components of patient-centered care will go a long way in paving the way to more widespread adoption of such models. While considerable opportunities exist to build upon this growing evidence base, the foundation for this work has begun. A bibliography of research and evaluation projects designed as a companion to this Guide will be available on the Planetree (planetree.org) and Picker Institute websites (pickerinstitute.org).

Although the bibliography focuses on traditional published "evidence," each organization should also take into account its own organization-specific evidence when considering implementation of patient-centered care. What are your patients, families, and staff telling you they need? For some practices, compelling quantitative evidence is available from traditional research methods, but in other cases the most compelling "evidence" that a practice is beneficial in your organization may be the qualitative perspective of your patients, families, and staff, coupled with experience and common sense.

MYTH #7: MANY PATIENT-CENTERED PRACTICES COMPROMISE INFECTION CONTROL EFFORTS, AND THEREFORE, CANNOT BE IMPLEMENTED.

Fundamentally, patient-centered care must be safe care, and any new practices being explored should be thoughtfully and rigorously examined through the lens of patient safety. A common stumbling block for hospitals introducing a patient-centered approach are concerns with regard to infection control, specifically around practices like open visitation, animal visitation, the installation of fish tanks in public gathering areas, and the introduction of carpeting, water features and live plants. In fact, Windber Medical Center in Windber, Pennsylvania has incorporated almost every one of these elements and yet the hospital's infection rate is less than one percent. Clearly, opportunities exist to create a vibrant and healing environment without compromising infection control efforts.

Concerns about the spread of infection are a common barrier to lifting traditional restrictions on visitation. A recent study focused on the particularly vulnerable population of ICU patients concluded, however, that "restricting visiting hours might be unjustified and unnecessary for protecting the sickest patients in the ICU because it does not reduce the rate of infectious

complications."[5] It should further be clarified that open visitation does not call for the universal elimination of all visitation limitations. Certainly, in cases of communicable disease or when the risk of infection is particularly high, precautions (such as providing gowns) and/or limitations may be necessary. In all cases, however, communication to the patient and family of the concerns and the rationale for any limitations and/or precautions is of paramount importance.

Just as risk of infection need not be a barrier to lifting restrictions to visits from people, nor does it need to be a reason for restricting visitation of animals. Numerous studies document the therapeutic value of pet visitation programs[6,7] and others have found that the introduction of dogs into the hospital did not increase infection rates.[8] Policies for pet therapy programs must specify grooming and health criteria, and oftentimes certification requirements that animals must meet prior to being invited into the hospital.

Beyond developing policies and procedures to limit the possible spread of infection from some of these practices, it stands to reason that a culture of patient-centered care could actually enhance efforts at infection control. When patients and providers work together in partnership, and when communication is open and trusting, sensitive conversations may be approached more easily. For instance, in many hospitals patients are advised to ask their providers if they have washed their hands. For patients, this may feel awkward and uncomfortable, so much so that they do not ask the question.   In a patient-centered hospital, however, a foundation of mutual respect and partnership means such a conversation can be initiated in the spirit of partnering for quality patient care, rather than an accusation. One patient-centered hospital has taken this spirit of partnership even further, engaging patients as "mystery shoppers" to monitor staff's hand hygiene practices.

Finally, since preserving and maintaining patient privacy is a priority of patient-centered care, many patient-centered hospitals opt to make the change from semi-private, shared rooms to private rooms, which growing evidence suggests is not only a patient-satisfier, but also decreases the incidences of hospital-acquired infections.[9]

MYTH #8: THE FIRST STEP TO BECOMING A PATIENT-CENTERED HOSPITAL IS RENOVATION OR CONSTRUCTION.

A healing physical environment is just one of several key aspects of a patient-centered approach to care, and many hospitals in outdated, space-challenged facilities have nonetheless managed to create remarkably healing environments by introducing music, humor, artwork, aromatherapy, pet visits and the like, all at a low cost, but yielding a high impact. Section VII.F. of this Guide presents a number of such strategies.

[5] Fumagalli S, Boncinelli L, Lo Nostro A, Valoti P, Baldereschi G, Di Bari M et al. (2006) "Reduced cardiocirculatory complications with unrestrictive visiting policy in an intensive care unit." Circulation 113:946–952.

[6] Cangelosi, P. R. and C. N. Embrey (2006). "The healing power of dogs: Cocoa's story." J Psychosoc Nurs Ment Health Serv 44(1): 17-20.

[7] Edwards, N. E. and A. M. Beck (2002). "Animal-Assisted Therapy and Nutrition in Alzheimer's Disease." West J Nurs Res 24(6): 697-712.

[8] Caprilli, S. and A. Messeri (2006). "Animal-Assisted Activity at A. Meyer Children's Hospital: A Pilot Study." eCAM 3(3): 379-383.

[9] Ulrich, R.S. and others (2008). "A Review of the Research Literature on Evidence-Based Healthcare Design (Part II)." Health Environments Research and Design Journal, 1(3), 61-125.

For one hospital on Long Island, New York with a rundown physical plant and limited financial resources to undertake facility improvements, a staff-led "Extreme Makeover" competition provided a fun, low-cost way to spruce up areas of the facility. With a budget of $1,000 per department, and their own creativity to spur them on, staff from several departments transformed their spaces. Over a twelve-month period, eight departments underwent an "extreme makeover," using only volunteer labor and their budgeted $1,000. Their renovations helped to eliminate clutter, resolve regulatory issues, improve work flow, and create a cleaner, brighter, more welcoming space, while also improving staff morale and fostering a sense of team work and collegiality.

MYTH #9: PATIENT-CENTERED CARE IS THE "MAGIC BULLET" I'VE BEEN LOOKING FOR TO _____. (IMPROVE PATIENT SATISFACTION, IMPROVE EMPLOYEE MORALE, ENHANCE REVENUE STREAMS, ETC.)

As addressed in Section IV of this Guide, patient-centered care is far from a "magic bullet." It is not a set of practices that when implemented according to a strict prescription will alter the experience of your patients, their families and your staff. For while such "magic bullet" changes are possible in the short term, they are not sustainable. Patient-centered care is about changing culture, not moving data points, and that requires a long-term commitment and understanding that change of this magnitude is gradual and not without its setbacks and challenges.

This long-term and steadfast approach may be a culture shift in and of itself. Employees in many hospitals have become accustomed to, and often disillusioned by, "flavor of the month" initiatives that are launched with much fanfare only to disappear when results do not materialize quickly enough. By communicating—and "walking the talk"—that patient-centered care is *not* a magic bullet, but rather a steady and measured effort toward comprehensive culture change, hospital leadership will set this effort apart from previous improvement endeavors that may have left staff feeling deflated and skeptical.

This "journey approach" also means that there are always opportunities for improvement, no matter how long your organization has been on the path to patient-centeredness. Sustaining a patient-centered culture demands adaptability and flexibility to meet the needs and expectations of your patients, families and staff—needs that will inevitably evolve over time. Patient-centered hospitals recognize that the goal is not to reach the destination, but to continue approaching it.

MYTH #10: WE CAN'T IMPLEMENT A SHARED MEDICAL RECORD POLICY. THAT WOULD BE A VIOLATION OF HIPAA.

Inviting a patient to read his or her medical chart is not only *not* a HIPAA violation, it is, in fact, **a patient right**, recognized by both federal and state law.

Patient-centered hospitals optimize the opportunities for education and communication that arise when a patient reads his or her chart by ensuring they understand the information contained and

have the opportunity to ask questions about its implications on their health, lifestyle, or prognosis.   Of course, patient privacy and confidentiality are of paramount importance, and a review of the medical record should only be done privately with the patient, or with loved one(s) whom the patient has expressly identified as those with whom such information can be shared. To protect patient confidentiality, only the patient has access to his or her medical record. If the patient would like a family member to have access to the chart, he or she can sign a form, releasing medical information to the designated person.

MYTH #11: WE HAVE ALREADY RECEIVED A NUMBER OF QUALITY AWARDS, SO WE MUST BE PATIENT-CENTERED.

Although patient-centered care is a core foundation for quality, the presence of award-winning clinical outcomes does not necessarily imply patient-centeredness. Many quality awards continue to focus solely on the outcomes of care, without considering the way in which the care is delivered. This distinction is not lost on patients faced with the choice of being treated at a highly-regarded, clinically renowned institution versus a lesser-known hospital with a reputation for patient-centered care. Anecdotes abound of patients opting to receive care at the site where they expected to receive comparable clinical care, but a superior patient experience.

The development, implementation, and national public reporting of HCAHPS survey results has raised the visibility of the patient experience to a new level. The forces of health care consumerism are now compelling even some of the nation's "best" hospitals to reconsider how well they are doing on areas other than clinical outcomes. With value-based purchasing and new patient-centered mandates from The Joint Commission on the horizon, patient-centered care is rapidly becoming a business imperative.

Despite these pressures, in some organizations the dichotomy persists that patient-centered care is essentially customer service "window dressing" on the more important clinical aspects of care. The patient safety literature highlights the fallacy in this thinking—by promoting effective communication and partnerships between and among patients, family and staff, a patient-centered approach can take quality and safety to new heights. As the Institute of Medicine has acknowledged, "[p]atient-centered care that embodies both effective communication and technical skill is necessary to achieve safety and quality of care." Patient-centered care is not separate from or less important than quality, it is an essential part of it.

MYTH #12: OUR PATIENTS AREN'T COMPLAINING, SO WE MUST BE MEETING ALL THEIR NEEDS.

Even for hospitals that are top performers in patient satisfaction, opportunities for improvement exist. While it is no doubt gratifying to report high percentages of patient satisfaction "always" ratings, perhaps more useful is to drill down into those survey questions where patients have responded "sometimes" or "never." Another strategy for identifying perhaps overlooked and unmet patients needs is to complement traditional patient satisfaction surveys with patient rounding or focus groups. These qualitative approaches provide opportunities for dialogue, moving beyond standard "always," "sometimes" and "never" responses to the sharing of

complete stories that may very well shed light on areas for improvement not identified previously through the survey process. A Patient and Family Advisory Council can serve as a group by which hospital personnel can test new ideas and is an ongoing source of input into hospital programs and practices.

Furthermore, just because patients are not complaining, does not mean that all their needs are being met. Despite the industry's preparation for a more discerning and empowered patient population, patient focus group comments underscore that hospitalization is a scary and overwhelming time when a patient may feel unsure about what to expect or what to ask, may fear reprisal if a suggestion for improvement is made or dis-satisfaction is expressed, or may simply be glad to be discharged, never looking back to consider *what could have been better about my stay*?

The truth is that there is no such thing as being *too good* at meeting patients' needs. There are always opportunities for improvement, and engaging your patients, families and staff in identifying where those opportunities are is an ideal first step toward becoming *more* patient-centered. Section VI of this Guide presents a number of strategies for engaging patients and families in organizational performance improvement efforts as a strategy for understanding and being responsive to the full range of patient needs.

MYTH #13: WE'RE ALREADY DOING *INSERT NAME OF MODEL* , SO WE CAN'T TAKE ON PATIENT-CENTERED CARE.

Health care organizations have a well-deserved reputation for adopting models and then rapidly changing them, leaving staff confused and frustrated by shifting priorities and demands. Overwhelmed staff members are understandably reluctant to embrace new initiatives that seem to be just one more thing to do and leaders sometimes express concern about how patient-centered care will interact with other operational initiatives. The beauty of patient-centered care is that it is an enduring philosophy that transcends any "flavor of the month." Recognizing and responding to the needs of your patients, families, and staff, promoting effective partnerships and open communication, and acknowledging all staff as caregivers will affect all aspects of hospital operations in a way that complements and enhances any other initiatives. Many organizations that have grown and sustained a patient-centered culture find it difficult to articulate precisely what they "do" that is patient-centered, because it has long since become "who they are" rather than a task list. Whether they are participants in another program, Baldrige award winners, Magnet hospitals, or organizations striving to achieve another goal, they approach all of these things from a patient-centered perspective.

MYTH #14: BEING PATIENT-CENTERED IS TOO TIME-CONSUMING. STAFF IS STRETCHED THIN AS IT IS.

Few health care professionals entered the field for the documentation, administrative duties and meetings that today are consuming much of their time. Patient-centered care provides a framework for enabling staff to do the work they likely entered the health care profession to do—caring for patients, interacting with and supporting families, and developing supportive,

mutually beneficial relationships with colleagues. Furthermore, with its focus on anticipating needs, a patient-centered approach has the potential to reduce the time- and emotionally-intense interactions that occur when patients feel alienated, disempowered, and upset that their needs are not being met.

Ultimately, many staff have discovered that patient-centered practices have saved them time. For instance, in one hospital, initial fears about the time it would take to educate family members as Care Partners to participate in patient care were unfounded. In fact, nurses have found that because Care Partners are able to respond to simple patient requests like a glass of water, their jobs are, in fact, made easier.

UHC Patient- and Family-Centered Care 2007 Benchmarking Project, Executive Summary and Strategy Map

UHC University HealthSystem Consortium

Executive Summary

Patient- and Family-Centered Care 2007 Benchmarking Project

This benchmarking study on patient- and family-centered care (PFCC) was conducted to help University HealthSystem Consortium (UHC) members (1) pinpoint their PFCC strengths and improvement opportunities, (2) identify useful metrics for monitoring progress toward PFCC goals, (3) develop an aggregate database of PFCC practices in academic medical centers, and (4) discover how organizations are successfully implementing PFCC's core concepts to address the principles of quality care as outlined by the Institute of Medicine (IOM). Twenty-six organizations participated in the PFCC survey and assessment; 6 organizations—MCG Health, Inc., Vanderbilt University Medical Center, University of Washington Medical Center, University of Colorado Hospital, The Methodist Hospital (Houston), and Denver Health—were interviewed about their PFCC practices and initiatives.

What Is PFCC?

The Institute for Family-Centered Care defines *patient- and family-centered care (PFCC)* as "an innovative approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care patients, families, and providers."[1] The core concepts of PFCC include dignity and respect, information sharing, participation in care decisions, and collaboration (Figure 1).

The successful implementation of PFCC concepts within a health care setting requires a true paradigm shift. Collaborative partnerships with patients and families are needed, with the goal of improving safety, quality of care, and operational efficiency. Within this paradigm shift, patients and families must be viewed as equal and important members of the health care team.

Core Concepts of Patient- and Family-Centered Care

- **Dignity and Respect:** Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care.
- **Information Sharing:** Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision making.
- **Participation:** Patients and families are encouraged and supported in participating in care and decision making at the level they choose.
- **Collaboration:** Patients and families are also included on an institution-wide basis. Health care leaders collaborate with patients and families in policy and program development, implementation, and evaluation; in health care facility design; and in professional education, as well as in the delivery of care.

Figure 1 – Source: Institute for Family-Centered Care

Why Is PFCC Important?

The senior leaders of UHC member organizations selected PFCC as a topic of great importance for a number of reasons. Beginning in late 2007, hospitals throughout the United States will be required to publish satisfaction data on the Medicare Web site to receive full Medicare reimbursement. The publication of this information is necessary because the perceptions and experiences of patients and families are at the core of health care and affect quality, safety, financial performance, market share, and staff and customer satisfaction.

Embracing PFCC also increases patient safety. Organizations such as Vanderbilt University Medical Center have aligned their organization-wide safety goals with PFCC goals as they work to build an organizational culture based on PFCC concepts.

In addition to Medicare, many health care professional, regulatory, and quality improvement organizations, including the IOM, the American Hospital Association, The Joint Commission, and the Accreditation Council for Graduate Medical Education (ACGME), support or require implementation of PFCC concepts. Patient centeredness is included in the IOM's "Six Aims for Healthcare Improvement."[2] According to the IOM, health care should be based on continuous healing relationships and should provide individualized care that encourages patients to be involved in their own care decisions. Better access to information for both patients and families is needed to realize true patient centeredness. The IOM has developed 10 rules for health care[2]:

- Care is based on continuous healing relationships.
- Care is customized according to patient needs and values.
- The patient is the source of control.
- Knowledge is shared and information flows freely.
- Decision making is evidence-based.
- Safety is a system property.
- Transparency is necessary.
- Needs are anticipated.
- Waste is continuously decreased.
- Cooperation among clinicians is a priority.

The American Hospital Association recognizes that the current health care environment is difficult for consumers to navigate and that patients and families are not universally involved in decisions made about their care.[3] The Joint Commission encourages patients to bring a trusted friend or family member to the hospital or clinic and has initiated the "Speak Up" campaign to urge patients

and families to take a role in preventing medical errors by becoming active, involved, and informed participants on the health care team.[4] Organizations have changed standards requirements to push PFCC forward. For example, as of July 2006, the ACGME required additional specificity for selected standards including interpersonal and communication skills.[5] Recently, the ACGME convened an advisory group that will evaluate patient-centered approaches to care and the relationship to resident education (written communication, "Charge to the ACGME Advisory Group on Patient-Centered Care," March 2007).

Implementing PFCC Is a Business Decision

The decision to shift a health care organization's culture to embrace PFCC concepts is a business decision. Recent changes at MCG Health, Inc., model this decision (see sidebar). Changing practices can improve the work environment, increase patient safety and satisfaction, and ultimately increase market share. At MCG, leaders feel that the commitment to PFCC and improved communication is a significant factor in the dramatic decrease in malpractice suits they have experienced in recent years (Figure 2).

Disconnect Exists Between PFCC Goals and Improvement Efforts

The majority of UHC organizations participating in the benchmarking project indicated that PFCC is part of the organization's mission (65%) and that PFCC is included in strategic planning (68%). However, 68% of organizations also responded "none" or "unknown" when asked about the annual budget for PFCC initiatives. Forty-two percent agreed that PFCC is part of the philosophy of care, but none of the organizations included patients and families in the development of that philosophy. Only 36% of responding organizations include PFCC in job descriptions and performance evaluations. Only 1 in 5 participants has created a paid patient and family leader position within the organizational structure.

Organizational Characteristics Vary With PFCC Status

All of the surveyed organizations are engaged in PFCC implementation. For about one third of the organizations, implementation is in the early stages; the majority (68%) reported partial implementation of PFCC concepts in selected locations. Analysis of self-assessment survey data suggests that there is a maturation cycle as organizations move to promote a patient- and family-centered culture. For example, organizations that have partially implemented PFCC concepts in selected

PFCC in MCG's Neurosciences Unit

When MCG began implementing PFCC in its neurosciences area, patient satisfaction and staff morale were extremely low. Patient and family advisers worked with caregivers to solve problems—including consulting on facility design and interviewing all staff members and physicians. Every staff member signed a commitment to PFCC concepts. Dramatic improvements in staff turnover, patient safety, and length of stay were seen almost immediately. Most notably, the department's Press Ganey satisfaction scores increased from the 10th to the 95th percentile, and its market share increased by 12% in 3 years. (See the MCG case study for more details.)

Recent Trends in Malpractice Litigation at MCG Health, Inc.

Figure 2 – Source: MCG Health, Inc.

Executive Summary

locations are more likely to have written procedures and policies in place for family presence and participation than organizations that have just begun implementation (65% vs 31%, respectively) and to include patient and family advisers in facility design (50% vs 13%).

Leadership Strategies Can Facilitate PFCC Implementation

The benchmarking project identified several leadership strategies that can help facilitate implementation of PFCC core concepts within health care organizations. Organizations must collaborate with patient and family advisers to incorporate PFCC concepts into the institution's mission, vision, values, plans, safety initiatives, philosophy, and scope of care. A paid patient and family leader (supported by appropriate budget and resources) who has primary responsibility for overseeing, coordinating, and implementing PFCC initiatives across the enterprise can be a valuable advocate for PFCC. Leaders and providers, including outsourced service and equipment vendors, administrative leaders, and caregivers and medical staff, must subscribe to and practice PFCC concepts, serving as role models for other staff members. Finally, staff and providers must be held accountable for achieving and maintaining PFCC goals; job descriptions, evaluations, credentialing procedures, and contracts should all include PFCC concepts.

For More Information

To find the project documents for the Patient- and Family-Centered Care 2007 Bench-marking Project, log in to the UHC Web site at www.uhc.edu and go to the Benchmarking & Improvement Services area. Resources available include:

- Knowledge transfer meeting presentations
- Complete survey results
- Innovative strategies
- Action Plan
- PFCC listserver
- Information about the PFCC Implementation Collaborative

The Next Step Is Yours

Becoming a patient- and family-centered organization requires visionary leadership and a commitment to changing the organization's culture to view patients and families as equal members of the care team with the right to participate in decisions affecting the planning, delivery, and evaluation of care. It also requires a change in the mindset of the organization's leaders, clinicians, and staff. If your inclination is to dismiss the concepts and practices described here as "too impractical and expensive," think about how much it costs to *not* do these things. How expensive are medical errors and malpractice litigation? How much are you spending on service recovery and staff turnover? How much is spent on rework because of failure to understand patients' and families' needs and perceptions? How much would it be worth in market share to have loyal, satisfied customers and a stable, happy work force?

For more information about this project, log in to the UHC Web site at www.uhc.edu and go to the Benchmarking & Improvement Services area, or contact the project manager, Kathy Vermoch, at (630) 954-1030 or vermoch@uhc.edu.

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Patient- and Family- Centered Care Strategy Map

This Strategy Map outlines approaches that organizations can use to change organizational culture and implement the core concepts of patient- and family-centered care (PFCC).

What Is PFCC?

The Institute for Family-Centered Care defines *patient- and family-centered care* as "an innovative approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care patients, families, and providers."[1] The core concepts of PFCC are dignity and respect, information sharing, participation, and collaboration.

Challenges

- Health care providers are now required to publicly report outcomes and satisfaction data to receive maximum reimbursement and appropriate pay for performance.
- Organizations that have implemented PFCC concepts report improved outcomes such as fewer medical errors, improved patient satisfaction, and cost savings.
- Professional and regulatory organizations such as the Institute of Medicine, the American Hospital Association, and The Joint Commission endorse patient and family centeredness to promote safety, transparency, information sharing, and patient/family involvement in decision making.

The bottom line: The culture of health care must evolve to view patients and families as equal and important members of the care team with the right to participate in the planning, delivery, and evaluation of care.

What Was Studied

- Benchmarking program members (N = 26) completed a PFCC survey and organizational self-assessment.
- Project participants submitted 70 reports of innovative strategies implemented.
- PFCC-related health care literature was researched.
- The leaders of 6 organizations were interviewed about their PFCC practices: MGC Health, Inc., Vanderbilt University Medical Center, University of Washington Medical Center, University of Colorado Hospital, The Methodist Hospital (Houston), and Denver Health.

Project Focus/Objectives

- To assist UHC members in identifying their PFCC strengths and improvement opportunities
- To identify useful metrics for monitoring progress in achieving PFCC goals
- To develop an aggregate database of PFCC practices in academic medical centers
- To discover how organizations are successfully implementing PFCC's core concepts to address the principles of high-quality care as outlined by the Institute of Medicine

PFCC Leadership Strategies

- Partner with patient and family advisers to incorporate PFCC concepts into the organization's mission, vision, values, plans, safety initiatives, philosophy, and scope of care.
- Senior leaders should model PFCC concepts, make resources available, and hold staff accountable for achieving and maintaining PFCC goals through job descriptions, evaluations, credentialing procedures, and contracts.
- Create a paid patient and family leader position (supported by appropriate budget and resources) with responsibility for overseeing, coordinating, and implementing PFCC initiatives throughout the enterprise.
- Conduct an organizational self-assessment to identify and prioritize PFCC improvement opportunities. Select performance measures (including satisfaction, safety, and outcomes measures), collect baseline data, and monitor performance. Collaborate with patient and family advisers to interpret the data and design improvements, then implement changes and share the results across the organization.
- Work with early adopters and share success stories to incrementally implement PFCC concepts across the organization, including often-overlooked areas such as ambulatory care, outsourced services, scheduling and registration, and billing and payment procedures.
- Recruit one or more physician champions to incorporate PFCC concepts into education; encourage the use of patient and family advisers as faculty to train doctors, residents, caregivers, and other staff.
- Constantly ask, "Have we gotten patient/family input on this plan?" before beginning to interpret data or design and implement changes.

PFCC Core Concepts

Dignity and Respect

Partner with patients and families to:

- Put processes in place to ensure that staff always introduce themselves and explain their roles in the patient's care.
- Implement policies and procedures that recognize and respect the cultural and lifestyle needs of patients and families.
- Encourage family participation as part of the care team and train staff to listen to and respect the opinions of patients and families.
- Implement organization-wide practices to ensure privacy and confidentiality for patients and families.

Participation

Partner with patients and families to:

- Implement effective procedures for the competent, mature patient to define his or her family and to declare preferences for involvement.
- Offer open (24/7) visitation; *never* treat families as "visitors."
- Adapt procedures to accommodate patient preferences regarding family presence during care delivery (including painful, invasive, and emergency procedures).
- Use scenarios, scripting, and examples from other academic medical centers to train staff and address their concerns about potential problems that could arise from open visitation and family participation.

Information Sharing

Partner with patients and families to:

- Establish policies and practices encouraging patients and families to share information as equal members of the care team, including participation in rounds, goal setting, safety initiatives, and care decisions.
- Give patients and families easy and timely access to educational and personal health information and the medical record.
- Implement electronic and other systems to facilitate communication, information sharing, and education.
- Routinely follow up with patients and families to ensure that care instructions are understood and determine whether additional support is needed.

Collaboration

Partner with patients and families to:

- Develop one or more functional patient/family advisory councils that meet at least quarterly, include senior leaders, and make recommendations to the leadership.
- Encourage patient and family adviser input and participation in committees and other initiatives. Pair up administrators and advisers to conduct environmental rounds.
- Design a healing, supportive environment that includes family resource centers, sleeping spaces, training labs, and easily understood signage. Include patient and family advisers in all phases of planning and designing construction and remodeling projects.
- Involve patient and family advisers in the selection of leaders and providers who practice PFCC concepts, including administrators, caregivers, residents, and staff.
- Develop understandable educational materials and include patients and families as faculty for training programs designed for patients, families, board members, caregivers, residents, and all staff. Ask patients, families, and staff to share their (positive and negative) health care experiences, because stories change culture.

Action Plan

To implement the tactics listed in this Strategy Map, use the Patient and Family-Centered Care Action Plan. This workbook can be used to identify actions needed, instructions, responsible parties, due dates, completion dates, and results/comments. To find the Action Plan and other project documents, including the field book, innovative strategies, knowledge transfer meeting presentations, Web conference recording, survey results, and the sample Performance Opportunity summary and Scorecard, log in to the UHC Web site at www.uhc.edu and go to the Benchmarking & Improvement Services area.

UHC's 2007 PFCC Implementation Collaborative (including a listserver) is also available for networking and sharing information with colleagues. Additional resources are available from the Institute for Family-Centered Care at www.familycenteredcare.org.

Contact the project manager, Kathy Vermoch, at (630) 954-1030 or vermoch@uhc.edu for more information about UHC's Patient- and Family-Centered Care initiatives.

Goal

An efficient, safe, and high-quality health care organization with mutually beneficial partnerships among patients, families, and providers.

SETTING THE STAGE, STRENGTHENING THE FOUNDATION:
Strategies for Engaging Leadership, Staff, Physicians, Volunteers, Patients and Families

> *"I had a catheter and a morphine pump, so I needed something to put everything on and I was told the equipment was broken. Then another nurse came in and said I had to excuse this one nurse because she doesn't like to be asked more than once. The residents started to grumble that their instructions are never followed by this particular person on this floor. That says to me that there's something that needs to be looked at…If it was just my perception, that's one thing, but if everyone sees it, it is something that needs to be addressed."*
> (patient comment)

At the heart of providing patient-centered care are the interactions that occur within a health care organization with patients, with families and among colleagues. That means, then, that it is those individuals who are having those interactions—staff, physicians, administration, volunteers and board members—that are the drivers of any effective patient-centered approach. They are the faces of patient-centered care, and as such, they can be your greatest champions. When engaged, they are capable of generating enthusiasm, sustaining momentum and truly embodying the values of patient-centeredness. On the other hand, when not appropriately given a voice and a role in the culture change, and when not held accountable for their behaviors, these key stakeholders can be the greatest impediments to sustainable change.

In discussing strategies for setting the stage and strengthening the foundation for patient-centered care, there is no more important place to start than efforts to engage these key stakeholders. Inspiration, education, communication and revitalization are all necessary components of a coordinated approach for understanding and responding to the needs, expectations, hopes and dreams of all these groups that comprise the hospital community.

The Patient Perspective:

"I think human touch and the compassion can really aid in healing…You know when my daughter was bit, the nurse held her on her lap and rocked her and that really calmed her down… she stroked her head and that really made a difference."

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"My experience is that on the front end they welcome you when you get here, and they really introduce themselves. That end was wonderful. They were personable, sincere, and compassionate…They come along with the old- fashioned approach to taking care of the patient, being sure you were comfortable and calm you at your bedside. I felt like I was their father."

"If they took their time, spent more time with the patients, explained things and not be so rushed… And some warmth and compassion would go a long way."

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"The first person that I met in registration was very compassionate and comforting as I was so anxious."

The Staff Perspective:

"When I first came to [this hospital] it was sort of a nice place, but now I really feel that I can practice the way I've always wanted to."

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"I worked in other places with turf and rules, rules, rules; whereas here we're encouraged to take time to help people. We're even told [to] take a breather when you're helping somebody else."

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"My background is as an LPN. Before, when I was here, there was always someone sniping at someone else if they did something. Now they say thank you…it sounds small, but it's a huge change."

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"For me it's the way I was welcomed, the way staff interacts with each other and patients and families. We're so much more compassionate, even though we are still trying to collect the money."

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"The most important thing to me is a pat on the back from a co-worker. We have a good strong sense of community among ourselves."

The Leadership Perspective:

"We're still making the journey to get towards the position where the people, the public are the driving force of the health care system. And the people who work in it are basically providing a responsive service. And helping them to make that journey is hugely important. Giving them the tools, as it were, the bullets to fire, which at the end of the day will help you —all of us—deliver what they actually want." (Sir Donald Irvine, Picker Institute)

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"We want to create a culture of collaboration and respect, where everyone, the janitor, transporter, nurse and surgeon, are all valued and know that the purpose of their job is to help patients heal." (M. Bridget Duffy, M.D., Cleveland Clinic)

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"Unless we build strong working relationships between caregivers, we are never going to have good relationships with our patients." (Patrick Charmel, Griffin Hospital)

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"I always find units that have very high patient experience results, physician experience results, employee satisfaction results, have one common element which is a great leader. Quite frankly, it is the nurse leader who takes the whole paradigm of care and creates relationships with her staff, and creates a sense of community among all who serve patients on the unit." (Fred M. DeGrandis, Cleveland Clinic Regional Hospitals)

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"A person or a team can experience this great 'A-Ha!', but we find that we can't get the 'A-Ha' to work until there is a system in place to assure, via some means of accountability, that the concept or process is being executed. It takes continuous watchfulness to make sure that a change is happening before it finally becomes a natural element in day-to-day procedures. And once a change becomes natural and people see the value, we find we don't need so much oversight." (Marcia Hall, Sharp Coronado Hospital)

"How do we get [patient-centered care] from being this nice fringe benefit that is almost as important as real quality, to being recognized as intrinsic to real quality? Compensation is a good example of where you can embed it, performance appraisal, leadership development; but until it becomes part of all that, it's always going to feel like this nice superfluous thing that you put a lot of attention on when you have the time. And then, no one's got the time."
(Joel Seligman, Northern Westchester Hospital)

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"It is absolutely about leadership. It's not about how much you know, but how much you care. And you hit different units and you see it all the time but it starts at the top. The leader has to be out there leading…with your heart. And you've got to feel it… And you had better have the courage to step up and make changes and show your staff consistently that you're sincere about this." (Kenneth Mizrach, VA New Jersey Healthcare System)

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"One of my most significant insights was the value of early identification of those who have the passion for leading this kind of change, helping those who don't, but then making tough decisions early to separate from those who do not fit compatibly with our very special environment."(Richard A. Hachten II, FACHE, Alegent Health)

LEADERSHIP IN FOSTERING PATIENT-CENTERED CARE: WALKING THE TALK

Leaders determine, guide and communicate the vision of any organization, and as such, leadership engagement in any organizational culture change initiative is crucial. In their own behaviors and values, leaders set the tone for implementation of patient-centered care. *Walking the talk* means communicating openly, soliciting and responding to input from staff, patients, families and others, and ensuring staff members have the resources and flexibility they need to provide patient-centered care.

Building credibility as a champion of patient-centered care requires a leader to understand the hospital experience from both the patient perspective and the staff perspective. Many leaders at patient-centered hospitals accomplish this by spending considerable time "in the field." Leaders can schedule **frequent rounding on all shifts**, personalizing their discussions as they move through the organization to hear from patients and staff *first-hand* about what is happening on that particular day, on that particular unit, and so forth. The COO at Alegent Health at Midlands in Nebraska documents positive behaviors encountered during rounds, bringing a camera around in the departments and taking photos of what he finds inspiring. These photos are then used in presentations and newsletters to celebrate and reinforce patient-centered practices. Other sites enhance this rounding practice with **carts filled with snacks** for leaders to distribute to encourage interaction and dialogue between leaders and staff.

CEOs at high-performing patient-centered hospitals make the commitment to make themselves available to employees on an ongoing basis. **Fireside Chats** or **Chair Side Chats** are the equivalent of "office hours" wherein staff are invited to meet with leadership to share ideas or express concerns during established times. Fauquier Health System's **Breakfast with the President** is a quarterly event where a small group of employees is randomly selected from all areas of the hospital for breakfast. The program allows staff to initiate a dialogue on issues of concern, and provides an opportunity for leadership to hear different caregiver perspectives. Other patient-centered hospitals ensure every staff member's ability to participate in such a program at least once a year by coordinating invitations by birthday month or date of hire anniversary. Programs like these that provide opportunities for face-to-face dialogue between

leaders and staff also serve as antidotes to the misunderstandings that can result when communication occurs through multiple channels and relies primarily on indirectly relayed information rather than direct interaction.

Leadership's visibility and accessibility can, and should, begin at new employee orientation. **Welcomes or presentations by hospital leadership during orientation** ensure that new employees are familiar with leadership, emphasize leaders' commitment to patient-centered care, and set the stage for the cultivation of positive working relationships.

Leaders can also advance a patient-centered culture by routinely setting the context for meetings with a reminder of the organization's values or how every day caregivers are making a difference in the lives of patients. At Alegent Health out of Omaha, Nebraska, every meeting begins with a **mission moment**, oftentimes a patient or staff story, or perhaps the reading of a patient letter. This important agenda item establishes the tone for the rest of the meeting by making the point that all items up for discussion should be evaluated by their impact on the patient experience.

To clarify and support the organization's expectations of leadership, many organizations have developed **Leadership Development Institutes** that cover key aspects of patient-centered care, among them behavioral expectations for supporting a caring, respectful environment; accountability; behavioral interviewing and selection of the right staff; teamwork; generational differences; service excellence; and conflict resolution.

GETTING THE "RIGHT PEOPLE" ON BOARD

Another factor associated with success in patient-centered environments is that employees' behaviors consistently reflect the organizational values. Only when employees' personal values simulate the core values of the organization can the culture transform to a patient-centered care model. At Sharp Coronado Hospital outside of San Diego, California, every employee has completed the sentence **"I come to work to make a difference by…"** and the laminated statement is adhered to their name badge as a constant reminder that despite hectic schedules and piling paperwork, what they do is meaningful and is making a difference in peoples' lives.

Behavioral selection tools can be valuable resources for hiring employees whose personal values align with organizational values. *A sample candidate observation checklist that can be used during interviewing is included on page 64 as a resource.* New applicants exploring employment within the Alegent Health system first encounter an "electronic entryway" to the on-line application process that requires them to read and sign off on the system's core values in order to be eligible for consideration.

A particularly powerful way of fostering this alignment is by involving staff directly in determining the organizational values and defining the behaviors that exhibit the particular value. Fauquier Health System in Warrenton, Virginia goes one step further: 25% of every employee's annual performance evaluation is measured against how they consistently exhibit these **core values**. *A sample performance evaluation tool from Fauquier Health System is supplied on pages 52-57 as a resource.*

Another approach is to involve patients and families themselves in determining staff competencies to be reviewed during annual performance evaluations. When the University of Washington Medical Center in Seattle, Washington invited feedback from its Rehab Patient and Family Advisory Council while revising the unit's competencies for staff, it became evident how even small changes in the language could profoundly alter staff's understanding of the expectations for providing care in a patient and family-centered environment. Examples of changes made by patients included the following:

Original Duty and Responsibility	Patient/Family Centered Change
Able to assess patient pain interfering with optimal level of function or participation in rehabilitation – makes appropriate physician contact for intervention.	In discussion with the patient and/or family, assesses patient pain interfering with optimal level of function or participation in rehabilitation, makes appropriate provider contact for intervention.
Communicates appropriately and clearly to physicians, staff and administrative team.	Communicates, orally and in writing, appropriately and clearly to physicians, staff, patients and their families, the administrative team, and outside entities. Maintains records pertinent to personnel and operation of the department.
Coordinates and directs patient care to ensure patients' needs are met and hospital policy is followed.	Is attentive to ensure that the needs of patients and their families are met and hospital policy is followed. (For example: offering a glass of water, ensuring that the call light is accessible, etc).
New Professional Requirement recommended by Rehab PFAC	Introduces self and explains his or her role to patients and their families.

Refer to pages 58-61 for a sample job description that incorporates all of the new language recommended by the University of Washington Medical Center's Rehab Patient and Family Advisory Council. Also included on pages 62-63 are the University of Washington Medical Center's Guidelines for Inserting Patient and Family Centered Language into Competencies.

Making the organization's values prominently visible can serve to remind staff of the patient-centered behaviors expected of them, as well as to convey to patients and families what they can anticipate in a patient-centered environment. Many organizations have them posted in high-traffic areas, on employee name badges, and on their letterheads.

There will invariably be those employees who may exhibit behaviors that are inconsistent with the organization's core values, or worse are counter-productive to the patient-centered care goals. In these situations, leadership needs to intervene. If education and/or role modeling is not effective in changing an individual's behavior then the individual needs to move out of the organization.

<u>EMPLOYEE ENGAGEMENT: EVERYONE AS A CAREGIVER</u>

A recurring theme in any discussion on patient-centered care is that despite a name that may suggest otherwise, the model of care delivery is not limited to a focus on the patient. Considerable attention must also be paid to the experience of care providers. In a patient-centered environment, *all* employees are caregivers, each in their own way participating in the outcome of a patient's hospital stay. This way of thinking represents a significant cultural shift, and broadens out the role of every staff member to include caring for the patient. This recognition of everyone as a caregiver, with the patient at the center, is an important part of staff engagement.

Reward and Recognition

Plato, Machiavelli, and Rousseau each tell us that deep in everyone's psychological make-up is the need to be recognized as an individual worthy of respect. The longing for significance and the excitement of recognition can be a powerful platform from which to launch efforts to engage staff in fostering an atmosphere of patient-centeredness.

Recognition can be in the form of public acknowledgement of a staff member in a newsletter for how they made an impact on a patient, family member or another employee, or it can be the opportunity for them to share "their story" in front of the management team. Many patient-centered hospitals complement formalized **Employee of the Month** programs with on-the-spot and peer-to-peer recognition programs. **Tool boxes supplied with inexpensive items** like coffee gift certificates, gas cards or movie tickets can be tapped "on the spot" to thank an employee for a job well done. Small note cards completed by managers, peers or even patients with compliments for a particular staff member can be publicly posted and redeemed for pins or stickers to adorn an employee's identification badge. Even these small tokens can mean so much to employees who take great pride in a lanyard or badge full of "stars." Recognition need not be part of a formal program, though. For many employees, it is the impromptu but wholly sincere "thank you" that sustains them during a difficult work day.

Retreats: Education as Inspiration

A key best practice in achieving staff engagement is holding retreats to introduce and reinforce the organization's commitment to patient-centered care. With a focus on sensitizing staff to the patient and family experience and promoting relationship-building across departments and between organizational tiers, these retreats differ from traditional staff education efforts. While education about key aspects of patient-centered care and behavioral expectations is likely part of the curriculum, the primary objective of a retreat is inspiration and reconnecting staff to drew them to a career in health care in the first place. Experiential exercises remind staff of what the hospital experience is like from the vantage point of patients and underscore the important role that all caregivers play in contributing to that patient's overall experience and perception of care. Whether a half-day or overnight, on-site or off, such retreats can provide personal inspiration as well as fuel a collective sense of purpose throughout the organization.

Mid-Columbia Medical Center (MCMC) in The Dalles, Oregon provides such an inspirational educational opportunity at its **MCMC University**, a five day on-site cultural orientation process for all employees. The sessions are held in a specially-designated room called the "experience

center." With its curriculum structured as a journey of discovery through the power of storytelling with board game elements, the sessions are designed to not only be informative and educational, but also fun and interactive. Employees experience a variety of scenarios that allow them to feel what it is like to "walk in others' shoes," including what it is like to be a patient in a hospital as well as its CEO, faced with the kinds of resource allocation decisions that hospital executives contend with regularly. This allows employees to consider other perspectives and to foster an understanding of the challenges patients and co-workers experience on a daily basis. The week concludes with a team-building community project and official graduation ceremony where participants receive their "PHD."

Effective culture change, however, will not be sustained by a one-time retreat or training in the values of patient-centered care. These values and the patient perspective must be continually reinforced.

Communication
With the multitude of issues and demands competing for staff's attention, the message of patient-centered care must be regularly reiterated to ensure it remains a priority and is not "lost in the shuffle." Effective communication is fundamental to staff engagement and is characterized by multiple modes for communication during all shifts to meet the information needs of all staff. Email, electronic message boards, newsletters, bulletin boards and meetings are all important tools in the communication arsenal.

At Enloe Medical Center in Chico, California, the CEO or another member of the senior administrative team writes an **informational and inspirational weekly message which is then recorded on a dedicated phone line that can be accessed by any employee**. The current week's message and archived messages are also downloaded as MP3 sound files to the internal intranet and external website, and hard copies are posted in staff areas. Regular emails encourage staff and physicians to listen to the messages, and reinforce the information conveyed. While email is, without a doubt, a useful communication tool, organizations must also be aware of email overload. For organizations where email remains the primary source of updates and information, consideration must be given to staff's access to email (in terms of physical workstations, time to access messages and computer literacy levels), with appropriate accommodations made to facilitate its use. **Scrolling screen-saver messages** with updates and newsflashes have worked well in many organizations as a source of both information and inspiration. Screen saver messages may feature weekly reminders of upcoming events or important hospital news, as well as pictures highlighting current events, employee recognition, and reminders about the organization's core values.

An **Adopt-a-Bulletin-Board** program is a low-tech way many patient-centered hospitals use to transmit information. Each department assigns an employee with the up-keep of a bulletin board to ensure only current and relevant information is posted. Assigned employees may rotate monthly, and some organizations even hold friendly competitions with a "traveling trophy" or other reward for the best decorated or most original board.

Frequent, scheduled rounding and personal interactions with employees and patients by the CEO and other senior leaders not only demonstrates the visibility of leadership but also provides

time for employees to air any concerns they may have or to ask any questions that may be top of mind. A **town hall meeting** provides a more formal setting for leaders to update staff on important happenings. Scheduling town meetings for several different times during the day, including early morning and late night, ensures that staff from all shifts are able to attend, and ending each session with a question and answer session fosters two-way communication.

Empowering staff in making decisions about patient care and about the organization will promote staff accountability and staff involvement. Creating opportunities for staff participation in envisioning and implementing patient-centered care within the organization will encourage and promote staff ownership of the culture change. A **shared governance structure and/or employee action committees** comprised of both management and non-supervisory staff are ways to encourage participation, decision-making and communication in the organization.

PHYSICIAN INVOLVEMENT

As an integral part of the care team, it is essential that physicians support the patient-centered culture by role modeling the organizational values, championing specific patient-centered practices that resonate with them, and getting involved in implementation efforts. Just like all care providers in the organization, physicians should be included in organizational communication forums and employee activities and celebrations. Physicians should be invited to participate in employee retreats (though if time constraints present a challenge, some hospitals opt to hold a modified **physician retreat**), and on patient-centered care committees or initiative implementation teams.

Physicians' "bedside manner" needs to be consistent with all other care providers and should demonstrate some key nonverbal behaviors: sitting next to the patient, making eye contact, and involving the patient and family, to name a few. Griffin Hospital in Derby, Connecticut developed a document entitled **"Physician Aspirations for Practice and Conduct"** that explicitly outlines specific commitments and expectations to each other and to their community. *This document is included on page 65 as a resource.* Some patient-centered care organizations have incorporated physician performance measures to support these behaviors.

At the Aurora Health Care system out of Milwaukee, Wisconsin, physician engagement in the system-wide organizational culture change has been enhanced through its **Physician Advisory Council**. Comprised of physician leaders from throughout the system, the group provides a forum in which physicians can talk amongst themselves about challenges and opportunities in implementing patient-centered care throughout the system. This peer-to-peer exchange ensures a common basis of understanding from which to have these important discussions. Further leveraging this peer-to-peer approach, a number of Aurora physicians produced **video modules**, telling their stories to fellow physicians in an attempt to support the advancement of patient-centered care throughout the system.

In selecting physicians, some organizations choose to **invite patients to be part of the interview process**. This not only enables the organization to select the physicians that patients and families would prefer to see in the future, but demonstrates a commitment to the community that the organization values their needs and insights in the selection process. At the University

of Washington Medical Center, a patient is paired up with a clinical nurse specialist to interview prospective OB/GYN residents. To assist them in this role, they are provided with a list of interview questions that address specific patient-centered behaviors, qualities and skill sets that have been identified as key to their qualification for the position. *This tool, titled Patient and Family Centered Care Interview Questions, is included on pages 66-68 as a resource.*

The medical center's expectation that residents provide care in a way that reflects the institution's culture of patient-centeredness is reinforced with the use of an **MD Coach**. Employed by the Office of Medical Affairs, this coach is a nurse who mentors residents by observing them doing patient interviews and assessments and then providing feedback. The MD Coach uses a tool (*MD Coach Observation Points, provided on pages 69-70*) developed by UWMC to assess the resident's "bedside manner," and to identify those behaviors around which he or she may benefit from additional mentoring. Section III of the tool explicitly addresses patient-centered behaviors.

BOARD ENGAGEMENT

A board of directors' commitment to patient-centered care positions leadership to actively involve staff in initiating and sustaining a culture of patient-centeredness. Moving toward a culture that promotes the patient at the center takes time and board members may experience turnover and need to be re-educated on the philosophy. Regular presentations to the board keep directors apprised about patient-centered care progress and practices. To have these presentations made by staff is a powerful way to emphasize the critical role that staff members play in the culture change, while also providing recognition for jobs well done.

The discussions that take place in hospital board rooms can occur with a new perspective if preceded by **board members rounding on patients**. Inviting directors to come to the hospital an hour prior to the scheduled board meeting will afford them the opportunity to meet directly with patients and families in order to find out what their hospital experience has been like and where improvements could be made. These bedside conversations with patients can then profoundly inform the board room dialogue. If pre-meeting rounding is not feasible, consider **beginning each board meeting with a patient story**, either shared by a staff member or ideally by the patient/family themselves. Fauquier Health System includes a **board member on its Patient Advisory Council**. Board-level involvement on the Council reinforces to all members the importance of their role, while also providing the board member with a fresh perspective to bring to board meetings.

An additional strategy for engaging board and staff in any sort of organizational priority is to establish explicit, tangible goals that provide a framework for measuring and celebrating progress. This approach can be particularly effective when related to patient-centered care, with the potential to transform the somewhat nebulous concept of patient-centeredness into a defined and measurable organizational aim. Planetree's **Patient-Centered Hospital Designation Program** provides a practical, operational framework for evaluating the organizational systems and processes necessary to sustain a patient-centered culture. Organized around more than 40 specific criteria and recognized by The Joint Commission on Quality Check, the program was created to recognize hospitals around the world that have embraced and implemented patient-

centered care in a comprehensive manner.

VOLUNTEER ENGAGEMENT

In patient-centered hospitals, volunteers are vital members of the caregiver team. Just as every staff member contributes to the patient experience, so too do volunteers contribute greatly to personalizing, humanizing and demystifying hospitalization. The roles that volunteers play in patient-centered hospitals are many and varied, and numerous hospitals would be unable to realize their patient-centered vision without these invaluable resources. Volunteers are often invited to participate in staff activities like town hall meetings, hospital-wide celebrations and patient-centered care retreats. Reward and recognition take on special significance for volunteer caregivers who likely have several options of where they could contribute their talents and time. Ensuring volunteers are kept informed through newsletters, meetings, and invitations to hospital events underscores their importance to the team, and celebrations honoring years or hours of service conveys that even though their hours are "free," they do very much count.

PATIENT AND FAMILY ENGAGEMENT IN ORGANIZATIONAL IMPROVEMENT

Patient-centered hospitals are increasingly turning to the voice of patients and families themselves to guide their efforts to better satisfy consumer demands and expectations. What better way is there to understand what patients want from their health care providers than to ask, and then listen to what they have to say? These hospitals further recognize that needs may evolve over time, so efforts to engage patients and families in defining quality care must be ongoing versus a one-time meeting.

One of the most common ways to solicit patients' feedback about their care experience is the use of patient satisfaction surveys. These surveys, which can be customized, and can be conducted through the mail or over the phone, can be an effective way to collect timely information from a broad base of your patient population. The data collected can then be trended over time and can be used to identify opportunities for improvement. Valley View Hospital in Glenwood Springs, Colorado developed the following five questions that have been added to its patient satisfaction surveys to measure patient-centered approaches to care (each rated "very poor," "poor," "fair," "good," or "very good."):

- *Staff effort to include you in decisions about your treatment*

- *Extent to which you or your family were educated on how to report concerns related to care, treatment, services and patient safety issues*

- *Extent to which you and your family were educated on how to request additional assistance if an urgent response to your concern was needed*

- *Extent to which staff checked two forms of identification (i.e. asked your name and date of birth) before giving you medications, drawing blood, or taking you for a test*

- *Extent to which staff cleaned/sanitized their hands before examining you.*

Additional examples come from the University of Washington Medical Center in Seattle, Washington, which added these customized questions to its patient satisfaction survey:

- *Degree to which you and your family were able to participate in decisions about your care*

- *How well staff explained their roles in your care*

- *Degree to which the staff supported your family throughout your healthcare experience*

- *Degree to which your choices were respected to have family members/friends with you during your care*

- *Degree to which staff respected your family's cultural and spiritual needs.*

Patient focus groups can be a source of in-depth qualitative information for an organization. In addition to ongoing satisfaction surveys that may be done with patients and employees, focus group data can aid in identifying trends, common feelings and concerns. It is common to be able to encourage participants to share their ideas and suggestions for enhancements and improvements, which most mailed surveys are not able to obtain in any real depth. The use of neutral moderators in safe environments encourages comments of all types—positive and negative. An important goal in conducting focus groups is to identify where opportunities exist for organizational improvement. Many patient-centered hospitals that regularly conduct patient focus groups report that even those patients with complaints often express how much they appreciated the opportunity to air those grievances and the satisfaction they felt knowing that organization leadership wanted to hear from them.

Whereas focus group participants share their experiences and insights on a one-time basis, members of a **Patient and Family Advisory Council** meet regularly to discuss opportunities for improvement within the hospital from the patient perspective. This can also be a very valuable group for gauging reactions to patient-centered initiatives prior to their roll-out, and for soliciting input for the refinement of existing programs. Membership on a patient and family advisory council should be reflective of the hospital's patient population and could include patients, their families and community representatives. One avenue for recruitment is to contact patients or family members that have recently sent letters of both appreciation and complaint and invite them to participate. A rotating membership structure allows the organization to involve as many community members who have used the hospital's services as possible. *See pages 71-73 for a sample Patient and Family Advisory Council Charter (from Delnor Hospital in Geneva, Illinois).*

At Sentara Virginia Beach General Hospital, a membership requirement for the Patient and Family Advisory Council is that members attend a Planetree retreat and serve on at least one standing hospital committee, which further extends the reach of this vocal and insightful group to influence even more aspects of hospital operations. **Patient involvement on hospital committees** of all kinds—including ethics, safety, marketing, facility design, and others—is, in fact, becoming more widespread, and a common experience of even the most skeptical leaders is that patient input has shed entirely new light on even routine agenda items. Inviting **patients to participate on hiring committees** not only provides valuable insights into what patients are looking for in a provider, but also conveys a powerful message to all potential hires about the organizational culture. Another strategy hospitals use for gathering "real time" information from patients is to engage

current inpatients in a dialogue about their stay. Dana-Farber Cancer Institute (DFCI) has developed a comprehensive tool kit to assist organizations in initiating **Patient Safety Rounds.** As an opportunity to invite patient input, these patient safety rounds can become sources of information that influence decision-making at every level of the organization. DFCI's Patient Rounding Tool Kit is available on-line at: http://www.dana-farber.org/pat/patient-safety/patient-safety-resources/patient-rounding-toolkit.html.

At Northern Westchester Hospital in Mount Kisco, New York, care managers conduct **daily patient rounds** on new admits and patients ready for discharge to evaluate patient satisfaction. Patients are asked specific questions to determine their level of satisfaction and to identify any areas requiring improvement. Any concerns that emerge are immediately brought to the attention of staff so that they can be promptly rectified. Rounding sheets are completed by the care manager and handed in daily to the Nursing Director. This process builds in accountability to ensure that the patient rounds are consistently practiced every day. *See pages 74-75 for the guidelines used by Northern Westchester Hospital for patient rounding by care managers.*

Other hospitals have turned to current inpatients to serve as **"mystery shoppers"** to monitor for specific staff behaviors, such as hand hygiene or the offer to read one's medical chart. While staff know that such programs are in place, they are unaware of which specific patients have been engaged in this manner.

Patients who become involved in these hospital improvement efforts are often those who are most proactive, those who are not shy about expressing their opinions and speaking up when something does not meet their expectations. On the opposite end of the spectrum are patients who approach health care with the expectation that their role is that of a passive patient who comes to the hospital to be treated by the experts. These patients tend not to ask questions, make special requests, or exercise their freedom of choice because, often, they do not know what questions to ask or what options are available. These patients can be more actively engaged by equipping them with information about what is possible in hospitals (e.g. reading one's own chart, requesting alternate meal times, open visitation, etc.), thereby raising their expectations for their next hospital stay, and heightening their awareness of just what services and accommodations are possible in today's hospitals. Some hospitals are using a **List of Questions to Ask Your Hospital about Patient-Centered Care** to encourage patients to consider what may be important to them when making decisions about where to receive their care. *This List of Questions to Ask Your Hospital is included on page 76 as a reference.*

FIRST STEPS

When it comes to providing patient-centered care, less important than *where* to start is *when* to start, and the answer to that question is simple: right now. While the inclination is often to look to patient and/or employee satisfaction scores and develop action plans for improving the lowest measures, doing so may mean overlooking some potential early and easy "wins" that may significantly enhance the patient or staff experience and prime the organization for success in engaging all the key constituent groups discussed in this section. High visibility, high impact projects that can be completed in a relatively short turnaround time can generate enthusiasm and build momentum that may sustain you as you tackle some of your more difficult challenges.

Consider, for instance, developing a policy for reducing overhead pages or celebrating every new birth with a lullaby piped in overhead. Or look into upgrading to more modest side-tying patient gowns or adding a small notepad bedside for patients and family members to jot down questions for their doctor or nurse. These measures will enhance the environment of care and will be noticed by all, perhaps paving the way and building support for more "controversial" changes in the future.

IMPLEMENTATION TOOLS:

A. Fauquier Health System's Performance Evaluation Measures, *pg. 52*

B. University of Washington Medical Center's Sample Performance Evaluation (Rehab Dept.), *pg. 58*

C. University of Washington Medical Center's Guidelines for Inserting Patient and Family Centered Language into Competencies, *pg. 62*

D. Candidate Observation Checklist, *pg. 64*

E. Griffin Hospital's Physician Aspirations for Practice and Conduct, *pg. 65*

F. University of Washington Medical Center's Patient and Family Centered Care Interview Questions, *pg. 66*

G. University of Washington Medical Center's MD Coach Observation Points, *pg. 69*

H. Delnor Hospital's Patient Partnership Council Charter, *pg. 71*

I. Northern Westchester Hospital's Guidelines for Patient Rounding by Care Manager, *pg. 74*

J. List of Questions to Ask Your Hospital about Patient-Centered Care, *pg. 76*

Tool A.: Fauquier Health System's
Performance Evaluation Measures

Registered Nurse – 210A

JOB DESCRIPTION AND PERFORMANCE STANDARDS	
Date:	Last revision date: April 1, 2008
Department:	Reports To: Clinical Coordinator
Select one of the following: ☐New Job ☐90 Day Orientation Evaluation ☐Annual Performance Evaluation	Licenses*, Certifications*, Registrations* *indicates state mandate Current Virginia State RN License* BLS ACLS

MISSION STATEMENT
The mission of Fauquier Health System is to restore, promote and maintain the health of our community.

JOB SUMMARY
Performance Narrative
The Registered Nurse provides and directs clinically appropriate patient care to an individual or group of patients in accordance with the philosophy and mission of the Department of Nursing and the organization. Incumbent will be scheduled based on operational need, which may include but is not limited to: holidays, extended shifts, night and/or weekend shifts, standby and/or on-call. This job description is only meant to be a representative summary of the major responsibilities and accountabilities performed by the incumbents of this job. Employees may be directed to perform job-related tasks other than those specifically presented in this description.

STANDARDS OF EMPLOYMENT	
ALL EMPLOYEES MUST MEET THE FOLLOWING STANDARDS	
☐**Meets Standard** ☐**Does Not Meet Standard**	Attends all mandatory education programs.
☐**Meets Standard** ☐**Does Not Meet Standard**	All required competencies are current.
☐**Meets Standard** ☐**Does Not Meet Standard**	All position-required licenses, certifications, and registrations are current and have been provided to Human Resources.

RATING SCALE (see http://fhnet/dept/hr/performance appraisal information.doc)

Unacceptable 0 points	Marginal 2 points	Competent 3 points	Commendable 4 points	Exceptional 5 points

ESSENTIAL FUNCTIONS
Essential functions are those tasks, duties, and responsibilities that comprise the means of accomplishing the job's purpose and objectives. Essential functions are critical or fundamental to the performance of the job. They are the major functions for which the person is held accountable. Following are the essential functions of the job, along with the corresponding performance standards.

Indicate how the employee performed relative to these standards by checking the appropriate boxes.

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1. Assessment and Diagnosis Weight: 20%	UnAcc 0 pts	Marg 2 pts	Comp 3 pts	Comm 4 pts	Exc 5 pts
Symptom analysis - Performs symptom analysis of chief complaint on all patients entering the emergency care system within pre-established time frames.					
Patient problems - Differentiates severity of patient problems and prioritizes care, designating an appropriate acuity level consistent with patient evaluation.					
Nursing measures/diagnostic/treatment protocols - Initiates nursing measures, diagnostic, and treatment protocols, as indicated.					
Patient-care areas - Assigns patients to appropriate patient-care area based on triage assessment and acuity.					
Waiting area patients - Reassesses patients in the waiting area based on triage-acuity guidelines and re-categorizes, as appropriate.					
Pertinent information - Communicates pertinent information to the Resource Nurse and family/significant others, as appropriate.					
Complete documentation - Demonstrates complete documentation and consistency with triage protocols per case review.					
Patient flow - Facilitates patient flow through timely and consistent monitoring of the discharge rack, test results, etc.					
Performance Narrative					

2. Interventions/Routing Nursing Duties Weight: 20%	UnAcc 0 pts	Marg 2 pts	Comp 3 pts	Comm 4 pts	Exc 5 pts
Subjective/objective data - Obtains initial focused subjective and objective data through history-taking, physical examination, review of records, and communication with healthcare providers and significant others, as appropriate.					
Significant findings - Communicates significant findings to the physician and collaborates with other healthcare providers, patients, and families to coordinate medical/nursing interventions to achieve desired outcomes.					
Implements clinical/technical aspects - Independently implements clinical and technical aspects of care and nursing orders according to established policies and procedures.					
Evaluates nursing care - Evaluates nursing care provided through ongoing assessments as warranted by the dynamic status of the patient response. Makes appropriate revisions to achieve desired outcomes.					
Growth/development - Demonstrates knowledge of growth and development and the ability to assess and interpret age-specific data, provide age-specific data to other caregivers, and interpret age-specific response to treatment.					
Priority setting/decision-making - Demonstrates ability in priority setting and decision-making skills when dealing with changing patient conditions and census. Works efficiently to maintain continuous unit functions.					

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Policies/procedures - Adheres to infection control policies and OSHA standards related to standard precautions					
Equipment availability/condition - Ensures equipment is available and in working condition.					
Faulty/dangerous equipment - Reports faulty and/or dangerous equipment. Initiates appropriate communication documents: clinical or maintenance requests.					
Body mechanics - Utilizes proper body mechanics in all patient contacts.					
Performance Narrative					

3. Communication/Evaluation Weight: 20%	UnAcc 0 pts	Marg 2 pts	Comp 3 pts	Comm 4 pts	Exc 5 pts
Identified problems - Evaluates the identified problems, care provided and patient's responses.					
Discharge planning - Utilizing an interdisciplinary approach, initiates discharge planning to meet the discharge care needs of each individual patient.					
Patient/family education - Provides patient and family education in regards to the hospitalization and in preparation for discharge. Upon discharge, provides appropriate discharge instructions to include follow-up and referral needs.					

4. Documentation Weight: 10%	UnAcc 0 pts	Marg 2 pts	Comp 3 pts	Comm 4 pts	Exc 5 pts
Complete/legible/pertinent documentation - Documentation is complete, legible, and provides pertinent information regarding patient condition.					
Physiological parameters - Records physiological parameters (i.e., vital signs, cardiac rhythm, fetal monitoring).					
Patient response - Documents patient response to nursing and physician interventions and treatment.					
Patient status - Documents patient status upon transfer or discharge					
Discharge instructions - Documents appropriate discharge instructions and referral for follow-up care.					
Medication administration - Documents outcome to medication administration: response to new medication, side effects, and adverse reactions					
Hand-off communication - Independently identifies need for, and provides accurate and timely hand-off communication as indicated.					
Current regulations - Demonstrates awareness of current regulations governing healthcare and documents on appropriate form, e.g., inter-facility transfer, consents, etc.					
Performance Narrative					

NONESSENTIAL FUNCTIONS
Nonessential functions are those tasks, duties, and responsibilities that are not critical to the performance of the job. Following are the nonessential functions of the job, along with the corresponding performance standards.

Indicate how the employee performed relative to these standards by checking the appropriate boxes.

1. Professional Development Weight: 5%	UnAcc	Marg	Comp	Comm	Exc

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	0 pts	2 pts	3 pts	4 pts	5 pts
Problem resolution - Facilitates problem resolution among peers, as observed by the nurse manager and peers. Promotes a positive work environment through own professional conduct.					
Orients new employees - Participates in orientation of new employees.					
Emergency situations - Functions successfully in all emergency situations.					
Committee structure - Participates in committee structure of department					
Staff meetings - Attends and/or signs off on minutes from staff meetings					
Skills/knowledge update - Updates skills and knowledge by Attaining 10 CEUs annually and provides documentation of completion					
Performance improvement - Participates in performance improvement activities of department					
Team member participation - Participates as a team member by offering constructive input, accepting feedback in a positive manner, offering to assist others and consistently demonstrating productive work habits.					

Performance Narrative

GOALS

Goals should help focus employee's efforts on the tasks and responsiblities that will lead to personal growth and contributions to organizational success. Individual goals should reflect specific tasks and results for which the employee is responsible, be measurable and observable, and provide a clear focus for the employee.

Indicate how the employee performed relative to these standards by checking the appropriate boxes.

Goals Weight = 0%	UnAcc 0 pts	Marg 2 pts	Comp 3 pts	Comm 4 pts	Exc 5 pts
Goal 1					
Goal 2					
Goal 3					

Performance Narrative

CORE VALUES (see http://fhnet/dept/hr/performance appraisal information.doc)

Core Values provide the foundation for who we are and what we stand for as members of Fauquier Health System. *Core Values* guide everything we do and illustrate our care for all with whom we come in contact - - our patients and residents, their families and friends, our healthcare partners, and our co-workers. Most importantly, *Core Values* are the standards against which we measure performance excellence.

TEAMWORK - Everyone working together to foster an environment of mutual respect and support in order to achieve a common goal - 4% Weight					
EVALUATION CRITERIA	UnAcc 0 pts	Marg 2 pts	Comp 3 pts	Comm 4 pts	Exc 5 pts
1.1: Building and sustaining collaborative working relationships					

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1.2: Fostering an environment of mutual respect and support					
1.3: Recognizing accomplishments of coworkers					
1.4: Recognizing environmental factors which contribute to the client and visitors' perception of the facility					
Composite Evaluation					
Average Point Value for Teamwork					
INTEGRITY - Behaving ethically by demonstrating honesty, maintaining high standards and doing the right thing even when nobody else is looking - 5% Weight					
2.1: Demonstrating follow-through in all activities					
2.2: Admitting when you make a mistake					
2.3: Maintaining Confidentiality					
2.4: Demonstrate Reliability and Dependability					
Composite Evaluation					
Average Point Value for Integrity					
QUALITY - Striving for superior performance by consistently providing a product or service which is recognized as special and unique - 4% Weight					
3.1: Taking pride in your work					
3.2: Achieving and maintaining competence in designated areas					
3.3: Maintaining a reputation for high standards					
Composite Evaluation					
Average Point Value for Quality					
COMPASSION - Providing highly individualized care and responding to the emotional, spiritual and physical needs of all the people we serve, thus creating a caring environment conducive to healing, growth and well being for all, including those we work with - 4% Weight					
4.1: Taking time to listen					
4.2: Meeting other individuals where they are					
4.3: Demonstrating a non-judgmental approach to all individuals					
4.4: Demonstrating initiative in helping others					
Composite Evaluation					
Average Point Value for Compassion					
STEWARDSHIP - Utilizing the organizations' resources of money, property, time and talent as if they were your own - 4% Weight					
5.1: Taking care of property entrusted to us					

5.2: Taking care of ourselves so that we can give the most to our jobs					
5.3: Using time wisely					
5.4: Utilizing resources provided to fullest extent possible					
Composite Evaluation					
Average Point Value for Stewardship					
PARTNERSHIP - Partnering with clients, families, physicians, outside organizations and our community to share responsibility for exceeding the best outcomes - 4% Weight					
6.1: • Partnering with clients to achieve goals • Partnering with outside organizations to meet the needs of our clients, staff members, and the community • Partnering with physicians to provide the best quality of care for our patients					
Composite Evaluation					
Average Point Value for Partnership					

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Tool B: University of Washington Medical Center's Sample Performance Evaluation (pg.1-4 of 11)

UNIVERSITY OF WASHINGTON MEDICAL CENTER
UW Medicine

JOB DESCRIPTION / PERFORMANCE EVALUATION DRAFT
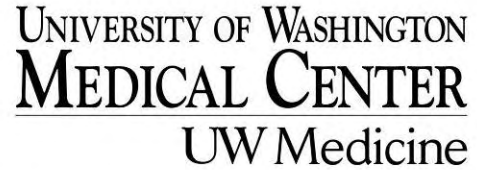
Employee Name: _____   Employee ID #: _____

Job Title: Occupational Therapist II
_____

Supervised by: Occupational Therapy Supervisor
Occupational Therapy Manager

Prepared by: _____   Approved by: _____

Date: _____   Date: _____

Job Summary: In collaboration with patients, families (as defined by the patient), and staff across disciplines and departments is responsible for evaluation, planning, directing and administering occupational therapy intervention to patients referred by a licensed provider. Administers treatments, training and physical agents as determined by the evaluation in an effort to restore function and prevent further disability following injury, disease or physical disability. Partners with the patient and family and, considering the patient's environment, evaluates and administers treatment for functional living skills such as self care, homemaking, range of motion, muscle testing, cognitive, visual perception, vocational and avocational skills, splinting, assistive technology and community integration. Reports data in both written and oral form following the policy and procedures of the OT department and the Medical Center. Provides supervision to less experienced therapists, students, COTAs, aides, and volunteers. Participates in the operational aspects of the department, maintains performance improvement activities within the department and participates in Quality Improvement activities. Follows procedures and standards for cost effectiveness. Ensures that patient charges are accurate and entered in a timely basis. Participates in all infection control, departmental equipment training, organizational safety and fire safety programs.

DUTIES AND RESPONSIBILITIES:

Note: Comments are required for ratings of Outstanding, Exceeds the Standard, Needs Improvement, and Doesn't Meet Standard. Please make comments on the last page.

5 = **O**utstanding in demonstrating skill and competencies.

4 = **E**xceeds the Standard in demonstrating skill and competencies. Sustained proficiency and excellent results.

3 = **M**eets the Standard in demonstrating skill and competencies. Consistently productive with good results.

2 = **N**eeds Improvement in demonstrating skill and competencies.

1 = **D**oesn't Meet Standard in demonstrating skill and competencies.

Demonstrates Competency in the Following Areas:	**O**	**E**	**M**	**N**	**D**
1. Using feedback from the patient and family, performs an appropriate evaluation as related to the therapy requested, observes and evaluates the effect of treatment and progresses the plan accordingly.	5	4	3	2	1
2. Involves the patient/family in the formulation of the plan of care by Interacting professionally and compassionately with the patient/family.	5	4	3	2	1
3. In discussion with the patient and/or family, assesses patient pain interfering with optimal level of function or participation in rehabilitation, makes appropriate provider contact for intervention.	5	4	3	2	1
4. Formulates a teaching plan, with the patient and family members, based upon identified learning needs and evaluates effectiveness of learning.	5	4	3	2	1

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Demonstrates Competency in the Following Areas:

		O	E	M	N	D
5.	Communicates, orally and in writing, appropriately and clearly to physicians, staff, patients and their families, the administrative team, and outside entities. Maintains records pertinent to personnel and operation of the department.	5	4	3	2	1
6.	Interacts respectfully with patients and their families. In collaboration with patients and their families, identifies and addresses psychosocial, cultural, ethnic and religious/spiritual needs.	5	4	3	2	1
7.	Is attentive to ensure that the needs of patients and their families are met and hospital policy is followed. (For example: offering a glass of water, ensuring that the call light is accessible, etc).	5	4	3	2	1
8.	Performs all aspects of patient care in an environment that optimizes patient safety and reduces the likelihood of medical/health care errors Manages and operates equipment safely and correctly. Maintains department cleanliness and safety.	5	4	3	2	1
9.	Directs COTAs, aides, and volunteers Participates in student training according to the AOTA guidelines and the guidelines of the department.. Assists with orientation and inservice training, participates in guidance and educational programs.	5	4	3	2	1
10.	Collaborates with patient and/or family members, and other departments, in the development of performance improvement activities.	5	4	3	2	1
11.	Assists in evaluation of staff including interviewing and hiring.	5	4	3	2	1
12.	Performs other related duties as assigned.	5	4	3	2	1
13.	Maintains productivity requirement of 5.5 billed hours per 8 hours worked/day or 68.75%.	5	4	3	2	1
14.		5	4	3	2	1
15.		5	4	3	2	1
16.		5	4	3	2	1
17.		5	4	3	2	1
18.		5	4	3	2	1

UWMC-Wide Competencies:

		M	N	D
19.	**HIPAA Compliance** – Demonstrates knowledge and understanding of patient privacy rights. Maintains complete confidentiality of all medical, financial, or other sensitive materials and information in printed, electronic or verbal form, which may jeopardize the privacy of patients. Accesses and uses the minimum necessary patient identifiable information and only when necessary to perform job responsibilities and duties.	3	2	1

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20. **HIPAA Compliance** - Demonstrates knowledge and understanding of, and maintains complete confidentiality of employee information and medical center strategic plans and initiatives, financial information or other sensitive materials and information in printed, electronic or verbal form, which may jeopardize employee rights or medical center operations. Accesses and uses the minimum necessary employee and medical center information and only to perform job responsibilities and duties.	3	2	1
21. **Compliance Program -** Demonstrates knowledge and understanding of, and adherence to, UWMC's Compliance Program policies, procedures and standards of conduct. Demonstrates conduct that reflects a commitment to these standards. Participates in training activities as required by the compliance program by the stated deadlines.	3	2	1
22. **Cultural -** Demonstrates an awareness of the patients' and coworkers' views, traditions, and actions in light of individual cultures. Asks patients and families about specific beliefs, practices, and customs that may be relevant and important during medical treatment and hospitalization. Understands and is able to incorporate into patient care how those preferences affect the way in which care should be delivered. Respectfulness is shown to coworkers.	3	2	1
23. **Communication -** Ability to proficiently read, write, understand, and communicate in English commensurate with the duties and responsibilities of the position to understand and respond to policies, procedures, overhead pages and alarms, in a manner that will ensure personal health and safety, and the safety of other staff, patients, and visitors, during the course of an emergency or an unusual incident, should one occur while present at the work site or in the facility.	3	2	1
24. **Service Orientation** – Supports the organizational and service area's mission and vision. Demonstrates knowledge of and applies the UWMC Standards for Service Excellence:	3	2	1

- **Introduces** themselves

- **Escorts** as needed

- **Responds** and follows through with complaints

- **Asks** what name the person wishes to be called and ends conversations by asking if anything else is needed

- **Refers** people to those who can give assistance

- **Apologizes** and provides additional services for patients who have been inconvenienced

- **Assists** if someone looks lost or needs special assistance

- **Privacy** is maintained and care-related discussions are conducted in private settings

- Demonstrates the **ARISE** (**A**ccountability **R**espect **I**nnovation **S**ervice **E**xcellence) values.

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25.	**Relationships and Teamwork** – Communicates effectively and respectfully with individuals and groups. Contributes to positive working relationships and collaborative teamwork with all disciplines, departments, patients and their families. Recognizes own stress and the impact on others. Identifies and manages stressors utilizing the guidance of others. Remains flexible with changes that are occurring in the department and/or medical center. Concerns/issues regarding departmental/organizational operations are communicated to the employee's supervisor/manager.	3	2	1
26.	**Economics of Care** - Demonstrates knowledge of cost efficiencies in the delivery of care such as identifying and pursuing quality improvement opportunities and utilizing appropriate supplies and resources.	3	2	1

	Professional Requirements:	**M**	**N**	**D**
27.	Appearance is neat, clean, and appropriate to position.	3	2	1
28.	Completes annual educational requirements.	3	2	1
29.	Attends annual review and staff meetings as scheduled and is responsible to keep self informed of department information.	3	2	1
30.	Reports to work on time and as scheduled; completes work in designated time.	3	2	1
31.	Introduces self and explains his or her role to patients and their families.			
32.	Wears ID while on duty. Turns time sheets in on time.			
33.	Attends committee, performance improvement and continuous quality improvement meetings as appropriate.	3	2	1
	Total Points	__ __	__ __	__ __

*Total of Performance Evaluation Scores: _____

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University of Washington Medical Center

Tool C: University of Washington Medical Center's Guidelines for Inserting Patient and Family Centered Language into Competencies

UNIVERSITY OF WASHINGTON
MEDICAL CENTER
UW Medicine

GUIDELINES FOR INSERTING PFCC LANGUAGE INTO COMPETENCIES
12/20/07
Authors: Ann Buzaid and Hollis Guill Ryan

WHY IS PATENT AND FAMILY CENTERED CARE IMPORTANT?

Patient and family centered care (PFCC) has been a deliberately chosen organizing principle at University of Washington Medical Center since 2002 although, of course, it had been practiced naturally by many staff members prior to that. Incorporating PFCC language in job descriptions, job competencies, and evaluations helps move PFCC from a concept to defined and measurable practices. PFCC language in job descriptions reinforces and supports those who already practice patient and family centered care, and instructs, informs, and guides those whose PFCC practices can be improved.

The practice of patient and family centered care has measurable results hospital-wide, resulting in higher patient satisfaction, higher employee satisfaction, and significant improvements in patient safety. Beyond that, it is simply the right thing to do.

WHAT IS PATIENT AND FAMILY CENTERED CARE?

Patient and family centered care is an approach to health care that actively engages patients, families, and staff as partners to shape policies, programs, facility design, and day-to-day care interactions. It leads to better health outcomes, wiser allocation of resources, and greater patient and family satisfaction. Some of its core concepts are communication, information-sharing, choices, respect, partnership, and the understanding that the presence of family is a strength, not an inconvenience.

HOW DO WE GO ABOUT INCORPORATING PFCC LANGUAGE?

You and your team may ask for training before engaging in rewriting staff competencies.

Here are some guidelines for updating staff competencies to include patient and family centered language:

- **MOST IMPORTANT: Make every effort to include patients and family members in the process of incorporating new PFCC language**
  - Include at least two advisors in the meetings **OR (and)**
  - Ask for a review by the Forms and Materials Review Committee
- Since patients and their families are the most important part of our job, it is important that the first sentence of the Job Summary start with the inclusion of patients and their families.
- Where PFCC language already exists, consider moving it to the beginning of the sentence.
- Work to shift language from "expert model" to "partnership model."
- Be willing to consider all suggestions for including PFCC language, and notice how it changes the emphasis. Maintain an open, positive, and accepting attitude toward suggested changes.
- Remember: Whatever changes you make will be a pilot project and will not be made permanent until it has been trialed. Allow this trial period to give you freedom to make radical changes in your documents and to observe the results.

Patient and Family Centered Care

Patient and Family Centered Care and Education Services 1959 N.E. Pacific St. Box 358126 Seattle, WA 98195 206-598-2697

WHAT ARE SOME EXAMPLES OF PFCC LANGUAGE ...

Consider using some of the following phrases, in addition to your own examples:

- Using feedback from the patient and family ...
- Interacting with patient and family ...
- Involving patient and family ...
- In discussion with the patient and (or) family ...
- Include patient and family in lists of involved personnel, thus: "physicians, staff, patients and their families, the administrative team, and outside entities ..."
- Collaborating with patient and (or) family members ...
- In partnership with patient and (or) family members ...
- ... family (as defined by the patient) ...

Tool D: Candidate Observation Checklist

CANDIDATE OBSERVATION CHECKLIST

Candidate Name: _____

Date: _____

Item	Yes	No	DNO
Accommodating			
Appropriate Eye Contact			
Assists Others (e.g., opens door)			
Considerate of Your Time			
Firm Handshake			
Fits Interview (Testing) Into Their Schedule			
Neat, Clean, Appropriate Dress			
On Time			
Positive Body Language			
Respects Personal Space			
Self Reliant			
Smiles Cheerfully			
Upbeat, Positive, Enthusiastic			

Item	Yes	No	DNO
Answers Questions			
Asks Appropriate Questions			
Clear Tone of Voice			
Initiates Conversation			
Interrupts			
Introduces Self			
Knows About Organization			
Laughs			
Polite Voice			
Responds to Greeting			
Speaks Clearly			
Speaks in Sentences			
Uses Humor			
Uses "Please", "Thank You"			

Other Comments: _____
_____
_____
_____

KEY

Yes - Observed Behavior

No - Behavior Not Exhibited

DNO - Did Not Observe; Behavior Could Not Be Evaluated Based On Circumstances

Candidate Observation Checklist

Tool E: Griffin Hospital's Physician Aspirations for Practice and Conduct

We the Members of the Medical Staff of Griffin Hospital are committed to providing medical care that is patient centered, safe, effective, efficient, timely and equitable. We aspire to provide the highest quality care and services to our patients and their families; to continually improve our care, and be recognized as the best Medical Staff in our region. We support Griffin Hospital's mission to provide personalized, humanistic, patient centered health care in a healing environment. We seek to maintain our community's trust and respect and to lead Griffin Hospital towards being recognized as one of the best hospitals in the country. In recognition of our enduring goal to provide the highest quality of care, we set forth these explicit commitments and aspirations to one another and to our community.

Griffin Hospital
Physician Aspirations for Practice and Conduct

Patient Care: We are committed to and aspire to provide the best possible treatment for our patients by providing care that is patient centered, safe, effective, equitable, timely, and efficient. The care of our patients is always our first concern, and we will focus on meeting their physical, emotional and spiritual needs.

Medical Knowledge and Skills: We are committed to and aspire to maintain knowledge and skills in our respective fields; to provide safe and effective patient care by maintaining competency within our scope of practice; to meet the Medical Staff's continuing medical education requirements, and to demonstrate consistent application of the best clinical evidence in patient care management.

Practice-Based Learning: We are committed to and aspire to actively learn from our practices by participating in hospital peer review activities, committees and rapid cycle improvement teams; and by collaborating with other members of the health care team to improve patient care practices through development of new systems of care, new diagnostic and therapeutic equipment and use of evidence based clinical guidelines.

Interpersonal Communication and Skills: We are committed to and aspire to exhibit excellent interpersonal and communication skills by listening, with empathy, to our patients, spending sufficient time with patients, their families and healthcare team, to provide for effective understanding; communicating availability, methods of access and coverage during absences; and by providing consultation and collaboration in a clear, concise, timely and courteous manner. We aspire to seek and provide information effectively using hospital established communication strategies at handoffs, and to provide written communication that is dated, timed, complete and legible.

Professionalism: We are committed to and aspire to uphold the ethical and professional standards of the medical profession honoring the trust others have placed in us. We aspire to abide by HIPAA confidentiality and privacy standards; maintain intellectual integrity; hold ourselves and our colleagues accountable for the standards of the profession; recognize and respect the cultural diversities of our patients and colleagues; acknowledge and respect our own limitations and seek consultation appropriately, and resolve conflicts in an open minded, respectful way.

Systems-Based Practice: We are committed to and aspire to practice effectively within the larger systems of healthcare. We will appreciate the complexity and multiple components of the healthcare system; adapting our care and practices to work within the system while advocating for our patient's best interests; practice in a cost effective manner; participate in the training and teaching of other members of the healthcare team; and participate in efforts to improve safety and quality of care for inpatients.

Patrick Charmel	*Anthony D'Souza*
Patrick Charmel, President & CEO	Anthony D'Souza, MD, Medical Staff Vice President
Paul Nussbaum	*Kenneth V. Schwartz*	*Lee Soto*
Paul Nussbaum, MD, Medical Staff President	Kenneth V. Schwartz, MD, Medical Director	Lee Soto, MD, Medical Staff Secretary/Treasurer

Tool F: University of Washington Medical Center's Patient and Family Centered Care Interview Questions

PFCC Interview Questions

	3 Exceptional	2 Good	1 Satisfactory	0 Unsatisfactory

Applicant Name: _____

PFCC Dimension 1: Awareness of concept of patient and family centered care

Q1: What does patient and family centered care mean to you?

	3	2	1	0
a. Emphasis is on patient and/or family needs.	3	2	1	0
b. Describes actions or behaviors that demonstrate patient and family centered care practices.	3	2	1	0
c. Shares full information with patient and family and checks for understanding.	3	2	1	0

PFCC Dimension 2: Awareness of patient and family experience

Q2: How does hospitalization or illness impact a patient/family beyond the clinical aspects of care? What approaches do you use to help you better understand your patients' and families' perspectives?

	3	2	1	0
a. Elicits information about the care experience from patients and families.	3	2	1	0
b. Empathetic response to the multiple ways hospitalization affects patients and families.	3	2	1	0
c. Understands that the patient experience goes beyond the physical hospitalization experience and also includes emotional and spiritual effects.	3	2	1	0

PFCC Dimension 3: Demonstrates respectful caring

Q3: Tell us how you show patients and their families that you respect them and care about their well-being.

	3	2	1	0
a. Actively solicits patient wishes and preferences, and integrates these into care plan.	3	2	1	0
b. Relates genuinely.	3	2	1	0
c. Arrives prepared.	3	2	1	0
d. Takes the time to be with the patient and family.	3	2	1	0

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PFCC Interview Questions

	3	2	1	0
	Exceptional	Good	Satisfactory	Unsatisfactory

PFCC Dimension 4: Demonstrates collaborative orientation to working with patients and families

Q4: How do you create a plan of care for your patient?

	3	2	1	0
a. Views patient as an essential partner in decision-making.	3	2	1	0
b. Reflects belief that patients and families are competent and capable of helping with their own care.	3	2	1	0
c. Knows and incorporates patient's goals.	3	2	1	0

PFCC Dimension 5: Ability to manage conflict

Q5: Tell us about a time when you had a conflict with a patient over their plan of care. How did you resolve the conflict?

	3	2	1	0
a. Asks about patient's point of view.	3	2	1	0
b. Respects patient's preferences.	3	2	1	0
c. Respectfully describes different points of view.	3	2	1	0
d. Recognizes the dynamics that factor into different perspectives.	3	2	1	0

PFCC Dimension 6: Recognition of and respect for differing value systems and the ability to build a professional relationship that transcends individual value systems

Q6: Tell us about a time you established a professional relationship with a patient whose value system was different from your own. How did you accomplish this?

	3	2	1	0
a. Nonjudgmental approach.	3	2	1	0
b. Recognizes that own values impact decision-making.	3	2	1	0
c. Respectfully describes different values and points of view.	3	2	1	0

PFCC Dimension 7: Communication skills demonstrated during interview

	3	2	1	0
Body Language: Conveys openness and nonjudgment; leans in to listen; eye contact present and appropriate throughout interview; facial expression neutral or warm; expressions match emotional context of what is being shared.	3	2	1	0
Verbal Language: Uses non-technical language and accessible vocabulary.	3	2	1	0

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Holistic Rubric for Patient and Family Centered Care

Scoring Scale: 3   2   1   0

3: Exceptional (Thoroughly present)

- Responses reflect a **strong belief** that patient and family needs and wishes must be **actively solicited and engaged**, and their **preferences must be the center of the care plan**.
- Care is viewed as a **collaboration** between patients, their families, and providers, and language shows this orientation, such that the spirit of the patient-provider relationship is "**us**" **and** "**we**" (**vs.** "**they.**") Furthermore, the care experience is **always viewed and described as** *with* **patients and families (vs. care provided "for" or "to").**
- Unwavering respect for patient and family strengths, cultural uniqueness, resources, and abilities pervades responses.
- This individual seems naturally empathetic and valuing of patient and family perspectives, and answers affirm a **strong commitment to furthering the practice of patient and family centered care.**

2: Good (Moderately present)

- Answer reflects the **belief** that patient and family needs and wishes matter in the care experience, and patient and family are **actively solicited and engaged when making care decisions**.
- This individual advocates that he or she views the patient-provider relationship as collaborative, and language **describing this relationship is consistently "with," and rarely "to" or "for" patients and families**.
- This individual seems naturally empathetic and valuing of patient and family perspectives, and response shows a **thoughtful awareness of, and a desire to practice, patient and family centered care.**

1: Satisfactory (Minimally present)

- Answer reflects the belief that patient and family needs and wishes matter in the care experience, and patients and families are asked their care preferences when making care decisions.
- Respondent has ideas for ways to work with patients and families, but does not view the provider-patient relationship as fundamentally collaborative. (Language reflects this belief; the care experience is sometimes described in terms of "with" and sometimes as "for" or "to" patients and families).
- However, the response showed respect and openness to the patient and family perspective and it seems that this individual would be a caring provider.

0: Unsatisfactory (Absent)

- Answer reflects the **belief that providers should make all of the care decisions**; patient and family needs and wishes are secondary to "professional" decisions.
- Language reflects this orientation, and the **patient-provider relationship is characterized by "I" and "they," or "to" and "for."**
- Patient and family centered care does not appear to be a value of this respondent.

Tool G: University of Washington Medical Center's MD Coach Observation Points

Author: D. M. Henderson, MD Coach, UWMC

UWMC MD Coach Observation Points: July 2008

Case ID: M   F   Age   Admit Date

		Yes	No	NA
1	**ID Badges:**	Yes	No	
	ID badges are worn above the waist & clearly visible to patients, staff, and visitors at all times			
2	**HIPAA Privacy Standards:**	Yes	No	
	HIPAA patient privacy standards are adhered to at all times.			
3	**Patient & Family-Centered Care**	Yes	No	NA
	Members of the patient care team are introduced to the patient and family.			
	The roles & responsibilities of team members are explained to the patient & family.			
	The patient and family are offered a means to contact their patient care team.			
	The patient is asked who he/she wants included in discussions and decisions about the plan of care.			
	Diagnoses and care plan options are explained in terms that the patient and family can understand.			
	The patient and designated family are actively involved in deciding which care options to implement.			
	Team members demonstrate tact, diplomacy, & compassion; they treat patients & family respectfully			
	Team members protect the patient's modesty and dignity.			
	In collaboration with the patient and family, the team identifies and addresses the patient's psychosocial, cultural, religious and spiritual needs.			
4	**Appropriate Use of Interpreters**	Yes	No	NA
	Interpreters are used when communicating with patients whose primary language is not spoken English.			
5	**Hand Hygiene**	Yes	No	
	Before and after each contact with a patient or the patient's immediate environment, team members cleanse their hands for 15 seconds with an alcohol-based gel or wash their hands for 15 seconds with soap & water.			
6	**Infection Control Measures**	Yes	No	NA
	Team members consistently observe Standard precautions			
	Team members correctly implement transmission-based precautions: Contact Precautions, Special Contact Precautions, Droplet Precautions, Airborne Precautions.			
	Team members correctly put on, take off, and dispose of personal protective equipment (gowns, gloves, masks, eye shields, and respirators).			
	If team members handle personal electronic equipment (e.g., pagers, cell phones) or other potential formites, they perform hand hygiene before touching the patient or the patient's immediate environment.			
	Team members practice cough and sneeze etiquette.			
7	**Wound Care/Dressing Changes**	Yes	No	NA
	When performing wound care/dressing changes, team members maintain aseptic technique.			
	1 Explain procedure to the patient			
	2 Wash/gel hands before commencing wound care/dressing change			
	3 Don nonsterile gloves			
	4 Remove dressings and discard them appropriately			
	5 Remove glove; wash/gel hands			
	6 Don a second pair of nonsterile gloves			
	7 Complete wound care/dressing change			
	8 Remove gloves, discard them appropriately, wash/gel hands			

Author: D. M. Henderson, MD Coach, UWMC

Case ID: _____ M F Age ___ Admit Date _____

		Yes	No	NA
8	**Other Documentation**			
	H& P documented within 24 hours of admission			
	Operative Report / Brief Op Note written immediately after the procedure			
	Discharge Summary written/dictated within 48 hours of discharge			
9	**Medication Reconciliation form**			
	A Medication Reconciliation form is completed on admission for each admission to UWMC, including ER admits & transfers to UWMC from other facilities.			
	Medication Reconciliation for Transfer has been documented			
	Medication Reconciliation for Discharge has been documented			
10	**Documentation Standards: All Orders**	Yes	No	⇵
	Documentation, orders, and signatures are legible			
	Each order set is signed, dated, and timed			
	No unacceptable abbreviations are used			
11	**Documentation Standards: Medication Orders**			
	Each medication order includes a drug name, dose, route & frequency of administration			
	An indication for use is documented for PRN medications with more than one use.			
	Duplicate therapy orders (e.g., two different types of pain medication) include guidance for use (i.e., instructions re: which medication to administer under what circumstances)			
	Double range orders (e.g., Demerol 25–50 mg IV q 4–6 hrs) are not used			
12	**Corrections to medical record entries follow UWMC policy & prudent medical practice standards**			
	Errors are crossed out with a single line, dated and initialed with an explanatory comment			
	Medical record entries are not overwritten or scribbled out			
13	**Documentation Standards: Medical Restraint Orders**			
	The restraint order is renewed at least once each calendar day			
	Each restraint order is signed, dated, & timed			
	The Physician Exam portion of each restraint order is complete			
14	**Consents**			
	Informed consent is obtained for designated procedures, transfusions, and anesthesia			
	The consent form is signed by the patient and matches the order for the procedure			
	Signature dates for the patient and physician match			
15	**Pre-procedure Preparation: Final Verification Checklist**			
	Final Verification is documented for invasive procedures that meet ONE or more of the following:			
	Informed consent, procedural sedation, laterality not physically visible (i.e., chest tube)			
	Any of the following procedures:			
	Arterial line insertion, bone marrow aspiration, central line insertion, ICP placement, lumbar puncture, paracentesis			
16	**Do Not Resuscitate / Treatment Limitation Orders**			
	Copy of Advance Directive is in the medical record			
	Code status order is consistent with the Advance Directive			
	MD discussion of limitation order with pt or authorized decision-maker is documented in medical record			
	If patient is DNR, discussion of code status during procedure is documented in the medical record			

Tool H: Delnor Hospital's Patient Partnership Council Charter

Delnor Community Hospital
Planetree Patient Partnership Council Charter

Purpose: The Patient Partnership Council (PPC) will serve in an advisory capacity to assist Delnor-Community Hospital in personalizing, humanizing, and demystifying the healthcare experience. Membership of this council will be a working task force to help Delnor always put patients and families first.

Scope
The scope of work for the PPC will:
- Actively promote and create new and unique opportunities for communication and collaboration that emphasize responsible and personalized patient-centered care

Objectives
The primary objectives of the PPC are:
- To use the tenants and principles of the Planetree Model to guide and inform the purpose and work of this Council
- To provide ongoing feedback that aids in establishing organizational priorities and to address patient service issues
- To assist in promoting highly effective practices in response to patient/family needs and priorities
- To improve the patient experience as measured by patient satisfaction survey scores, personal letters, and other data-gathering tools
- To educate the Patient Partnership Council membership so they can become community good-will ambassadors for Delnor-Community Hospital

Membership
The Patient Partnership Council will include:
- 12-15 patients and family members
- 4-5 Delnor leadership
- 3-4 Delnor staff
- Patient Advocate
- Administrative Assistant

Qualifications
As a member of the Patient Partnership Council, the patient or family member:
- Must have previously utilized services at Delnor-Community Hospital
- Needs to be available to attend monthly meetings
- Is willing to share and actively participate in moving the agenda of the council

Participation Guidelines for membership participation include:
- The Council will meet 11 times a year to support Patient Centered Care
- Meetings will be 2 hours in length and always include an educational component

- One meeting of the year will be informational in nature in order to recruit new membership
- A member will become inactive after three consecutive missed meetings
- Inactive members will continue to receive email notifications and meeting minutes during his/her term
- Voting privileges of inactive members will be reinstated after attending 2 consecutive meetings.
- Participants will be encouraged to serve on other hospital committees that would be beneficial to the work of the Council and regularly communicate the work of the committees to the PPC

Terms of participation and Council leadership include:
- General membership will have renewable two-year terms beginning in January of the appropriate year
- The Council will be directed by a four-person Leadership Team consisting of:
  - Patient Chair and Delnor Chair
  - Patient Vice-Chair and Delnor Vice-Chair
- The Leadership Team will meet monthly to set agenda items, prepare an annual evaluation of activities, and recommend budget items related to PPC work
- Patient leadership terms of service will be determined by the Council
- Delnor staff leadership terms of service will be determined by the hospital leadership
- The Patient Vice Chair will rotate to the position of Patient Chair
- The Outgoing Patient Chair will be encouraged to remain a member of the PPC for at least an additional year
- Elections will be held as set by the Council with nominations taken at October meeting and elections at November meeting
- Patient leadership will take office starting in January of the new year

Recruitment
Recruitment guidelines for new membership for the PPC include:
- Using current members to assist in the new membership recruitment process
- Providing information about the Council on the consumer portal of the hospital's website
- Providing brochures in all patient areas, the Health and Wellness Center, and other offsite locations to recruit new membership
- Soliciting personal recommendations by Delnor staff and members of Governance

Membership Ethics and Responsibilities
Members of the PPC will uphold the highest standards of ethics and responsibilities in accomplishing the purpose and scope of the Council by:
- Being active participants at all meetings
- Informing the Chair if unable to attend
- Maintaining patient confidentiality
- Registering as a hospital volunteer which includes a background check and orientation and permits the member to receive volunteer benefits
- Attending a Planetree Retreat

Issues not to be addressed or considered by this Council include, but not limited to, are:
- Financial Aid
- Special Interests
- Support Group and/or Therapy
- Personal Health Issues

Approved April 14, 2008

Tool I: Northern Westchester Hospital's Guidelines for Patient Rounding by Care Manager

NORTHERN WESTCHESTER HOSPITAL
PATIENT ROUNDING BY CARE MANAGER

PURPOSE:

Care Manager will conduct daily patient rounds on new admits and patients ready for discharge to evaluate patient satisfaction. We will be focusing on patient key drivers from the Press-Ganey/HCAHPS surveys focused on:

1 Communication regarding their plan of care and responsiveness to pain

2 Emotional support of the patient and family

3 Visitor accommodations (seating, sleeper chairs and noise levels)

4 Responsiveness to patient requests, questions concerns and complaints

Patients will be asked specific questions to determine level of patient satisfaction and areas requiring improvement. Staff nurses will be encouraged to join patient rounds as necessary.

PROCESS:

- Be prepared. Schedule rounding times into your daily schedule
- Have copies of your rounding sheet – one for each patient.
- Ask the primary nurse if there is anything you need to know about the patient and their experience to date before going into the patient's room.
- Ask the primary nurse if she has the time to join you for the rounding session.
- Address concerns presented to you during rounding immediately
- Escalate concerns to the Nursing Director and Patient Advocate as necessary.
- Document using the rounding sheet and hand in sheets daily to the Nursing Director. Weekly all forms to be submitted to Quality Management for data entry and reporting.

Patient Name: _____
Room #:   _____
Date: _____

CARE MANAGER ROUNDING QUESTIONS

Has your nurse explained to you the plan for your care today? Is there a particular thing that I can be helpful in getting you more information about?	Yes No _____ _____
Are we doing a good job controlling your pain?	Yes No - If not why? _____ _____ Interventions made/offered _____
Are we **always** responding to your requests in a timely manner? On a scale of 1-5 (with 5 being the highest) when you press the call bell how responsive is the staff to your requests?	Yes No - If no, why? _____ _____ 1 2 3 4 5
Have the nurses provided you with information about the medications you are receiving? Are there any questions regarding your medications that I can answer for you or get you information about?	Yes No _____ _____
Do you have specific spiritual or religious needs that we can assist you with?	
Are you happy with how we accommodate your visitors? Did we keep the noise level outside your room quiet?	Yes No - If no, why _____ _____ Interventions made/offered: _____ _____ Yes No - If no – ask patient to tell you time of day that noise levels were too loud _____
If there was one thing that you could change or enhance about your stay, what would that be?	_____ _____
Do you have any questions about your discharge instructions that I can clarify for you?	Yes No
Is there anyone from your care team that you would like to acknowledge?	_____ _____
Our goal is to make sure you feel safe, comfortable and well informed. We also want to make sure we are being responsive to your needs. How would you rate your overall experience (on a scale of 1-5)	1 2 3 4 5 If not a 5 – what can we do to make your experience better for you?
Other Comments/Suggestions	

Adapted by Northern Westchester Hospital from Hardwiring Excellence by Q. Studer

Tool J:

Questions to Ask Your Hospital about Patient-Centered Care

Patient Preferences and Comfort

- What do the patient rooms look like? Will I be able to see outside? Will I be able to adjust the lighting and the temperature myself? If I am not in a private room, is there a place that I can go to have a private conversation?
- Are there any activities other than television available, such as music or reading material?
- Are there lounges available for me and my family/friends to use? Are there patios, gardens, or other outdoor spaces for patients and families?
- Is it possible for you to adjust mealtimes and routine checks around my schedule? For example, if I am a late sleeper, can I receive my breakfast and have my temperature taken later in the morning instead of being awakened?
- Is food available to me 24 hours a day if I am hungry? Can my family/friends cook food for me at the hospital? Will I have a variety of food choices that take my personal or ethnic preferences into consideration?
- Are complementary and integrative therapies such as massage available? What types of services? How would I arrange for those services?

Access to Information

- Do you have a consumer health library?
- What type of information will you provide to me about my condition and treatment options? If I would like more background information, how could I obtain that information?
- What process would I use to access my medical records while I am in the hospital? Will someone review the records with me and answer any questions I have? Do I have the option to add my own information and perspectives into my record for my healthcare team to read and review?

Involvement of Family and Friends

- Are there any limitations on when I may have family/friends with me? Can they stay overnight?
- If I want them to be involved, can my family and friends be trained to help care for me while I am in the hospital? If a family member/friend will be caring for me after discharge, what type of information and training is available to them before my discharge?

Responsiveness to Patient or Family Concerns

- What process should I (or my family member/friend) use to raise a concern while in the hospital?
- Do you have a process for a team to rapidly assess a patient who is deteriorating? Can a patient or family member initiate the team?

Involvement of Patients in Hospital Operations

- What processes do you use to get input from patients and family members?
  - Do you have a patient and family advisory council?
  - Are patients involved on other hospital committees?
  - Do you conduct patient focus groups?
- What type of orientation and support do you provide for patients and family members involved in hospital operations?
- How do you use the feedback obtained from patients and families?

Patient Feedback

- How do patients rate their experience in your hospital?*

* To review how patients rated their experiences at individual hospitals, visit the CMS Hospital Compare website (www. hospitalcompare.hhs.gov) where hospitals' HCAHPS patient survey data is now available.

PRACTICAL APPROACHES FOR BUILDING A PATIENT-CENTERED CULTURE

"Despite all of the challenges of the broken system, there are hospitals that are figuring out a way to create patient-centered culture—they're doing it…And it's the little things that they put into place that actually impact the patient's experience. But when you take them all together they begin to change the culture. And even though they may not have a huge impact on the macro system, in that hospital and for those patients, they are making a difference." (Susan Frampton, Planetree)

The following section details more than 150 practices in place at patient-centered hospitals across the country. These practices were identified during a series of site visits and conference calls undertaken in early 2008 with hospitals whose leadership and staff generously shared their time, their insights and their implementation strategies in order to assist other like-minded hospitals in creating their own patient-centered cultures.

The practices are organized around those aspects of the patient experience prioritized by patients themselves, as indicated by focus group data collected and analyzed by Planetree. The programs, policies and practices spotlighted in the pages that follow have been selected because they have effectively responded to expressed patient needs and preferences. To reinforce how these practices are satisfying what patients are looking for in their health care experiences, each section begins with direct quotes from patients detailing their previous experiences with hospital care and envisioning what could be done to improve upon the care they receive. Their perspective is complemented by the points of view of both leaders and staff from patient-centered hospitals. Their invaluable insights shed light on how they have managed to overcome many widely perceived barriers to providing care the way patients prefer, and the differences they have observed in the overall environment of care.

Consistent with the patient-centered care model's dual focus on both patients *and* staff*,* for maximum effectiveness, the practices described here should also be considered for their potential to enhance the staff experience. The staff experience will be explicitly addressed in Section VII.K., *Care for the Caregiver*. Implicit throughout the Guide, however, is that whether exploring opportunities for enhancing the environment of care, communication, spirituality, caring interactions, food and nutrition (or any of the other aspects of the health care experience covered), the staff experience also should be considered thoughtfully.

COMMUNICATING EFFECTIVELY WITH PATIENTS AND FAMILIES

"The care is great, and the service is outstanding. But sometimes I don't know what I should have asked. I go home and don't feel like I really know what's going on." (patient comment)

Communicating effectively with patients and families is a cornerstone of providing quality health care. The manner in which a health care provider communicates information to a patient can be equally as important as the information being conveyed. Patients who understand their providers are more likely to accept their health problems, understand their treatment options, modify their behavior and adhere to follow-up instructions. If the single most important criterion by which patients judge us is by the way we interact with them, it stands to reason that effective communication is at the core of providing patient-centered care. Patient surveys have demonstrated when communication is lacking, it is palpably felt and can lead to patients feeling increased anxiety, vulnerability and powerlessness.

In one-on-one interactions with patients, and in organizational systems in place to promote dialogue, patient-centered hospitals are demonstrating the profound difference between communicating to patients and families and communicating *with* them. This section of the Improvement Guide details ways that these hospitals are humanizing and personalizing even the most routine interactions with patients, and how they are working to open up the lines of communication between patients and families and providers. The representative patient comments below corroborate the profound importance of communication to the overall patient experience.

The Patient Perspective:

"On the unit in particular, I don't remember being called by my name in the six days I was there. They asked me what name I would like to be called and I told them but they didn't use it."

***

"I felt like I was interrupting them when I asked for help."

***

"There was one nurse who was really rude. I had an epidural and I couldn't feel my legs so I got scared, but this other nurse just said, 'Relax and enjoy that your pain is relieved.'"

***

"I was treated badly by a nurse. I would have wanted to complain, but there is no way to do that. You don't want to jeopardize your care. It would be nice if there was a way to get the message across that this nurse needs some attention for her behavior."

"As for the documentation in checking me in, it took them several hours to check me into my room. But I was okay with that because they told me what was going on and that ten other patients had come in at the same time, which I totally understood. When you're in a situation like that the communication is what soothes you. Not knowing scares you more."

The Staff Perspective:

"The niceness of the nurses really has an impact. The happier they are, the more it feeds on itself."

<p style="text-align:center">***</p>

"Having patients know that we want them to ask us questions, and that we are receptive and responsive to the questions, helps us build stronger relations with our patients."

The Leadership Perspective:

"On the one hand, we need to treat [patients] as partners, and as intelligent, and somebody who we need to engage in a positive way, but we also have to recognize that the environment that we are placing them in is very foreign to them, and it is creating feelings of helplessness, fear and anxiety. And we're not really being responsive to that." (Patrick Charmel, Griffin Hospital)

<p style="text-align:center">***</p>

"...how do we [communicate to] patients...that they can open up to the front line caregivers, they can question things, they can ask questions, that they have the right to expect this type of personalized attention?" (Raymond Troiano, M.D., Sentara Virginia Beach General Hospital)

Optimal patient and family communication is about conveying a message and establishing a connection. As caregivers, our intentions for communication are rooted in our desire to help, support and provide care. We want to be understood so that our patients will benefit from our expertise. Continually, though, we are surprised when feedback from patients indicates that we did not communicate effectively. The following guidelines developed by Northern Westchester Hospital can assist caregivers in setting the stage for effective communication:

1. **Prepare yourself for the optimal exchange:**
   - I will give this patient my full attention.
   - I will truly listen to what my patient is saying before I respond.

2. **Create an environment that enhances a true exchange and connection**:
   - I will acknowledge the patient by the name they prefer to be called.
   - I will introduce myself and will share some information about me.
   - I will sit near my patient, rather than stand.
   - I will make eye contact with my patient.
   - I will be aware of my body language and its subconscious meaning.
   - I will, whenever possible, reassure my patient through the power of touch.
   - I will repeat what my patient has asked me to ensure my understanding of their question.
   - I will engage family members present, recognizing their important role in the care of the patient.

    79

3. **Provide information and confirm understanding:**
   - I will explain what I am saying slowly and in small doses, giving my patient adequate time to process the information.
   - I will gently ask my patient to tell me what they understood.
   - I will assist my patients to be true partners in their care by giving them access to information about their disease process. I will suggest articles, websites, books, and consumer libraries that might be helpful for further understanding.
   - I will use technology, as appropriate, to highlight my point.

4. **Ask for feedback on your communication style:**
   - I understand that each person learns differently.
   - To make sure we establish an open and clear dialogue, I will ask if the manner and style in which I am communicating is effective for the patient.

Communicating health care information is difficult. The concepts are complex and emotional. However, establishing a connection from the onset enables patients to open up, be somewhat less frightened and concentrate on what is really important—the information you are providing.

PATIENT-CENTERED APPROACHES TO COMMUNICATING WITH PATIENTS AND FAMILIES:

Scripting Tools for Effectively Communicating
Regardless of your role in health care—nurse, doctor or patient transporter—communication is central to the role. A number of patient-centered hospitals, including Northern Westchester Hospital (NWH) in Mount Kisco, New York, are using practical tools to guide staff in communicating with patients in an effective and compassionate manner. NWH's **communication standards** have been implemented in both inpatient and emergency department settings. Its **7 P's Nursing Report tool,** designed by nursing staff at the hospital, enhances the reporting process to be both focused and efficient by standardizing the exchange.

The Perinatal Advisory Committee of the University of Washington Medical Center in Seattle, Washington developed communication guidelines, called **Communication Cues**, for the residents and fellows in its Maternity and Infant Center to reinforce not only important communication behaviors for building rapport with patients and families, but also the special sensitivity required when communicating with the particularly vulnerable population of patients with high risk pregnancies or facing premature labor.

Special care and sensitivity is also in order when communicating with a patient or family member who has a complaint about their care. The Cleveland Clinic uses the acronym H.E.A.R.T. to describe how staff members are expected to respond to patient and family complaints and/or concerns:
- **H**ear the Story
- **E**mpathize
- **A**pologize
- **R**espond to the problem
- **T**hank them.

To keep this important approach to handling sometimes difficult conversations top of mind, the hospital provided staff members with a badge, reminding them to "Respond with H.E.A.R.T."

These tools are all included at the end of this section as resources: Communication Standards (page 84-85); 7 P's Nursing Report Tool (page 86); Communication Cues (page 87); and Respond with H.E.A.R.T. (page 88).

Patient and Family Communication Boards

Effective communication is not just verbal. Other tools can be used to enhance the learning process and can help patients remain informed for the duration of their stay. An easy and cost-effective way to help patients and their loved ones remain involved and informed is through the use of patient and family communication boards. These boards, usually in the form of dry erase boards, allow the care team to post their names for patient and families, and include some basic information, such as the room number and patient room telephone number. Placed in easy view of the patient, the board is a convenient place for caregivers to write information that is important for the patient to remember, such as "CT Scan will be done today at 1 pm." The boards also serve a purpose for families, allowing them the opportunity to write reassuring messages to the patient or post pictures of loved ones.

Patient Television Systems

Beyond a source of entertainment and diversion, patient television systems can be an effective vehicle for patient education. As many hospitals enhance their surroundings to flat screen, LCD television systems, they may opt to take advantage of opportunities to digitize the videos formerly rolled into patient rooms for education purposes. By digitizing educational videos, the patient and family can play them at any time. Many times the television systems can be programmed to interface with the electronic medical record systems allowing documentation of patient viewing.

Questions for Your Doctor or Nurse Notepad

A common patient experience is that of knowing exactly what questions they would like to ask the physician or nurse, only to find the questions no longer on their mind when their caregivers are present. An easy way to address this issue is for each room to have a pad of paper labeled "Questions for Your Doctor or Nurse" which is placed in the room upon admission. The nurse lets the patient and family know should they have questions to jot them down on the pad. Questions for the doctor can be collected from the patient and placed on the patient's chart, so that the doctor is aware of any questions the patient has before entering the room. Family members also have a place to write down their contact number so the physician can call them regarding their question.

Just Ask Campaign

Equally as important as giving patients a vehicle to jot down questions is clear communication that questions are strongly encouraged. After a series of patient focus groups, Northern Westchester Hospital discovered that patients did not know that they could ask some basic questions, such as requesting alternative times for blood draws or meal delivery. In response, the hospital introduced the Just Ask Campaign. This campaign, simple in its design, consists of a

sign posted in every patient room encouraging patients and families "*if they think it, to ask it.*" *Sample Just Ask signage is included on page 89.*

Staff Attire

> *"When you're medicated and the world is one big fog, when you can identify who is coming into your room easily, it makes you feel a little less anxious."* (patient comment)

Hospitals have also examined how staff attire helps to facilitate effective communication between patients and caregivers. When staff attire is homogenous, coupled with staff not introducing themselves nor telling the patient what they are doing, patients are often left to try to delineate caregiver roles for themselves. Some hospitals have taken the position that attire should convey the role the provider is serving. This can be done without compromising staff individuality and creativity. Some organizations have started with looking at their environmental services and patient transport teams and selecting attire that is fitting for the role and easily identifiable to both patients and other staff. Other organizations have considered the role of nurses and how to best convey the professionalism of nursing to patients. Some hospitals color code nurses' uniforms by specialty. For example, all maternity nurses wear pink and blue, while medical surgical nurses are in navy and white. Other organizations delineate roles through badges with large visible role definition, such as "RN."

Caregiver Photographs

A common adage suggests that a picture is worth a thousand words, which is why many institutions have made a practice of posting photographs of each member of the care team along with their role and credentials in visible spots (such as unit bulletin boards or in the main reception area) to foster an atmosphere in which staff are recognizable and approachable. At Mid-Columbia Medical Center in The Dalles, Oregon, pictures of all the members of the medical staff are framed and posted along the main patient thoroughfare.

At Waverly Health Center in Waverly, Iowa, a dry-erase magnet with photos of the caregiving team is placed in each outpatient surgery suite. Every day, the staff members caring for the patient on that particular day are identified with a simple check mark in the circle near their photo. This simple and low-cost tool ensures that patients and their family are familiar with—and can recognize—the individual staff members who will be providing care that day. *Waverly Health Center's "Your Staff Today" magnet is included on page 90 as a resource.*

Discharge Phone Calls

See Discharge Phone Calls in Continuity of Care, Section VII.C, page 118.

Communication with Family Members

Communication with family members can at times be hard to manage. Caregivers sometimes struggle with who they can release information to or find themselves trying to juggle calls from multiple loved ones all looking for the same information. When patients have multi-system issues with various specialists involved, communication can be even more challenging. One effective way to address these issues is to **document in the medical record the designated contact identified by the patient as the person to receive frequent updates** from the physician or nurse about the patient's condition. This contact is responsible for updating other family and loved ones. Other hospitals have adopted technology that allows caregivers to **record updates**

about a patient's condition on a confidential line that is password protected. Designated family members can then check the status of their loved one through this service. **Family meetings with caregivers** can also be a very effective method for addressing family needs. These meetings can be quite beneficial when patient advocacy is used to help coordinate the meeting. Patient advocates or representatives can help the family list the questions they wish to be addressed and ensure the appropriate caregivers are present. Advocates also help clarify information that is provided and serve a role after the meeting to ensure the family's comfort with the process.

IMPLEMENTATION TOOLS:

A. Northern Westchester Hospital's Communication Standards, *pg. 84*

B. Northern Westchester Hospital's 7 P's Shift Report, *pg. 86*

C. University of Washington Medical Center's Communication Cues, *pg. 87*

D. Cleveland Clinic's Respond with H.E.A.R.T. Badge, *pg. 88*

E. Northern Westchester Hospital's Just Ask Campaign, *pg. 89*

F. Waverly Health Center's "Your Staff Today" Magnet, *pg. 90*

Tool A: Northern Westchester Hospital's Communication Standards

COMMUNICATION STANDARDS: In healthcare, where fears and anxieties are high, it is important to use phrases that are easily understood and convey our dedication to providing the highest quality healthcare.

ESTABLISH A CONNECTION: When we break down communication barriers with our patients and families, we create an environment of open dialogue and trust. By adopting the following effective communication strategies, you will see the positive impact on patient satisfaction levels and the increased partnership that manifests between patient and caregiver.

FIVE IMPORTANT KEY POINTS IN DELIVERING HIGH PATIENT SATISFACTION

PATIENT SATISFACTION REQUIRES: C.P.R.

C: COMPASSIONATE COMMUNICATION
P.   PATIENT INFORMATION/PAIN MANAGEMENT
R.   RESPONSE

C.P.R REQUIRES CONSISTENT DELIVERY OF THE FOLLOWING:
1. <u>Communicate</u> to the patient <u>who you are</u>, <u>what you do and who are the members of the team.</u>
2. <u>Inform</u> the patient daily what their <u>plan is for the day</u> and set expectations – write on the whiteboard.
3. <u>Inform</u> the patient and family if they have any questions, concerns to call - <u>you are here to help</u>.
4. <u>Encourage</u> the patient to communicate how we are doing in managing their pain – their comfort is vital!
5. <u>Include the patient</u> – tell them what you are doing in the room, even the simple things like adjusting IV's or taking a vital sign. The more you communicate about what you are doing, the more comfortable they will be with asking questions.

Step 1: Establish Rapport: Good Morning, Mr. Smith, I am Susan your nurse today. I have received report from Carol your night nurse and she told me you had trouble sleeping during the night. I also spoke with your physician this morning, so let's go over what is planned for today. Please feel free to ask me questions. I have been a nurse on the surgical unit for 12 years, so I am confident I can answer most questions, and if not, I will find out the answer for you. It is important for you to be informed about your plan of care. Today, you will be going down to Radiology for an MRI. My best estimate for when this will happen is mid morning. But, I will speak with Radiology to confirm a time. Have you had an MRI before?	You have communicated: <u>Who</u> you are, your <u>expertise</u>, your commitment to keeping patients <u>informed</u>
Step 2. Introduce other staff the patient may encounter: Another important staff member on our team is Andrea. She is your nursing tech. Andrea is wonderful and assists me with your care. I just want to make sure you know are names; so to help you remember, I will write them down on the white board.	You have communicated: We work <u>as a team</u> to care for you
Step 3: Reinforce our commitment to being responsive to patient needs: It is very important to us that we do our very best to make you as comfortable as we can during your stay. I will be coming in periodically to assess how you are doing and to check if you are experiencing any pain. Please tell me how I can best manage your pain. Please call me if your level of discomfort increases. We want to be responsive to your level of pain and manage it effectively for you.	You have communicated: <u>We are responsive to your pain</u> and any other needs you may have.

Step 4: Set Expectations and offer Encouragement: Mr. Smith, you are doing very well, considering it only 8 hours since you came from surgery. I am going to check on my patient next door now. I will be back in to see you in about one hour. As I said before, Andrea your tech will come in next to help you freshen up and the physical therapist will be in shortly after that. Please call if you need anything. Before, I go, is there anything else I can do or answer for you?	You have communicated: <u>Immediate next steps</u> in the plan of care and <u>when you will be back</u>.
Step 5: Communicate Reasons For Delays: Mr. Smith, I know I told you this morning that your MRI would happen mid morning. I just received word from Radiology, that there will be a delay. We had an emergency situation and the MRI machine is needed. Radiology assured me you are next on the list. This means you will have your MRI around 1pm. I have arranged for your lunch tray to be delivered to you when you come back from MRI. Mr. Smith, I apologize and I thank you for your patience and understanding.	You have communicated: <u>The reason for the delay</u>, that you <u>care</u> about them and your <u>appreciation</u> for their patience.
Helpful Patient Comfort/Communication Strategies	
- Conduct an environmental assessment (e.g. Can the patient reach the telephone, tissue, trash can, TV controls, food tray, water) - Ensure each patient is covered and comfortable - Tell the patient that you round routinely to check comfort levels - Ask the patient if there was anything else you can do for them prior to leaving the room - Tell the patient when you will be returning - Tell the patient when you are going off shift and the name of the nurse who will be relieving you. When possible, bring the relieving nurse into the room and introduce the nurse to the patient. _____ **Acknowledge**—Acknowledge the patient by name. Make eye contact, smile – remember the power of touch. **Introduce**—Introduce yourself, share with the patient a little bit about yourself. **Duration**—Give an accurate time expectation for tests, physician arrival and tray delivery, etc. **Explanation**—Explain step by step what will happen, answer questions and how you can be reached. **Thank**—Thank the patient for coming to us. Thank the family for assistance and being there to support the patient.	
IMPORTANT KEY PHRASES	
- No, or I can't **What I can do is….** - I don't Know **I'll find out for you.** - That's not my job **I'll get someone to help you.** - Your right, this stinks **I understand your concerns.** - That's not my fault **Let's see what we can do about this.** - We're short staffed **Tell me how I can help you.** - Calm down **I am sorry you feel…** - I'm busy right now **I'll be with you in just a moment.** - I'll tell you how to go there **I'll take you were you need to go.** - I can't release any information to you **As I am sure you understand, patient privacy is very important. Let me check with the patient first.**	
Sources: Hardwiring Excellence, by Q. Studer Press Ganey – What Patient's Love – Press Ganey's Guide to HCAHPS	

Tool B: Northern Westchester Hospital's 7 P's Shift Report

NWH NORTHERN WESTCHESTER HOSPITAL
Expertise • Technology • Humanity

Shift Report

7 P's

REMEMBER
"AIDET"
Acknowledge
Introduce
Duration
Explanation
Thank

"SBAR"
Situation
Background
Assessment
Recommendation

Date: Room #:	Date: Room #:	Date: Room #:
PATIENT Name: Age: MD: Dx: Hx: Adv. Dir.:	**PATIENT** Name: Age: MD: Dx: Hx: Adv. Dir.:	**PATIENT** Name: Age: MD: Dx: Hx: Adv. Dir.:
PRECAUTIONS	**PRECAUTIONS**	**PRECAUTIONS**
PURPOSE: Reason for Stay	**PURPOSE:** Reason for Stay	**PURPOSE:** Reason for Stay
PLAN OF CARE: For Today	**PLAN OF CARE:** For Today	**PLAN OF CARE:** For Today
PRIORITIES	**PRIORITIES**	**PRIORITIES**
Procedures	Procedures	Procedures

PROBLEMS
N:
CV:
R:
GI:
GU:
Skin:
PAIN Scale ____/ 10
   Location:_____
   Meds/Treatment_____
   _____
Psychosocial Issues:
	PROBLEMS
	N:
	CV:
	R:
	GI:
	GU:
	Skin:
	PAIN Scale ____/ 10
	   Location:_____
	   Meds/Treatment_____
	   _____
	Psychosocial Issues:
		PROBLEMS
		N:
		CV:
		R:
		GI:
		GU:
		Skin:
		PAIN Scale ____/ 10
		   Location:_____
		   Meds/Treatment_____
		   _____
		Psychosocial Issues:

IV's Meds Labs Tests Glucs Tele Y N Rhythm	IV's Meds Labs Tests Glucs Tele Y N Rhythm	IV's Meds Labs Tests Glucs Tele Y N Rhythm
Comments	Comments	Comments

FACE: GRADUATED LOGO SCREEN 5%-100%

Tool C: University of Washington Medical Center's Communication Cues

Patient and Family
Centered Care

Communication Cues
Partnering with Patients and Families in the
Maternity and Infant Center and Neonatal Intensive Care Unit

The Perinatal/NICU Patient and Family Advisory Council has compiled a list of suggestions on ways to communicate with patients and families during their stay at UWMC. Please recognize that each family situation is unique. Some admissions and births are planned and celebrated, while others are not planned and may be a time of great personal and family stress. Thank you for considering the following:

Introductions and Courtesies

Please…

- Introduce or reintroduce yourself every time you meet a family.

- Build rapport with families and take the time to engage in friendly conversation.

- Congratulate parents on the birth of their baby, even the most high-risk delivery. Acknowledge the celebration of their baby's arrival.

- Respect a family's privacy by:

    - Knocking before entering a room.

    - Regarding them as you would if entering their home.

    - Honoring privacy screens in the NICU and the limited private time parents have with their infant.

    - Refraining from talking about other patients within earshot of parents and families.

- Be sensitive to differences among families with regard to the stress of their hospital stay:

    - Most families see this experience as an emotional and spiritual transition.

    - Recognize that for most patients and their families, the medical environment is unfamiliar territory.

    - Recognize individuals have differing styles of coping with stress.

    - Avoid making assumptions and judgments about patients and families.

    - Remember that minor things to a professional might be major things for patients and their families.

    - Recognize that patients and families may be grieving even with the birth of a healthy baby, due to a disappointing birth experience or a difficult family situation.

UNIVERSITY OF WASHINGTON
MEDICAL CENTER
UW Medicine

Tool D: Cleveland Clinic's Respond with H.E.A.R.T. Badge
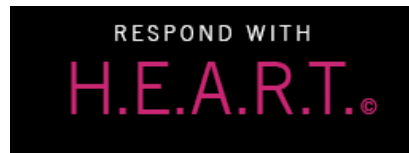
RESPOND WITH

H.E.A.R.T.©

Hear the Story
Listen attentively

Empathize
"I can hear/see that you are upset."

Apologize
"I'm sorry you were disappointed."

Respond to the Problem
"What can I do to help?"

Thank Them
*"Thank you for taking the time
to talk with me about this."*

Cleveland Clinic

Tool E: Northern Westchester Hospital's Just Ask Campaign

Northern Westchester Hospital

Just Ask!

IF YOU'RE THINKING IT... ASK IT

For example:

- May I request a different meal selection?
- Can my vital signs and blood work be drawn at a more convenient time for me?
- What medications are you giving me and what are they for?
- How can I arrange for a complementary relaxation session?

Please ask, so that we can better meet your needs and make your stay more comfortable.

NWH NORTHERN WESTCHESTER HOSPITAL
Expertise • Technology • Humanity

For more information, visit www.nwhc.net

Tool F: Waverly Health Center's "Your Staff Today" Magnet

PERSONALIZATION OF CARE

> *"I didn't feel like an individual,*
> *I felt like a patient."*
> (Patient Comment)

Building in processes and mechanisms to customize and personalize the patient experience is a key strategy for overcoming the fear, anxiety and stress associated with being at the hospital. To enter the hospital and subsequently be told what to wear and what and when to eat, to have normal sleeping patterns disrupted by inflexible hospital routines, to suddenly become dependent on others for basic personal needs like toileting and hygiene, and to be known as a room number versus a name, can all contribute to a feeling of being dehumanized.

Encouraging patient involvement and empowerment, including patients and families in the experience and focusing on how to create a more homelike experience are some ways health care providers may begin to reframe past practices. Patient-centered hospitals are implementing unique programs geared toward validating patient preferences, preserving patients' normal routines as much as possible, and maintaining the patient's personal identity throughout the health care experience.

The Patient Perspective:

"I come in on medication, and they always try to tell me how to take my thyroid medication. I know how to take it, and then they insist that I take it their way. I know it has to be taken first on an empty stomach, and before all the rest. I ask them to give it to me the way I know how to take it. They insist that it's hospital policy to take it their way, all at once with breakfast. But I know my medications, and they wouldn't even listen to me."

***

"The next night they finally gave me a sleeping pill at 1:30 and woke me at 5 to take my blood. I know you don't come to a hospital to get rest but there should be some way for the nurse to let the lab know that I didn't sleep and not to wake me up."

***

"When I was finally able to fall asleep and get some rest, they started doing the rounds. At around 5:30 in the morning one of the residents came in to start poking and prodding. If she had done it an hour or two hours later, I would have been exactly the same patient."

***

"I was never given a food list to make a menu choice. I came in and the first meal I get as a heart patient (I am very diet conscious) they give me bacon, eggs, white toast and jam. I told them I can't eat this [because] I am a heart patient…when I left they put on my discharge form 'very little appetite.' That wasn't true. I probably could have eaten the desk but I wasn't allowed to pick what I wanted to eat. I never saw the people who delivered it—I don't know if I was out in the hall or what."

***

"I didn't want [my baby] to be bottle fed. When I found out he was given a bottle in the nursery, I was mad! When I asked the nurses about that, they said 'When there are ten babies crying in the nursery, what else can we do?' I told them they should pick my baby up and bring him to me!"

The Staff Perspective:

"I've seen a real focus on the patient, not just treating them as a unit being handled at the hospital, but treating them as a whole person, personalizing their care."

***

"[Patient-centered care] is the way I've always practiced, to treat the patient in a flexible way, and here I get to practice that way. I treat my patients like family members."

The Leadership Perspective:

"[Staff and physicians] have a thousand things to do, and yet amongst all [these things], they need to provide empathy, care, information in time… they are so harried, so busy, so many things to do, that things fall through the cracks, and our patients suffer. But we ask an awful lot of our staff. So, I think one of the questions to ask is how do we deal with it? How do we deal with all of the things we ask for our staff to do, and remain efficient with our staffing and productivity to provide this kind of care?" (Robert Devermann, M.D., Aurora Health Care)

PATIENT-CENTERED APPROACHES FOR RESPECTING PATIENT PREFERENCES, PRESERVING PATIENT DIGNITY AND PROMOTING PATIENT AND FAMILY EMPOWERMENT:

Patient Attire
Eliminating the use of the open back gown in favor of side tying dignity gowns that cover the patient preserves an individual's sense of modesty and dignity. Some facilities also use pajama shorts or pants, or allow patients to wear their own pajamas or street clothing.

Flexible Times for Hospital Procedures
The common practice in hospitals of standardizing times for routine procedures such as blood draws, vital signs and others is often done to accommodate the preferences and convenience of staff. Implementing a flexible schedule geared toward patient preferences provides patients a much appreciated measure of control over their day—and night. Some patient-centered hospitals have introduced a **no night shift procedure philosophy** to maximize the opportunity for patients to sleep, recognizing that rest promotes healing.

Self-Medication Policy
A self-medication policy allows patients to begin taking responsibility for their own care while they are in the hospital. A pharmacy consult provides oversight for those drugs appropriate for self administration. For patients accustomed to taking their medications on their own at home, a self-medication program validates their ability to manage their own care. For those on new medications, such a program can build their comfort-level and confidence in their new regimen prior to discharge. Pharmacy and nursing personnel involvement is important so as to avoid drug-drug interaction and/or food-drug interaction.

Patients Sign Off on Plan of Care
The daily review of the patient plan of care in a number of patient-centered hospitals includes the patient signing off on this plan. By involving the patient, miscommunications can be avoided, patient education is enhanced and discharge planning is facilitated.

Capturing Patients' Stories

Gathering a short bio from each patient upon admission can be an invaluable tool for reframing care from the traditional "diagnosis and room number identity" to the patient as a person. Trained volunteers can be engaged to interview patients about who they are *really*. This one page description of the patient is included in the patient chart and reviewed during handoffs. *A story telling interview sheet is included on pages 97-105 for reference.*

Inspired by the memory of a patient, Alegent Health Lakeside Hospital created a "My Story" poster that serves as an essential communication tool for the entire health care team. The poster features a series of questions that the patients or their loved ones can answer in writing to help caregivers learn more about the patient's personal story. *Alegent Health's "My Story" poster is included on page 106.*

PATIENT-CENTERED APPROACHES FOR ENCOURAGING CARING INTERACTIONS:

Oftentimes it is the simple gestures of human kindness and compassion that can most profoundly transform a stressful time or a bleak setting. Patient-centered hospitals develop programs and systems to maximize these considerate interactions and to reinforce the *care* in health care. Manned by volunteers, **roving comfort carts or caring carts** are stocked with complimentary snacks and beverages (including baked goods, coffee/tea, juice boxes, microwavable soup, instant oatmeal, etc.) and provide refreshment (in the broadest sense) to patients and their visitors. Being approached by an attentive volunteer offering refreshments, a newspaper, or a blanket can also help to ease the anxiety of those waiting in lounge areas for a test or procedure, or for news on the status of their loved one. This kind of cart takes on special significance to loved ones of a patient who is actively dying. Often reluctant to leave the bedside, the provision of a **compassion cart** stocked with nourishing foods enables loved ones to remain close.

A **concierge program** is another way that many patient-centered hospitals are making life easier for patients and their families during what are often hectic, overwhelming days. Whether it be arranging reduced rate hotel reservations for an out-of-town relative visiting a hospitalized loved one, arranging for bedside hair and nail care for a patient, or providing convenient drop off and pick up drycleaning services, the role of the concierge is to make the hospital stay as comfortable as possible and to minimize the interruptions to daily life that hospitalization can cause.

In patient-centered hospitals, all staff—clinical and non-clinical, alike—are considered caregivers. These hospitals optimize the impact that staff members have on the environment of care by providing special opportunities for caring exchanges. At Sharp Coronado Hospital in Coronado, California, the role of housekeepers has been expanded. Through its **Host and Hostess Program**, housekeepers not only keep patient rooms clean, they also present each patient with a warm facecloth and a newspaper. These simple gestures emphasize to patients that *every* staff member is there to be responsive to their full range of needs. *The duty list outlining the role of Hosts and Hostesses is included on page 107 as a resource.*

At Windber Medical Center in Windber, Pennsylvania, housekeepers leave a "calling card" of sorts to notify patients that their rooms have been cleaned. The card includes a phone number

the patient can call should they require any additional housekeeping services during their stay, and as a small token gift, a crossword puzzle for entertainment.

PATIENT-CENTERED APPROACHES TO FOOD AND NUTRITION:

For many patients, food becomes particularly important, not only for nutrition, strength and sustenance, but also as a positive distraction during the day. Unappetizing food served at the convenience of the staff versus the preference of the patient feels impersonal and institutional. Food that tastes and looks appealing conveys caring. And when patients are provided the opportunity to choose what and when they will eat, their sense of autonomy is maintained. Patient-centered hospitals find ways to address patients' varied preferences and traditions around food and meal times. Because accommodation of "special requests" is the norm versus the exception, patients are able to preserve some of their normal routines without feeling like they are placing a burden on staff.

Room Service
Creating a more restaurant-like service is the goal of many hospitals. Patients are provided a diversified restaurant style menu (including international food selections) and a phone number. When they are hungry, patients call in their order and it is delivered within an established time period (30-40 minutes). Diet technicians answer the call directly to assure choices are aligned with dietary restrictions. Restaurant type menus may take on a bistro style, a Mediterranean style, or another style depending on the community and its ethnic diversity.

Personalized Menus
Hospitals for which room service is not a viable option have found a host of different ways to personalize food service. **Daily dietary visits** are an opportunity for staff and the patient to talk together about what would taste good on that particular day. Another strategy for ensuring that patients are satisfied with their food and that it is meeting their dietary needs is a personal **visit from the chef** to any patient who has not eaten the meal provided to them in order to identify how best to meet their food needs/preferences.

Kitchenettes in Units
In an effort to create a more home-like environment, many patient-centered hospitals are creating unit-based kitchenettes. These kitchenettes may be used by volunteers to bake bread or cookies and families may choose to bring in a meal to share around a dining room style table. On holidays it is not uncommon to see multiple families sharing a meal together in this type of a setting.

PATIENT-CENTERED APPROACHES FOR CREATING SIGNATURE MOMENTS:

Each patient comes to us with his or her own personal history, established routines and preferences. Yet for many, it can feel like these individual traits are disregarded in a health care system that tends to be oriented more toward staff convenience than patient preferences. The following practices in place at patient-centered hospitals are designed to personalize the hospital experience:

"What would you prefer?"
Asking the patient on arrival, "*What is your #1 priority during this stay?*" creates the opportunity to anticipate patient needs and preferences. By communicating the patient's response on a white board in the room, all caregivers will be alerted and attentive to the patient's specific and personal needs or concerns.

VIPeds/Peds on the Move
While creating a fully decorated Pediatric Unit may not be an option for your hospital, creating a pediatric room conversion kit on wheels may be the answer. This Peds on the Move/VIPeds mobile cart may contain such items as pediatric linen, a back pack with age appropriate games, and any needed pediatric equipment. *See page 108 for a list provided by Valley View Hospital of suggested age-appropriate items to include in a "Peds-In-A-Box."*

ASSIST Program
Coordinated by the Valley View Hospital Auxiliary out of Glenwood Springs, Colorado and run by volunteers, the ASSIST Program was originally conceived of as a service to out-of-town visitors who encounter medical problems, but has been broadened to address a wide variety of needs. ASSIST volunteers are available to arrange lodging or transportation, provide companionship to a loved one, and share information about the area. ASSIST is triggered at the hospital when a staff member recognizes that a patient is from out of town or in need of some extra companionship and compassion. An ASSIST volunteer is then arranged, generally through the Volunteer Coordinator, Case Manager or Shift Supervisor, to respond to the call. *Valley View Hospital's ASSIST Program poster is included on page 109 as a resource.*

PATIENT-CENTERED APPROACHES FOR RESPONDING TO DIVERSE CULTURAL EXPECTATIONS:

From accommodating the diversity in what represents comfort foods for different ethnic groups, to providing translation and interpretation services and ensuring that cultural traditions for birth, death and illness are honored, patient-centered hospitals must be equipped to provide personalized care to patients and families of all different traditions and experiences.

Cultural Competence Training
Providing education to staff on different cultural norms prepares them to understand diverse needs and expectations. Inservices and trainings can be complemented by user-friendly resources available for quick reference when a patient or family from a specific culture is receiving care. Such resources should be available on every unit to provide information on cultural norms around religion, health care traditions, family involvement, food, holiday traditions and more. Of course, though, consistent with the values of providing individualized, patient-centered care, it is important for anyone using such resources to recognize that they are intended as a guide to promote understanding of different cultures in a *general* way. Being responsive to *individual* needs means seeing the person as a unique individual rather than applying a generic and restrictive cultural label.

Accommodations for Diverse Spiritual Practices
Chapels or spiritual spaces must be designed to offer solace and comfort to individuals of any spiritual tradition. This can be accomplished by creating a neutral sacred space where resources

for a variety of faith traditions are available, such as rosary beads, a Bible, prayer mats, a compass, and a menorah.

Overcoming Communication Barriers
Communication in health care settings can be wrought with opportunities for misunderstanding and miscommunication even when the patient and caregiver speak the same language. These challenges are considerably amplified with communication barriers exist, and patient-centered hospitals work to overcome these barriers. Northern Westchester Hospital in Mount Kisco, New York serves a diverse population and must be responsive to a variety of language needs. The patient navigator on staff is available to arrange translation or interpretation services when needed. In addition, a dual handset phone is available to provide 24-hour a day access to medical interpretation in more than 150 languages.

To help facilitate patient-caregiver communication when language is a barrier, Highline Medical Center in Burien, Washington created a **Multicultural Pointing Tool**, a "picture book" populated with illustrations of body parts and other words and phrases commonly used in hospitals. *The Multicultural Pointing Tool is included on pages 110-111 as a resource.*

An on-line tool released by MedlinePlus provides access to printed health information in languages other than English and Spanish. With more than 2,500 links to information in more than 40 languages and covering more than 250 health topics, such a resource can offer comfort and reassurance to patients and loved ones who prefer to read consumer health information in their native language. The tool can be found at: http://www.nlm.gov/medlineplus/languages/languages.html.

Communication barriers are not limited to language. Accommodations such as volume control, listening aides, large-button phones, speaker phones and telecommunication devices for the deaf must also be made for patients and families with visual and/or hearing impairments.

IMPLEMENTATION TOOLS:

A. Sharp Coronado's Guidelines for Recording Your Family History, *pg. 97*

B. Alegent Health Lakeside Hospital's "My Story" Poster, *pg. 106*

C. Sharp Coronado Hospital's Environmental Services Department Duty List, *pg. 107*

D. Valley View Hospital's Peds-In-A-Box Tool, *pg. 108*

E. Valley View Hospital's ASSIST Program Poster, *pg. 109*

F. Highline Medical Center's Multicultural Pointing Tool, *pg. 110*

Tool A. Sharp Coronado Hospital's Guidelines for Recording Your Family History

RECORDING YOUR FAMILY HISTORY

History is all around us, in our own families and communities, in the living memories and the experiences of older people. We have only to ask them and they can tell us enough stories to fill a library of books. This kind of history - that we all gather as we go through life - is called ORAL HISTORY.

Everyone has a story to tell about their life, which is unique to them. Some people have been involved in momentous historical events like the Second World War, but many others haven't. Regardless of age or importance we all have interesting experiences to share.

Everyone forgets things as time goes by and we all remember things in different ways. Some people's memories are better than others and for reasons we don't really understand, many people actually remember their early years more as they get older. This is helpful when we want to tape-record peoples' memories. All memories are a mixture of facts and opinions, and both are important. The way in which people make sense of their lives is valuable historical evidence in itself. Few of us are good at remembering dates, and we tend to telescope two similar events into a single memory. So when we interview people it is important to get them to tell us about direct personal experiences - eye-witness testimony - rather than things that might have been heard second hand.

There are some points to cover in every interview: date and place of birth, what their parents' and their own main jobs were. Whatever the topic, it usually helps to get the interviewee talking if you begin with their earlier life: family background, grandparents, parents and brothers and sisters (including topics such as discipline). Then you should discuss childhood home (housework, chores, mealtimes), leisure (street games, gangs, sport, clubs, books, weekends, holidays, festivals), politics and religion, schooling (key teachers, friends, favorite subjects), early relationships, working life (first job, a typical working day, promotion, pranks and initiation, trade unions and professional organizations), and finally later family life (marriage, divorce, children, homes, money, neighbors, social life, hopes). Most people find it easier to remember their life in chronological order, and it and it will take you three or more sessions to record a full life story.

The best interviews flow naturally and are not rehearsed. Don't over-prepare. Don't use a script. Tape recorded life stories should be lively, spontaneous and vivid. Allow people to be themselves.

Keep your questions short and clear:
- Don't interrupt: Don't ask too many questions. Your aim is to get them to talk, not to talk to yourself. Always wait for a pause before you ask the next question. Listen carefully and maintain good eye contact.
- Respond positively: body language like nodding and smiling is much better than "ers" and "ums" and "reallys".
- Be relaxed, unhurried and sympathetic.
- Don't contradict and don't get into heated debate.
- Don't be afraid to ask more questions, but don't jump from one subject to another too abruptly. As well as a mere descriptive retelling of events, try to explore motives and feelings with questions like "Why?" and "How did you feel?"

Getting behind stereotype and generalization is one of the most challenging aspects of interviewing people. But remember to be sensitive and always respect confidences.
* Use tape recorder
* Avoid mike fright
* Play back first few sentences spoken
* listen and wait
* take breaks
* label the tape and give to patient matter of trust
* don't edit the original tape
* be aware of time – stop when patient seems tired
* always schedule the time for the next session

The following is a list of suggested areas to be discussed.

Family History
- Age, birthdate, birthplace
- Where parents and grandparents were born
- Emigration stories
- Grandmother and grandfather on both sides
- Family heirlooms
- Parents
- How they fell in love
- Their childhood
- Description of parents
- Social class – education
- Interests and civic involvement
- Skills and talents learned from both parents
- Religious beliefs
- Health and death of parents
- Other family members

- Brothers and sisters
- Aunts and uncles and cousins

Childhood
- When were you born
- Early memories
- Neighborhood and playmates
- Interaction between brothers and sisters
- Discipline
- House brought up in
- Religious training
- First school experiences
- Happy and sad memories
- Dreams and ambitions
- Strange or unusual experiences
- Celebrating holidays
- Geographical moves

Youth
- Teenage years
- Where did you live? Who lived in your household?
- What was you house, your neighborhood, your community like?
- Did you have relatives living nearby?
- How did your family earn a living?
- Did religion play a part in your childhood
- What neighborhood gatherings, social or working, do you recall?
- Where did you go to school? How many grades did you complete?
- Did you have a job? Doing what? How much money did you earn?
- How did you use your earnings?
- What were your dreams or plans for the future? Which became reality?
- School memories – junior and high school
- Teenage friends – special teachers
- Pranks
- Ambitions
- Teenage activities
- Clothing and hairstyle
- Athlete or scholar
- Social class
- Heroes and idols
- Entertainment and interests
- Political experiences

- Religious experiences
- Music and books
- Jobs and household responsibilities
- Dating, courtship and sex
- Teenage conflicts
- Trouble gotten into
- Conflicts with parents
- Friends, dating, drinking, smoking, sex
- School performance
- Jobs, career choices, political and religious beliefs
- Time to stop – schedule next meeting

College, military, job and marriage
- College- where and when attended
- Leaving home
- Money
- Fraternities and sororities
- Money – did you work – have a scholarship[
- College major – were you a good student
- Did you have best friends during that time
- Political activity – sports
- Periods of depression turmoil – saddest/happiest memories
- Graduate or professional school after graduation
- Military experiences
  - Drafted or enlisted – what branch of military
  - Parents' reaction
  - General attitude of public re war
  - Combat – wounded- experiences
  - Army stories
  - Medals won
  - Coming home
  - Attitudes about women in military

Adulthood
- Where did you live?
- Did you marry- Age
- Courtship – stormy or calm
- Parent's reaction
- Honeymoon – memorable stories
- First home after marriage
- Jobs - jobs of spouse – first job

- Household budget
- Wages
- First career
- Best and worse things

Middle Age
- Turning forty
- Did life change
- Career at that time
- Spiritual development
- Biggest changes in your life (divorce, change jobs, sicknesses)
- Children/grandchildren
    - Names – ages
    - Impressions of each grandchild
    - Special message for him/her
- Menopause - mid life crisis – lost youth
- Achievements
- Best and worse years
- Main tasks and concerns

Senior years (65+)
- Still working or retired
- Finances – keeping up with inflation
- Receive Social Security
- Join organizations
- Boredom – loneliness – family visits
- Health problems – diet
- Fears of aging
- Greatest concerns/worries
- Mental/psychological health
- Compare physical and mental changes as you aged
- What kind of a grandparent are you
- Share family history with grandchild
- Your childhood vs their childhood
- Memories of you
- Best/worse thing about getting older
- Your legacy
- Heirlooms and personal possessions
- A typical day in your life

Historical Events

- Memories of world events
- Transportation before automobiles
- Telephones – electricity – airplanes
- First president remembered – first election voted in
- Vaudeville
- Titanic
- World War 1
- Sinking of The Lusitania
- Social changes during the war – role of women
- Armistice day
- Women's voting rights
- Income tax
- Radio – music – dances – movies – movie stars
- Lindbergh's flight across Atlantic
- Prohibition
- Stock market crash of '29
- Depression – bread lines – poor people – bank panics
  - Short and long term effects
  - How it affected you and family
- Franklin and Eleanor Roosevelt
- Labor movement
- World War II
- Pearl Harbor
- Hitler
- Personal war experiences
- Blackouts – victory gardens – food and gas rationing
- Treatment of Japanese Americans
- American's efforts to support war
  - War bonds
  - Food – meatless days
  - forgo pay raises
- Roosevelt's death
- Truman
- Atomic bomb
- Nazi atrocities
- Wonder Drugs – modern medicine – polio vaccine
- Modern appliances – television
- Korean War
- McCarthyism - communism

- Airplanes
- Civil rights movement
- President Kennedy's assassination
- Martin Luther King's assassination
- Robert Kennedy's assassination
- President's: Nixon, Ford, Carter, Reagan
- Rate the presidents
- Women's Lib
- Sexual Revolution
- Outer space

Religion
- Read the bible
- Pray
- Belief in God
- Immortality
- Miracles
- Religious experience
- Changes in religion and values
- Spiritual turning point in your life
- Celebrating holidays as youngster and now

The Future
- The next president
- Will you vote
- Message to those listening to these tapes
- Feelings about these interviews
  - What will happen to these tapes
  - Will they be your memoirs
- Anything else you'd like to add?

The following questions are general and unusual life experience probes. The questioner might want to ask a few of these at the beginning of a session, in the middle of a session or at the end. They may be an additional way of stimulating the narrator to express his or her personality. If the questioner receives a positive response, he/she should ask follow up questions.

- Has anything strange or unusual ever happened to you?
- Do you believe in ESP, and if so why?
- Have you ever seen a ghost?
- Do you believe in UFO's? What do you think they are?

- Have you had psychic experiences or gone to a fortune teller?
- Are you superstitious?
- Do you believe in luck?
- Have you been through a natural disaster (fire, earthquake, tornado, drought, flood, unusually cold or hot weather conditions)?
- Have you had major illnesses on your life – someone in your family?
- Have you confronted your own mortality?
- Do you believe in miracles and have you witnessed one?
- Do you identify with a special cause? Have you worked for it?
- Tell me about your first love. Who, when , what happened?
- How important is beauty or good looks in life?
- What was the work achievement of which you are most proud?
- What was your smartest/dumbest business deal?
- Do you believe in the power of forgiveness?
- Were you ever a hero? Did someone ever save your life?
- Do you believe the "Youth is wasted on the young?" Why?
- What is the meaning of friendship to you? Who was your best friend?
- Have you ever had any food or weight problems?
- Have you ever smoked?
- What are your sleep habits? Are you or were you ever an insomniac?
- Have you traveled? What was your favorite/least favorite vacation?
- Have you ever felt you were going to have a nervous breakdown?
- Do you have any phobias/fears?
- Was there ever a turning point in your life?

June, 2008

Reference: Recording Your Family History by William Fletcher

FOR INTERVIEWING PEOPLE OTHER THAN THE PATIENT:

In some cases the patient may be unable to respond to the Life Memories questionnaire. However, medical personnel would still be interested in obtaining additional information about the patient. If family members or friends are available and willing to be interviewed, many or all of the following questions would be helpful in providing the best care for the patient. It is recommended that this process proceed as quickly as possible upon arrival of the patient.

- Age, birthdate and birthplace of patient
- Family members and their health histories
- Describe the neighborhood of the patient's youth, friends, interactions between siblings in childhood and as adults.
- Religious training, school experiences, unusual experiences
- What was the house, the neighborhood, the community like?
- How did the family earn a living?
- Did religion play a part in the patient's youth/present time?
- What jobs did the patient have?
- Were there special friends, teachers, experiences?
- Were there conflicts with parents, friends, relatives?
- Were there special people he/she dated?
- Did the patient attend college and if so, where, when?
- What were his/her military experiences (enlisted, drafted,combat, medals, wounded, special military experiences)
- Did the patient get married, (who, when, where)?
- What was the first career and future jobs?
- What were some of the biggest challenges and changes in life?
- Are there children, grandchildren?
- Was there a mid life crisis?
- Is the patient still working or retired?
- What were/are the patient's greatest concerns?
- Describe a typical day in the life of the patient.
- Does the patient read the Bible, pray, believe in God?
- What are your (person interviewed) concerns?
- Is there anything you would like us to know that was not covered in this interview?
- Is there anything that hospital personnel could do to make it easier for the patient?

Tool B. Alegent Health Lakeside Hospital's My Story Poster

My Story

Thank you for your help

Your Healthcare Team

At Alegent Health, excellence means more than just clinical expertise. It also means providing warm, personalized care. Please take a few minutes to answer the questions, and to provide any other details you would want us to know. It will help us to provide excellent care.

Share With Us

Please call me by

Things I'd like you to know about me

My loved ones include

My pet(s) include

My job/career

My favorite food is

My favorite music/ TV show is

My hobbies/ interests/ accomplishments

I am happiest when

My care partner is

Images I Cherish

Care Partner

Alegent Health
This is your healthcare

Inspired in memory of Michael G. Dann

Tool C: Sharp Coronado Hospital's Environmental Services Department Duty List

Sodexho
HEALTH CARE SERVICES

Sharp Coronado Hospital
ENVIRONMENTAL SERVICES DEPARTMENT
DUTY LIST

POSITION: 1 First floor
DAYS: Sun - Sat
HOURS: 7:00 to 3:30 PM
BREAK TIMES: 9:00 to 9:15, 12:00 to 12:30, 2:00 to 2:15

Areas of Responsibility: Following Steps 1-7

The Housekeeping Host is the Liaison between
housekeeping staff, nursing and patients.
The position performs daily and terminal clening on Med Surg.
In addition to normal cleaning tasks this kposition is empowered to respond to patients non-clinical requests.
Warm wash clothers are distributed twice daily after breakfast and lunch and lavender scented cards are used to encourage Aromatherapy.

Time	Duty
7:00:00 AM	Clock in
7:10:00 AM	Stock housekeeping cart and supplies
7:15:00 AM	Clean early morning discharges/ open areas
8:30:00 AM	Break
9:15:00 AM	Greet patients with warm towel Med Surg
10:00:00 AM	Continue cleaning patient rooms
11:00:00 AM	Check 4th floor overflow rooms
12:00:00 PM	Lunch Break
12:30:00 PM	Greet patients with warm towel and
	inspect rooms/correct deficiencies MS
1:30:00 PM	Complete discharges or leftover patient rooms
2:00:00 PM	Break
2:15:00 AM	Continue discharges or cleaning patient rooms
3:00:00 PM	Clock out

7 CLEANING STEPS
1) Pull waste/Linen
2) High Dust
3) Damp Wipe
4) Dust Mop/Vacuum
5) Clean Bathroom
7) Inspect Room

POLICING
1) Dust & Spot Mop Floor
2) Check Waste
3) Check Dispensers
4) Spot Clean Walls,
   Glass & Fixtures

NOTE: 1) Discharges are a priority and will be completed as soon as possible.
        2) Duty list should be followed unless other wise directed by your supervisor.

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Tool D: Valley View Hospital's Peds-In-A-Box Tool

APPENDIX C

CONTENTS OF PEDS-IN-A BOX BOXES

Infant (0-2) Yellow
Infant quilt
Teddy bear wall stickers, or Winnie the Pooh
Wall plugs (electric outlet covers)
Wobble Ball
3 rattles (they can keep one to take home)
Learning links
Jack-in-the-box
Visual stimulation cards
Sippy cup (disposable - they can take home)
Infant spoons (they can take home)
Video (nursery rhyme songs)
Busy box
Medi-bottle/syringe
Infant size blood pressure cuff
Infant size stethoscope
Peds team welcome card
Vital sign normals laminated sheet
Laminated sign for door

Toddler/Pre-School (2-5) Green
Blues Clues or Scooby Doo wall stick-ups
Blues Clues or Scooby Doo comforter
Blues Clues Learning Lessons computer
Memory game
Doctors kit
Blue's Clues Learning Letters or Leap Learning
Pond
Storytime surprise book
Pinwheels
Sippy cup (they can take home)
Videos (Richard Scary - Counting, etc., Disney)
Coloring book and crayons
Books
Child size blood pressure cuff
Chid size stethoscope
Outlet plugs
Peds normal vital signs chart
Laminated sign for door
Peds team welcome cards
Stickers

Early School Age (5-7) Orange
Sports ball or fish/ocean comforter
Sport balls or tropical fish wall stickers
Pinwheels
Playing cards

Simon
I Spy puzzle
Magna Doodle or Etch a Sketch
Operation or Trouble game
Paper bag craft kit
Foam animal craft kit
Videos
Pediatric "normal" vital signs laminated card
Laminated card for door
Get well cards
Child size stethoscope and BP Cuff

Mid-School Age (8-10) Red
Sports Ball Comforter
Sports Ball Stickers
Craft Kit (they can take home)
Simon game
Boggle game
Trouble game
Twist and Shout multiplication game
Battleship game
Playing cards (they can take home)
Books
Videos
Peds Team cards
Peds sign for door
Laminated Peds - normal vital signs card
Stuffed animal (to take home)

Late School age/adolescent (10 and up) Blue
Sport balls or Coca Cola wall stickers
Sport balls or Coca Cola comforter
Playing cards
Hangman or Wheel of Fortune electronic hand-held
game
CD player and CD's
Rubik's Cube
Clue or Monopoly game
Battleship or Scrabble game
Videos
Crossword puzzle book and word search book
Art kit
Pediatric "normal" vital signs laminated card
Card for door
Get well cards

Tool E: Valley View Hospital's ASSIST Program Poster

NEED ASSIST HELP?!!

Please remember if your patient needs
a little extra care and human touch
we have assist volunteers available to assist
with patients, provide a ride home or hold hands.

Please contact Becca at x6656
She will arrange for a volunteer to assist them.

Tool F. Highline Medical Center's Multicultural Pointing Tool

CONTINUITY OF CARE

"I have been intimidated in the x-ray department. You have the technician and it is like Oz. The technician takes the picture and takes it to the radiologist (Oz) and then comes back and delivers a message—tell her to go to her gynecologist immediately because she has a serious problem and will need to have surgery. It was 5 on a Friday night. I asked for more information—what is the problem and was told they weren't at liberty to tell me." (Patient Comment)

While health care professionals interact with the health care system regularly, it is important for us to remember that for many patients, health care can feel like a complex and intimidating maze that they are forced to navigate without the benefit of a map or a guide to help them find their way—a metaphorical Oz minus the helpful and ever-present yellow brick road. Patients do their best to steer a clear course, but many report feeling left to wonder 'why?' 'what now?' and 'what if?' with inadequate support from caregivers to help answer these pressing questions.

These patient experiences reinforce the importance of systems and tools to assist patients and their loved ones in anticipating what to expect for the duration of time that they are in our care, to address their anxiety and questions, and to help them plan for their needs once they leave the hospital. Providing information on the discharge plan from the onset of treatment (and in some cases, even before) is an extension of this work to foster continuity of care, equipping patients and their loved ones with the knowledge, skills and confidence that will enable them to better manage their health once they are no longer in our care.

By providing patients with the tools and information they need to manage their own health care needs, patient-centered hospitals are emphasizing the important role of the patient as the one constant for the duration of their health care experience. Nonetheless, patients rely on us, as the health care professionals, to help guide them through the maze. Unfortunately, many patients express frustration with their perception that caregivers are not talking with one another about their condition and plan of care, which in their view is compromising care coordination efforts and leaving the often daunting task up to patients on their own. In a patient-centered setting, care is delivered in a manner that is coordinated among numerous caregivers and that involves the patient and family in the exchange of information between providers.

The Patient Perspective:

"...I thought I was checked in after the two hour interrogation with big nurse. Then I found out that I wasn't registered...Finally I said, 'If you can't figure out who needs to fill out this form I will.' This was not a good relaxing beginning for the surgery."

***

"To me the most important thing is the communication. My stay was short-lived and quick. Once I was admitted for ultrasound and they sent me to [hospital]. The girl here said she couldn't tell me why but they would tell me when I got to the hospital. Obviously they knew I was coming, but they didn't forward any information. They put me in an emergency room, and the doctor wondered why I was there."

***

"My whole experience was really positive. I was in the orthopedic surgery area; there was physical therapy there and the typical patient is there for a hip replacement...When nurses came in, they seemed to think that I had a hip replacement. The therapists thought so too. I had a broken hip and it scared me that they didn't know."

***

"I had a very good experience except I think the coordination of information between the hospital and the doctors and the doctors to each other is not very good. I thought I had every test done that I needed but two days before I had to traipse over here for more tests. Supposedly all of the doctors are on line together and can share information."

***

"When you are discharged from the hospital, they always give you your medications. This last time, I was not able to get the pain pills because the open pharmacy would not take insurance. Everyone was closed at that time for discharge. I could not get morphine over the counter, so I went home with pain. They should have given me a couple of days worth of pills. I was in pain and they did not tell me how to sit on the toilet."

***

"I was here for three nights and four days for a surgical procedure and the basic care was good. Where we ran into some problems was the second day. The residents make their rounds and they said that I should get right out of bed and walk. Someone would be there to help me do that. They were supposed to come back and nobody came. I called for the nurse and nothing happened, and I called again and nothing happened. I waited another two hours—after dinner—and nothing happened."

***

"Once you are here and you are in the room, you don't know about things or don't remember things. They should have pamphlets in the drawers explaining what's happening. They should be right in the room in a drawer."

***

"I had a problem with the billing department. I was coming in three times a week and talked to three or four people and no one could tell me where I was at, what I owed. If they could coordinate that better it would make you feel better."

The Leadership Perspective:

"...a patient on our Patient and Family Advisory Council, who formerly owned one of the top Lexus dealerships in the country,... said, 'you need GPS...and I don't mean way-finding, I need a navigator. I mean, somebody who supports me getting access into your system, guides me while I'm there, and then supports me and connects me to resources when I leave." (M. Bridget Duffy, M.D., Cleveland Clinic)

***

"The patient and family at home are managing their meds, and managing their care. Too often they come to the hospital, and staff and physicians essentially say, 'We're going to talk

about you on rounds and at nurse change shift report, but you are not part of these discussions. When using the computer for your care, we'll turn it, in fact, the other way, so you can't see it.” (Bev Johnson, Institute for Family-Centered Care)

<div align="center">***</div>

“The characteristics that define a superior patient experience from the consumer perspective have as much to do with respect, kindness, privacy, information, autonomy, choices, care coordination and inclusion, as they do with good clinical care.” (Susan Frampton, Planetree)

PATIENT-CENTERED APPROACHES FOR FOSTERING CONTINUITY OF CARE:

Patient Navigators

For many patients, hospitals are foreign, intimidating places with a maddening number of unfamiliar policies, processes and protocols. Patient Navigators are paid staff members who help to demystify the health care system. Their role is to work closely with patients to identify and mitigate any barriers that may impede patients' abilities to access optimal care, including financial, language/communication and informational barriers. For patients struggling with the emotional impact of a new diagnosis, Patient Navigators can be particularly valuable resources, assisting with the coordination of multiple appointments and tests, the completion of necessary financial paperwork, and connecting the patient and his or her loved ones to other community resources that may be of benefit. Patient Navigators can also work to ensure that patients' special needs are met, for instance arranging interpretation and translation services, or securing special equipment for patients with hearing or visual impairments.

Patient Advocates

In patient-centered hospitals, the role of the Patient Advocate extends beyond responding to patient complaints. Patient advocates strive to improve patient satisfaction, quality of care, and promote patient rights by facilitating communication with physicians, nurses and all other hospital services. This requires proactively reaching out to patients, and in many patient-centered hospitals, Patient Advocates round daily to meet individually with every patient to ensure that the full scope of their needs is being met and any concerns are being addressed. Patient Advocates are well-connected within the hospital, and accordingly are uniquely qualified to inform patients and their families of other services available to them while they are hospitalized, whether it be how to access additional health information at an on-site consumer health library, the availability of spiritual support services, or how to request a massage.

Medication Reconciliation

When a patient arrives at the hospital, a list of current medications is crucial, but relying on patient reporting often yields less than accurate information. In fact, studies show that patients' inconsistent medication knowledge and record-keeping seriously jeopardize patient safety, and are a common cause of medication-related errors in hospitals. Patient-centered hospitals have employed a number of both low-tech and high-tech approaches to assisting patients in managing their medication information. A simple, low cost strategy is to provide **wallet medication cards** that patients can continually update with the names of all the medications they are taking, including prescriptions, over-the-counter medications, vitamins and herbal supplements. **AHRQ's "How to Create a Pill Card"** provides step-by-step instructions for creating a pill card, and can be found at: www.ahrq.gov/qual/pillcard/pillcard.htm. *In addition, see pages 120-*

123 for a sample wallet medication card provided by the South Carolina Hospital Association, along with its brochure "What You Need to Know About Your Medicine."

Fauquier Health System in Warrenton, Virginia developed an automated system, called Rcopia AC, that not only tracks medications prescribed internally, but also electronically gathers patients' external medication records instantaneously. What results is a comprehensive list of current prescriptions against which new medications can be checked for potential interactions. This prescription information can also be electronically accessed by the patient's regular physician to ensure a continuum of care.

Bedside medication verification is not only an important patient safety strategy, but one that also enhances patients' knowledge of their medications.

Elimination of Medical Jargon

Health care has a language all its own. For those well-versed in the multitude of acronyms, multi-syllabic terms and abbreviations, following the signs for radiology to get an x-ray is second nature. But for patients unfamiliar with these terms, the confusing language of health care can exacerbate feelings of stress and anxiety. Furthermore, if patients do not understand the instructions given to them for taking care of themselves, they will be far less able to ask informed questions and, ultimately, will be less likely to adhere to their treatment regimen. Patient-centered hospitals understand this and work to ensure that all information provided to a patient is provided in such a way that it makes sense to them. For instance, the Aurora Health Care system, headquartered in Milwaukee, Wisconsin, has established **plain language guidelines** for all patient education materials.

Another patient-centered strategy is to conduct daily **Family Rounds** during which the nurse meets with the patient and family to discuss the goals for the day from the perspective of the patient. Rather than focusing on unfamiliar test results that mean little to the non-clinician, the goal discussed for the day may be something as straightforward as getting out of bed and walking down the hall.

In many hospitals, medical jargon is also pervasive throughout the facility on signage. **Wayfinding** in patient-centered hospitals is enhanced by using straightforward language that patients understand, oftentimes complemented by easily identified icons to further assist with comprehension. For more information on universal icons for wayfinding, refer to the ***"Universal Symbols in Health Care Workbook"*** developed by Hablamos Juntos and the Robert Wood Johnson Foundation, available at http://www.hablamosjuntos.org/signage/PDF/Best%20Practices-FINALDec05.pdf.

Patient Pathways

Written in an uncomplicated way that patients and their loved ones can understand, patient pathways describe the typical care and treatment of patients with a specific diagnosis. Modeled after the traditional clinical pathway, patient pathways can be a valuable tool to assist patients and loved ones in understanding their plan of care (e.g. when and why certain tests may be performed, how long to expect before receiving results, what the expected length of stay is). By setting expectations, the patient pathway may also empower patients to take a more active role in

their care, asking questions when treatment veers from the pathway or proactively seeking out test results. Patient pathways provided in admission packets serve to set expectations for the entire length of stay, and can be reinforced using white boards affixed to the walls in patient rooms to outline the plan and goals for each day.

Griffin Hospital's Patient Pathway for Congestive Heart Failure (CHF) patients delineates the tests that will occur over the course of 3-4 days, as well as medications that may be administered, vital signs that will be checked, diet restrictions and any day-specific discharge planning and/or teaching that may occur. *See pages 124-125 for Griffin Hospital's CHF patient pathway.*

The University of Washington Medical Center's **"After You've Had Your Baby" poster** (*see page 126*) is another example of a tool that helps patients to anticipate what comes next. Developed in direct response to feedback from a number of new mothers (*"I wish I knew what to expect"*), the poster is hung in every postpartum room in the Maternity and Infant Center and explains in simple terms what criteria both mother and baby must meet in order to be discharged. Results of a follow-up survey with patients and staff evidenced that patients found the poster very useful as a reference, and nurses found it helpful for orienting and teaching patients.

Pre-surgical Orientations
Many patient-centered hospitals have introduced pre-surgical orientations for patients about to undergo specific procedures such as joint replacement. Such orientations offer opportunities for patients and their loved ones to familiarize themselves with the individuals and information they need to know at a time when they are best poised to hear and absorb it, instead of shortly before surgery or immediately before discharge when one may be feeling overwhelmed. Patients hear from a nurse, physical therapist, and others about what to expect in the first few hours and days following surgery, as well as a discharge planner who works with patients even before they are admitted to ensure they understand the discharge plan. Some hospitals have found the benefits of participation in such an orientation so advantageous (as demonstrated by clinical outcomes), that they have made them mandatory for patients.

At Mid-Columbia Medical Center (MCMC) in The Dalles, Oregon, this education is reinforced with the provision of a Total Joint Experience Manual that contains a variety of checklists, specific expectations for each day of the hospital stay, physical therapy activities and community resources. *The table of contents for MCMC's Total Joint Experience Manual is included on pages 129-131 as a resource.*

In addition to helping patients understand what to expect from surgery, some patient-centered hospitals have resources to help patients prepare mentally and emotionally for their surgery, including some relaxation exercises and mind-body techniques to help ease anxiety.

Patient-centered hospitals take special care to address the unique needs of children about to undergo surgery. Hospitals have introduced kid-friendly programs that serve to demystify the hospital for its youngest patients and their families prior to their being admitted for surgery. For instance, with a goal to reduce the stress levels for patients and families, Valley View Hospital's In-Cider Tours feature a pre-surgical tour and interactive activities that allow children and their

parents to become comfortable in the hospital setting so that when they return for their surgery, they are met by familiar sites and sounds. *See pages 127-128 for the In-Cider Tour brochure.*

Bedside Shift Report
Traditionally, off-shift reporting has been the process by which a nurse whose shift is ending shares information about each patient with the nurse whose shift is beginning. From many patients' points of view, however, the intent of this process to foster continuity of care has been overshadowed by the impression that during this change of shift information-sharing, nurses are unavailable to meet patients' needs. In patient-centered hospitals, traditional off-shift reporting is expanded beyond a peer-to-peer exchange of information to also involve the patient. This patient-centered adaptation to a traditional nursing task provides the opportunity for the patient to actively participate in the dialogue about the plan of care, concerns that have arisen, and progress made. The patient's role is to verify information conveyed and to ask questions as necessary. Furthermore, by moving the location of the off-shift report to the bedside, it addresses the common patient concern about nurses' unavailability during change of shift. Rather than being unavailable, bedside shift report provides another opportunity for staff to be responsive to patients' needs.

Hourly Rounding
Conducted by nurses, hourly rounds are comprised of an established set of behaviors that take place consistently with each patient every hour, including a check that the patient's pain, potty and positioning needs are being met. This enables patients not only to anticipate when next they will see their nurse, but also to anticipate what interactions will occur during the rounds.

Interdisciplinary Rounds
Another strategy for care coordination is interdisciplinary rounds in which representatives from all disciplines—including clinical staff, nursing, dietary, social work, physical and occupational therapy, pastoral care, case managers, and others as appropriate—meet regularly to review the status of patients and work together to achieve optimal patient outcomes. Inviting patient and family participation in interdisciplinary rounds reinforces the crucial role that patients and their loved ones play in managing their own health and wellness.

Collaborative Care Conference
Another strategy for involving the patient and family in a dialogue about expectations for the hospital stay is to hold a collaborative care conference. These brief meetings include the patient, any family member the patient wants involved, the physician and nurse, and occur shortly after admission (within 24-48 hours). The purpose of the conference is to discuss early on in the hospitalization the plan of care and goals for the hospital stay, as well as to begin planning for discharge. *Griffin Hospital's Patient Care Conference Form is included on page 132 as a resource.*

Palliative Care Response Team
Another example of a multidisciplinary approach that fosters care coordination is a palliative care consultation service which holistically addresses needs of patients with life-limiting illnesses. Members of the team may include physicians, nurses, social workers, pastoral care,

dieticians, and pain management specialists who work together with the common goal of quality of life through the end of life for patients and their loved ones.

Health Information Notebooks
Sentara Virginia Beach General Hospital has developed this highly useful and effective tool to assist patients in managing their own health care information. In essence, it serves as a mini-patient record in a three-ring binder that can easily be updated by the patient. Sections include diagnosis, treatment plan, medical history, medications, and others. Patients are encouraged to carry the notebook with them from physician to physician and from hospital to hospital. This encourages the patient to be the owner of their own health information and health condition.

Other facilities opt to provide a copy of the medical record to the patient on discharge. The patient is encouraged to take this information to their primary physician for use in planning ongoing care. And others are providing secure on-line access to medical information for patients to access as needed.

Medication Briefs and Automated Web-Based Discharge Systems
Recognizing that discharge can be a time of information overload, some patient-centered hospitals have developed tools that patients can refer to once they have left the hospital, such as printed medication instructions and discharge summary notes. The information can be printed off and reviewed with the patient, and then provided at discharge for future reference.

Discharge Phone Calls
Discharge phone calls can be an effective way of bridging hospital to home. When completed in a timely manner after discharge, the discharge phone call is an optimal opportunity to foster continuity in care by ensuring patients have made any necessary follow-up appointments and have read and comprehended any discharge instructions provided to them, as well as to answer questions that may have arisen about the discharge plan since they left the hospital. *See pages 133-136 for Northern Westchester Hospital's guidelines for discharge phone calls.*

At Sharp Coronado Hospital in Coronado, California, discharge phone calls are made to joint replacement patients not only immediately upon discharge, but also 30-days, six months and one year later to check in on progress and respond to any questions.

Follow-Up Appointment Scheduling
Returning home from the hospital can be an overwhelming time for patients and families as they strive to adapt new regimens of medication, doctors' appointments, rehabilitation exercises, etc. into their daily routines. Care coordination is critical to ensuring continuity of care and patient safety during care transitions. Patient-centered hospitals have found a number of ways to streamline this transition, and to facilitate information sharing among all of a patient's physicians, including their admitting physician, primary care physician and specialists. Some hospitals have implemented systems to ensure that a patient's first follow-up appointment is made for them prior to their discharge from the hospital. Mid-Columbia Medical Center in The Dalles, Oregon made a commitment to its patients to have their hospitalist make calls to the primary care physician of every patient being discharged to update them on the patient's status.

Involving Family and Friends

Patient-centered hospitals provide meaningful opportunities for family members to actively participate in their loved one's care. (*See Care Partner Program, Section VII.E., Family Involvement, page 149.*) Providing education and training of the person who will be most involved with the patient's care at home will help to ease the transition from hospital to home.

At Northern Westchester Hospital in Mount Kisco, New York, special care is taken to ensure that parents returning home with a newborn from the NICU feel comfortable in caring for their child at home. The night before discharge, families can stay with their baby, at no charge, in a specially-designed hotel-like room located directly across the hall from the NICU. There is no special equipment in the room and although the baby is still officially a patient of the hospital, other than taking occasional vital signs, the NICU staff does not monitor the baby. Once the family has entered the room, it is as if the baby has gone home, but NICU staff is available right across to hall to assist immediately upon request. This process allows the family to face their natural fears about caring for their infant in a safe setting, and promotes families' expertise, confidence, and comfort with caring for their baby at home. A family journal containing comments from families who have previously used the room is available to provide additional reassurance and wisdom. Families are able to replicate many of the situations they will encounter at home, and to get immediate responses to any questions and concerns by either crossing the hall or picking up the room telephone, which directly connects to the NICU.

IMPLEMENTATION TOOLS:

A. South Carolina Hospital Association's Universal Medication Form, *pg. 120*

B. South Carolina Hospital Association's "What You Need to Know about Your Medicine" Brochure, *pg. 122*

C. Griffin Hospital's Patient Pathway for Congestive Heart Failure Patients, *pg. 124*

D. University of Washington Medical Center's "After You've Had Your Baby" poster, *pg. 126*

E. Valley View Hospital's In-Cider Tour Brochure, *pg. 127*

F. Mid-Columbia Medical Center's Total Joint Experience Manual Table of Contents, *pg. 129*

G. Griffin Hospital's Patient Care Conference Form, *pg. 132*

H. Northern Westchester Hospital's Discharge Phone Call Guidelines, *pg. 133*

Tool A. South Carolina Hospital Association's Universal Medication Form

SCHA South Carolina
Hospital Association

UNIVERSAL MEDICATION FORM

Fold this form and keep it in your wallet   **Date form started:**

Name:	Address:
Phone Number:	
Birth Date:	

Emergency Contact/Phone numbers:

IMMUNIZATION RECORD (Record the date/year of last dose taken, if known)		
TETANUS	FLU VACCINE(S)	
PNEUMONIA VACCINE	HEPATITIS VACCINE	OTHER

Allergic To /Describe Reaction:	Allergic To /Describe Reaction:

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

DATE	NAME OF MEDICATION / DOSE	DIRECTIONS: Use patient friendly directions. (Do not use medical abbreviations.)	DATE STOPPED	Notes: Reason for taking / Doctor Name

Refer to back of form for directions, benefits of using the form, and how to get more copies.

(01/08)   Page _____ of _____

UNIVERSAL MEDICATION FORM

Patient:

1. **ALWAYS KEEP THIS FORM WITH YOU.** You may want to fold it and keep it in your wallet along with your driver's license. Then it will be available in case of an emergency.

2. Write down all of the medicines you are taking and list all of your allergies.

3. Take this form to **ALL** doctor visits, when you go for tests and **ALL** hospital visits.

4. WRITE DOWN ALL CHANGES MADE TO YOUR MEDICINES on this form. If you stop taking a certain medicine, draw a line through it and write the date it was stopped. If help is needed, ask your Doctor, Nurse, Pharmacist, or family member to help you to **keep it up-to-date.**

5. In the NOTES column, write down the name of the doctor who told you to take the medicine(s). You may also write down why you are taking the medicine (Examples: high blood pressure, high blood sugar, high cholesterol).

6. When you are discharged from the hospital, someone will talk with you about **WHICH MEDICINES TO TAKE AND WHICH MEDICINES TO STOP TAKING**. Since many changes are often made after a hospital stay, a new form should be filled out. When you return to your doctor, take your new form with you. This will keep everyone up-to-date on your medicines.

HOW DOES THIS FORM HELP YOU?

1. This form helps you and your family members **remember** all of the **medicines you are taking**.

2. Provides your doctor(s) and others with a **current list of ALL of your medicines**. Doctors need to know the herbals, vitamins, and over-the-counter medicines you take!

3. **Helps you**—concerns may be found and prevented by knowing what medicines you are taking.

SC Emergency Medical Service Association

SC Pharmacy Association

The Carolinas Center *for* Medical Excellence
Improving healthcare quality since 1983

South Carolina Society of Health System Pharmacists

EVERY PATIENT COUNTS
The SC Partnership to Advance Patient Safety and Quality Healthcare

South Carolina Medical Association
Voice of One. Power of Many.

PHTS
RISK MANAGEMENT SERVICES

For copies of the **UNIVERSAL MEDICATION FORM** visit the South Carolina Hospital Association web site at **www.scha.org**.

SCHA South Carolina Hospital Association

(01/08)   Developed by AnMed Health and South Carolina Hospital Association 2004

Tool B: South Carolina Hospital Association's "What You Need to Know About Your Medicine" Brochure

What You Need to Know About Your Medicine

Tips for Medicine Safety

Use the UNIVERSAL MEDICATION FORM to keep track of your medicines

Forms are available at www.scha.org

SCHA South Carolina Hospital Association

Taking an active role in your care can help prevent medicine errors.

Maintain your personal UNIVERSAL MEDICATION FORM and keep it in your wallet/purse for easy access.

SCHA South Carolina Hospital Association

South Carolina Pharmacy Association

The Carolinas Center for Medical Excellence
Improving healthcare quality since 1983

South Carolina Society of Health-System Pharmacists

South Carolina Medical Association
Voice of One. Power of Many.

South Carolina Emergency Medical Service Association

PHTS
RISK MANAGEMENT SERVICES®

Thanks to SCHA's Patient Safety Committee, CCME, and SCMA for development of this publication.

Special thanks to the Massachusetts Coalition for the Prevention of Medical Errors, AHRQ, and JCAHO.

WHAT I NEED TO KNOW ABOUT EACH MEDICINE THAT I TAKE

- What is the name of each medicine?
- What is it for?
- What time should I take it?
- How much of it should I take each time?
- How should I take it?
- Should I take it with food?
- How long should I take it?
- What should I do if I miss a dose?
- Are there any side effects? What should I do if I have any?
- Is it safe to take with other medicine that I am taking, including over-the-counter medicine, vitamins, or herbals?
- What food, drink, or activities should I avoid while taking it?

AT THE DRUGSTORE

- Take new medicine prescriptions and refills to the same drugstore. The pharmacist then has a list of your medicines. He or she can make sure that all of the medicine works together and will not make you sick.

- If you use more than one drugstore, make sure each one has a list of all of your medicine.

- Ask the pharmacist the name of the medicine and how you should take it. Make sure that this information matches what your doctor told you.

- Make sure that any refill of the medicine is the same color, size, and shape. If there is any difference, ask why.

- If you have ANY questions about your medicine, ask your pharmacist.

AT THE DOCTOR'S OFFICE

- Always take your updated Universal Medication Form. This will tell your doctor everything you are taking, including prescription medicines, over-the-counter medicines, and herbals.

- Tell your doctor about any allergies or reactions that you have had to medicine in the past.

IN THE HOSPITAL

- When you are admitted to the hospital, take your updated Universal Medication Form, or bring all of your medicines in the original bottles. Include over-the-counter medicines, vitamins, and herbals.

- Tell your doctor or nurse about any allergies or reactions that you have had to medicine in the past. Also, write these on your Universal Medication Form.

- If you feel that any medicine is making you sick or causing you pain, tell the doctor or nurse right away.

- When you are being sent home from the hospital, ask your doctor or nurse to clearly tell you what medicines you should be taking, and how to take them. You will be given an updated Universal Medication Form before you leave the hospital.

You Should Never Be Afraid To Ask Your Doctor, Nurse, or Pharmacist About Your Medicines.

Your Health Is Too Important!

SPEAK UP!

AT HOME

- Take only the medicine given to you by your doctor or pharmacist. Do not share other people's medicine.

- Each time you take your medicine, read the label to make sure you are taking it correctly. If you have questions, call your doctor or pharmacist

- Never take medicine in the dark.

- Do not stop taking the medicine just because you feel better unless your doctor tells you to stop taking it.

- Do not take your medicine out of one bottle and put it in another one.

- Put all of your medicine in a place where children and pets cannot reach it.

- Keep your Universal Medication Form updated.

- If you take medicine each day, using a compartmental medication box may be helpful.

- Do not keep medicine in the car, by the stove, or in the bathroom, since heat and dampness can affect how it works.

- Check the date on all medicine. Throw away all medicine if the date written on it has passed.

- If you feel that any medicine is making you sick or causing you pain, call your doctor right away.

Tool C: Griffin Hospital's Patient Pathway for Congestive Heart Failure Patients

Patient Pathway

Congestive Heart Failure (CHF)

Welcome to Griffin Hospital. This patient pathway has been designed as an aid to inform and prepare you for what you can anticipate during your stay with us. Please keep in mind this is only an outline of the way your health problem might be managed. The information in this pathway may vary to meet your individual needs as determined by your physician.

Any questions you may have regarding these guidelines or any aspect of your care should be directed to your physician or primary nurse.

The estimated number of days you might be in the hospital is four (4). This could vary depending upon your progress.

Patient Name _____

Primary Nurse _____

Extension # _____

Griffin Hospital   **A Planetree Affiliate**

130 Division St., Derby, CT 06418
(203) 735-7421

www.griffinhealth.org

Your discharge diagnosis is **Congestive Heart Failure (CHF).** There are several things you can do to feel better and improve your health. They include the following:

1. Take all medications listed on the Discharge Instruction Sheet as directed. Always carry your medication list. Make sure you always have an ample supply of your medications at home.

2. Limiting salt in your diet and cutting back on cholesterol and saturated fat are important parts of your treatment and management of your CHF. You may also need to limit your fluid intake and eat foods rich in potassium.

3. Each morning, you should weigh yourself (after you urinate and before you eat breakfast) and record your weight. Remember to take your weight chart with you to every physician's appointment.

4. Quitting smoking is a vital part of your treatment and management of your Congestive Heart Failure and can help prevent the development of other diseases that may shorten your life. You can contact the Connecticut QuitLine at 1-866-363-4224 for information on smoking cessation classes available in our community.

5. Daily exercise can be an important part of your treatment plan. You should check with your physician before starting any plan. Exercise should be done in moderation.

6. When Should You Call Your Physician?
- You have severe difficulty breathing.
- You notice you are getting tired faster.
- You gain more than 2 lbs or more in 1 day, 3 lbs or more in 2 days or 4 lbs in 1 week.
- Your pulse is less than 60 for 2 days in a row.
- Your feet swell more than usual.
- You have side effects from your medications.
- You cough or have trouble breathing when you lay down at night.

Call 911 if you have the following:
- Severe dizziness, fainting or shortness of breath
- Tightness or pressure in your chest.

Discharge Plan (continued)

You may be discharged any time between Day 3 and Day 4 depending on your status and doctor's decision. Discharge time is 11:00 a.m.

Teaching - Before you go home, your nurse will review your discharge instructions, explain your plan of care and answer any questions you may have about the items listed above.

Day Four

Essentially the same as Day 3. You will receive more information and education about your diagnosis. Before you go home, your nurse will review your discharge instructions, explain your plan of care, and answer any questions you may have.

Day One

(Admission-First 24 Hours)

Consults - Your physician may request that a specialist in cardiology examine you (consult). This may occur at any time during your hospitalization.

Tests - Blood for testing may be drawn, an ECG (electrocardiogram) and an echocardiogram may be done, which will give the physician important information related to the function of your heart

Vital Signs - Your temperature, pulse, and blood pressure will be checked as ordered by your physician. You may be weighed daily.
Treatments - You may receive oxygen. An intravenous (IV) will be started, to administer medications and fluids as needed.

Medications - Medications will be ordered by your physician. Inform him/her of medications you are taking at home. You may receive a diuretic medication (Lasix) that will probably increase the frequency with which you urinate. Measurement of liquid intake and output will be monitored, so you may be required to use a bedpan or urinal.

Activity - Your activity level will be ordered by your physician depending on your condition. Report to the nurse any feelings of shortness of breath, chest discomfort or extreme tiredness.

Diet - You may be given a low salt diet and may have a limit set on the amount of fluids you drink.

Discharge Plan - Your nurse may ask you questions about your home situation and contact our Continuing Care Department based on your needs for discharge. A Griffin Hospital Continuing Care Coordinator may contact you about plans for discharge.

Teaching - Your nurse will review with you a brochure called "Speak Up." The "Speak Up" program is intended to help you become more involved in your care. You will be instructed about the importance of your activity levels, diet restrictions, sodium restriction, fluid balance, and daily weights. Within 48 hours of admission, your physician or nurse will review your plan of care with you.

Day Two

Tests - Blood for testing may be drawn. An ECG and/or x-ray may be done if ordered by your physician.

Vital Signs - Temperature, pulse, blood pressure and respirations will be checked as ordered by your physician.

Treatments - Oxygen and your IV may be continued depending on your physician's orders.

Weight - You may be weighed daily. Your nurse will explain why this is important. Medications - You will probably continue to receive a diuretic (Lasix). The physician may adjust the doses of your medications. Please ask your physician or nurse to explain the medications you are receiving if you do not understand what they are for.

Activity - Your activity will be increased as tolerated.

Diet - You will continue on a low salt diet with possible fluid restriction.

Discharge Plan - Your Continuing Care Coordinator may meet with you today to begin to discuss discharge plans with you and your family.

Teaching -Your nurse will review with you your plan of care for today. Ask questions if you don't understand your plan of care.

Day Three

Tests - There may be no tests scheduled for today. Your physician may discuss a weight goal with you today and ways for you to achieve and/or maintain it.

Vital Signs - Your temperature, pulse, blood pressure, and respirations will be checked as ordered by your physician.

Treatments - Your oxygen and IV may be discontinued today.

Medications - Continue to ask questions about the medications you are receiving if you do not understand what they are for.

Activity - Your activity will continue to be increased as tolerated. Please report any shortness of breath or extreme tiredness to your nurse. Let your nurse know if you have not had a bowel movement since admission.

Diet - You will continue on a low salt diet with possible fluid restriction.

Discharge Plan - Definitive arrangements for discharge will be made, including follow up appointment, and arrangements for any necessary outpatient testing. Your case manager from the Continuing Care Department and/or nurse may discuss any unresolved issues with you.

Tool D: University of Washington Medical Center's "After You've Had Your Baby" Poster

After You've Had Your Baby

This chart will help you know what to expect during your stay and when you and your baby can safely go home.

What to Expect During Your Stay

- Physical care by your nurse
- Use "Please Do Not Disturb" sign as needed
- Assistance with feeding your baby
- Pain assessment/management
- Education about self and baby care
- Visit the car seat display
- Fill out the Birth Certificate form
- Visits by your provider (doctor or midwife)

What to Expect During Your Baby's Stay

- Nursing care
- Screening blood tests
- Hearing test
- Hepatitis B vaccine
- Daily check-in by Pediatric or Family Medicine team

When Can You Safely Go Home?

- Your bleeding is normal
- You have no active infection
- Your pain is controlled
- Your high-risk complications are under control
- You've recovered from surgery enough to eat, drink, and walk around
- Your questions about health care have been answered
- Your follow-up care has been discussed with you

When Can Your Baby Safely Go Home?

- You and your baby have started to figure out the basics of feeding and know who to call if you have questions once you are home
- Your baby has been evaluated for jaundice
- Your baby has normal breathing, peeing, pooping, and temperature
- Your baby has normal lab tests
- Your questions about baby care have been answered
- You have a safe car seat
- Your baby's follow-up care has been discussed with you

If your baby is in the Progressive Care Nursery (PCN) or Neonatal Intensive Care Unit (NICU), speak with your nurses and pediatricians about what to expect.

Created in partnership with the Perinatal Patient and Family Advisory Council

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07/2007 Rev. 04/2008

UNIVERSITY OF WASHINGTON
MEDICAL CENTER
UW Medicine

Tool E: Valley View Hospital's In-Cider Tours

In-Cider Tours for Kids

To help prepare your child for surgery:

- Encourage your child to talk about feelings related to illness or surgery.

- Encourage and answer your child's questions

- Encourage your child to talk about his or her exprience with others. Be there to listen and correct any misinformation or misunderstanding.

- Go to the surgery "In-Cider Tour" as a family to familiarize yourself and your child with the hospital and the staff.

- As a parent, become informed about the procedure. Information will reduce your own anxiety and reduce the ammount of fear you transmit to your child.

Providing information and a greater comfort level for pediatric surgical patients and their families

VALLEY VIEW HOSPITAL

1906 BLAKE AVENUE
GLENWOOD SPRINGS, COLORADO
970.945.6535 • WWW.VVH.ORG

What is an In-Cider Tour?

The In-Cider Tours at Valley View Hospital provide an inside look at the surgical services department for pediatric patients and their families. The tours inform and prepare children and their families for an upcoming surgery, offering a chance to become familiar with the surgical environment. Young patients and their families may be more comfortable at the time of surgery being familiar with the location, procedures and outcomes, terminology and the staff. Our tour guides are able to answer many of your questions in advance of your surgery.

The tours are offered Thursday evenings starting at 6:30 pm for about 30 to 45 minutes. Pre-registration is not mandatory; however, preregistration does help us to plan for enough cider and cookies.

The In-Cider Tours meet in the Upper Lobby of the Hospital (see map on back). You are more than welcome to use our Valet parking (a free service) or park in any of the spaces near the upper entrance.
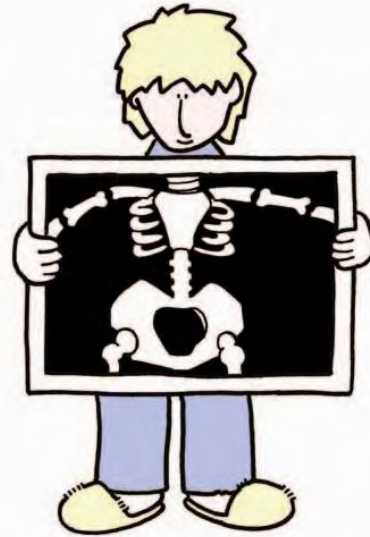
The tour will include:

- Registration requirements for your surgery
- A short visit to the Laboratory and Radiology Departments
- The opportunity to touch and experience monitoring equipment
- A short video about surgery and recovery
- A visit to the Acute Care department if the child is anticipated to stay overnight.
- A look at the surgery waiting room
- A walk through the Healing Garden
- Time for questions to be answered
- Cider and cookies!

TOURS EVERY THURSDAY EVENING • 6:30 – 7:15 pm

Tool F: Mid-Columbia Medical Center's Total Joint Experience Manual Table of Contents

MCMC
TOTAL JOINT EXPERIENCE

Table of Contents

Mid-Columbia Medical Center • 1700 East 19th Street, The Dalles, Oregon 97058 • 541-296-1111

— ix —

Mid-Columbia Medical Center • 1700 East 19th Street, The Dalles, Oregon 97058 • 541-296-1111

Tool G: Griffin Hospital's Patient Care Conference Form

Griffin Health Services Corporation
Griffin Hospital

Patient Care Conference Form*

As a Planetree hospital, we encourage you to ask questions about your treatment and to be an active participant in your care and safety.

Patient Name: _____

❏ Patient present, but unable to participate

❏ Language Barrier
❏ Cognitive Impairment
❏ LOC

Patient Care Conference Date and Time: _____

Physician Name: _____

Physician Signature: _____

Nurse Name: _____

Nurse Signature: _____

At your Patient Care Conference, we discussed the following with you:

❏ Your Patient Information Packet
❏ Griffin Hospital's Culture of Safety
❏ Your Diagnosis
❏ Your "Patient Pathway" or Course of Treatment
❏ Your Expected Length of Hospitalization
❏ Case Management Services (available upon request for discharge needs)
❏ Your Wishes Concerning Resuscitation
❏ Access to Your Medical Record
❏ Your Patient Progress Notes

_____
Patient/Significant Other Signature

If you have questions about any of the information discussed at your Patient Care Conference, please ask your primary nurse. You can also call Griffin Hospital's Health Resource Center directly at ext. 7399 to request additional information on your condition (see Information Request Form in your Patient Information Packet).

*When completed, place white copy in Bedside Chart; place yellow copy in Patient Information Packet.

mr#940
Approved by MRC 8/2/07

Tool H: Northern Westchester Hospital's Discharge Phone Call Guidelines

NWH Post-Visit Discharge Phone Calls (Inpatient)

Surveyor Points:

1. Call patients that have been discharged within 24 hours of discharge.
2. Ask the following questions. If there is a specific issue that requires follow-up, inform the patient that you will get back to them with an answer in an expeditious time frame. (Goal: To call the patient back within 24 hours)
3. Document Responses in the feedback column.

Purpose:

A good discharge phone call does a number of things. It demonstrates empathy and concern; assesses clinical outcomes; harvests reward and recognition, asks about the service the patient received; identifies opportunities for process improvement and expresses appreciation.

Process:

1. Daily at 7am, Chart Coordinators print the discharge list from the day before and give to the Care Manager.
2. The Care Manager creates a daily schedule assigning nurses to handle discharge phone calls, allowing approximately ten minutes per phone call.
3. Nurse makes the calls from a quiet area that has a phone and a PC.
4. Before calling, Nurse checks Meditech to familiarize themselves with the patient
5. Nurse documents on discharge list with a "check mark" if the patient is reached and can take the survey, "LM" if message is left on answering machine, "NA" if no answer. Nurse or Care Manager will try one more time that day if LM, NA or if a time was scheduled with the patient to call back.
6. If answering machine, nurse will leave message "Hello, this is _____ from Northern Westchester Hospital calling to speak with _____ to see how you are doing. We will call you again at _____ (leave a specific time). Thank you".
7. Negative feedback will be handled within 24 hours. The nurse receiving the information immediately notifies

   the Care Manager or designee. Care Manager will consult with Patient Advocacy on appropriate service recovery.
8. All surveys are to sent to the Quality Department every Friday. Survey results are documented in Midas. Report will be sent to

   Nursing Director and Advocacy.

Patient Name: _____

Telephone Number _____

Patient Account Number_____

Surveyor: _____

Date of Survey: _____

Unit: _____

Making the Call:

Hello, this is _____, I am a _____ at Northern Westchester Hospital. You were discharged from my unit yesterday and I am calling to find out how you are doing? If you wouldn't mind, I'd like to ask you a few questions about your stay with us. Is this a good time?

(Please circle Yes or No) Question	**Feedback**
1. When you called for your nurse, did the nurse respond to your requests in a timely manner? YES NO	If no,
2. While you were in the hospital, did you experience pain? YES NO 3. If yes, did you find the treatments offered effective in relieving your pain? YES NO	If no,

(Please circle Yes or No) Question	Feedback
(Please circle Yes or No) Question	Feedback
4. Did we keep you informed about what was happening with your care? YES NO	If no, what could we have done differently?
5. Did the nurse teach you what was important to know about caring for yourself at home? YES NO	If no, what could we have done differently?
6. Were the discharge instructions we gave you about caring for yourself at home easy to understand? YES NO	If no, is there anything that we can help clarify?
7. Cleanliness is very important to us. Was your room clean? YES NO	If no,
8. Was the area around your room quiet at night?	If no,

(Please circle Yes or No) Question	Feedback
YES NO	
(Please circle Yes or No) Question	Feedback
9. We like to recognize our employees. Can you tell me who did an excellent job for you while you were here?	
10. We want to make sure you were very satisfied with your care; how would you rate your care on a scale of 1-5, with five being the highest? **1 2 3 4 5**	
11. (If answer to previous question is less that 5), We are always working to improve patient care. What could we have done differently to get a score of 5?	
Thank you for taking the time to participate in this survey. Feedback from our patients is very important in helping us improve our systems and processes.	

OTHER FEEDBACK

Adapted by Northern Westchester Hospital from Hardwiring Excellence by Q. Studer

ACCESS TO INFORMATION AND PATIENT EDUCATION

> *"I always want to participate in my health care, and I think they think I ask too many questions. It seems like I need to get through just to keep them on their tight schedule."* (Patient Comment)

The health care industry is in the midst of major information systems transformation. The veil of secrecy has been removed, and today we are inundated with health related information on radio and TV commercials, in the newspaper, and in the popular magazines. Yet, despite this information deluge, in many hospitals, information remains guarded and parsed out on as "as needed" basis, though who and what defines the need is often based on providers' comfort with sharing the information rather than patients' interest in hearing it. In patient-centered hospitals, the exchange of information is a key component of the health care experience. Through customized information packets, community health libraries, open chart policies, bedside exchanges of information, and the like, patients and families are encouraged to become informed, active participants in their care. These hospitals further recognize the immense value of the information that patients can offer providers. By acknowledging the very specialized expertise that patients possess over their own bodies and health care needs, many of the practices described in this section promote partnership and information sharing toward a mutual goal of optimal health outcomes.

The Patient Perspective:

> *"I take a lot of medications, so when I was here, I went over the list and questioned a few things because I'm always afraid of reactions. The sense was that they were offended that I was questioning them."*
>
> ***
>
> *"My mother had a tumor. The doctor came out with all the big words and not explaining it so I can understand it. They wanted to operate right away and I told them I wanted a second opinion. The doctor brought in his own second opinion. If there had been a library on site, I could have researched all the terms that he was using. I felt that we were rushed into it and had I known then what I know now, she wouldn't have had the operation."*
>
> ***
>
> *"They don't discuss things as much as they should and patients don't know what to ask. The initiation should be from the health care person."* [on the topic of reading medical records]

PATIENT-CENTERED APPROACHES FOR EMPOWERING PATIENTS AND FAMILIES WITH INFORMATION:

Shared Medical Record

While health information of all kinds is increasingly accessible, for most patients the medical record remains a mystery. Opening the medical record is a key strategy to overcoming the fear, anxiety and stress associated with the patient care experience. Focusing on how to use the health

record as a teaching tool is one way patient-centered hospitals are reshaping how care is provided to encourage patient involvement and empowerment and invite participation from the patient and family in the experience. Upon arrival, patients are informed and educated about the open access to their record. A single consent form signed by the patient validates this education has occurred. During the hospitalization the patient's record is brought to the bedside, lab results are shared and treatment plans are reviewed in the presence of a health care professional who can help to explain results, decipher unfamiliar terms and acronyms, and ensure that any questions are answered. *See pages 140-143 for a sample open medical record policy from Sharp Coronado Hospital, along with guidelines for sharing the record.*

Patient Progress Notes
This program emphasizes the *exchange* of information. Offering the patient a formal place in the medical record to note any comments or concerns for the health care team can save time, prevent miscommunication and encourages patient and health care team partnership. *Included on page 144 is the form provided to patients at Sharp Coronado Hospital for documenting their notes and questions as part of their medical record.*

Personalized Patient Information Packet
Compiled in take-home packets, health information can be customized to meet the specific information needs of the patient and family. Packets may include fact sheets, recent articles, and information on local support groups and/or relevant complementary modalities. Packet information can be added throughout the hospitalization as subjects of interest are discussed.

Health Information Notebooks
Refer to Section VII.C., Continuity of Care, page 118 for a description of Health Information Notebooks.

Interactive Patient Education
Through the development of Internet-based programs, Sentara Virginia Beach General Hospital is on the cutting edge of patient education. They have developed an interactive television-based patient education system, currently being used by cardiac patients. Each day, education relevant to that day of treatment is provided via the system as a mini television program. At the completion of the module, the patient responds to a brief set of questions to assess comprehension. The answers provided generate additional customized learning modules for the patient, and/or alert the nurse to the patient's additional education needs.

Resource Centers
Staffed by knowledgeable health professionals and volunteers, a Health Resource Center serves as a community resource and offers a variety of health information, including lay books, medical texts, technical journals, newsletters, materials for adult and new readers, audiovisual media and computer services. Multilingual materials and community cultural influences are also reflected in the collection of materials provided. Ease of use for community members is enhanced by an easy to use classification scheme, such as the Planetree Classification Scheme, which is organized in a way that makes intuitive sense to a layperson.

Navigating Health Information on the Internet

Increasingly, health care consumers are turning to the Internet for health and wellness information. However, while the Internet offers a wealth of information on any number of health-related topics, the scope and breadth of the information available can be vastly intimidating at best and misleading or detrimental at worst. Health Resource Center staff and volunteers can provide a valuable service by supporting consumers conducting Internet searches and guiding them to trusted health web sites. Several consumer-focused web sites have emerged in recent years that serve as virtual clearinghouses of reliable health and medical information, including:

- **Health on the Net** (http://www.hon.ch/individuals.html)
- **Medline Plus** (http://medlineplus.gov)
- **Medscape (**http://www.medscape.com/home)
- **Web MD** (http://www.webmd.com)

Health care professionals are also recognizing the value—and the challenges—of easily accessible on-line health and medical information for their patients. Directing patients and family members to resources that are accurate and up-to-date is an important aspect of empowering patients with information that can guide their decision making and their own self-management of conditions. Beyond providing individual consultation to patients on this topic, some physicians have gone so far as to publish resource guides for patients directing them to credible on-line health information. One example is the guide *Best Health Resources on the Web* by Dr. Harlan R. Weinberg, Medical Director of Critical Care at Northern Westchester Hospital. The resource has been made widely available to patients and families throughout the hospital, particularly in areas where individuals may be searching for information on-line, such as in the ICU family waiting room, the Health Science Library, and the Ken Hamilton Caregivers Center (*see page 150*).

Patient Pathways

Refer to Section VII.C, Continuity of Care for a description of patient pathways on page 115, and a sample of Griffin Hospital's CHF Pathway on pages 124-125.

Bedside Shift Report

Refer to Section VII.C., Continuity of Care, page 117 for more information.

IMPLEMENTATION TOOLS:

A. Sharp Coronado Hospital's Open Medical Record Policy, *pg. 140*

B. Sharp Coronado Hospital's Guidelines for Open Medical Record, *pg. 143*

C. Sharp Coronado Hospital's Patient Progress Notes Form, *pg. 144*

A. Sharp Coronado Hospital's Open Medical Record Policy

<table>
<tr>
<td rowspan="3">**SHARP**®</td>
<td colspan="2">P A G E 1 O F 3</td>
<td rowspan="2">**DEPARTMENT GUIDELINE**</td>
</tr>
<tr>
<td>ORIGINAL ISSUE DATE
11/04</td>
<td>CURRENT EFFECT DATE
10/04</td>
</tr>
<tr>
<td colspan="3">**TITLE:**

PATIENT ACCESS OPEN RECORD

SUBJECT: Protected Health Information

KEYWORD(S): HIPPA, PRIVACY, COMPLIANCE; AMENDING MEDICAL RECORD</td>
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 [ ] SRS   [ ] SCH
 [ ] SMPMG [X] SCOR
[ ] OTHER   [ ] SCVMC
 [ ] GPSC   [ ] SGH
 [ ] SCMG   [ ] SMH
 [ ] SHH   [ ] SMBHW
 [ ] SHP   [ ] SMV
 [ ] Sub/LTC [ ] SVP</td>
<td>AFFECTED DEPARTMENTS:
   All Departments

ORIGINATOR:

   Health Information
   Planetree, Coronado Hospital</td>
<td>ACCREDITATION:
   JCAHO - IM

STANDARDS/LEGAL REFERENCES:

   Sharp HealthCare</td>
</tr>
</table>

I.   **PURPOSE:** To establish policy and procedures in support of patients' rights, as required in state and federal law, to review, comment and request amendments to their open medical record maintained by Sharp.

II.   **DEFINITIONS:** Open Medical Record is a record in process, produced during ongoing hospitalization and/or treatment. Once the patient has been discharged from care, the Medical Record is considered closed. All requests for information on Closed Medical Records are to be referred to the Health Information Management Department.

III.   **POLICY:** Adult patients have the right to read their medical record during hospitalization
Sharp recognizes the patient's right to review/inspect and obtain copies of their health information except in circumstances under law/regulations where access may be denied. Requests for inspection and copies must be in writing and directed to the Health Information Department or Nursing Care Unit were the patient is currently being cared for.

Adult patients have the right to request an amendment or add a comment to their protected health information created by Sharp at any time while the organization maintains the information. This may be accomplished by use of Coronado Hospital, Patient Comment/Addendum Form (Attachment A) or referral to "Health Information request for Amendment" Policy # 01964.99.

IV: **TEXT:**

V.   **PROCEDURE:**   **RESPONSIBILITY:**

Patients will be offered the opportunity to review their medical record upon admission.   A. Care Unit RN

B.   The offer to review the medical record will be documented in the Nurses Notes by the patient's nurse   B. RN receiving request.

F.   A representative of the health care team will be present to explain the   F. Patient's Nurse

	PAGE 2 OF 3		DEPARTMENT GUIDELINE
SHARP.	ORIGINAL ISSUE DATE 11/04	CURRENT EFFECT DATE 10/04	

TITLE:

PATIENT ACCESS OPEN RECORD

SUBJECT: Protected Health Information

KEYWORD(S): HIPPA, PRIVACY, COMPLIANCE; AMENDING MEDICAL RECORD

contents of the medical record.

G. Time of review: Obtain patient authorization: Patient must complete an "Authorization for Use or Disclosure of Health Information Form (Attachment B). Place the original form in the patient's medical record and provide the patient/representative with a copy.

G. Hospital
    Representative

H. Provide patient with "Patient Comment/Addendum Form". Explain to patient or designated representative that they are welcome to address concerns, make comments, corrections or additions on the provided form. Ensure that each page contains; Patient identification, identification of the author and date produced. The reviewer may not write directly on, amend or cross out any existing documents within the original record.

H. Hospital
    Representative

I. At the end of review by patient or representative, place a completed Addendum Form(s) in the Progress Notes by date order.

I. Hospital
   Representative

J. Return record to appropriate storage area.

J. Hospital
   Representative

VI. REFERENCES:
   a. California State Confidentiality of Medical Information Act
   b. California Code of Regulations, Title 22
   c. Federal Law 42 CFR, part 2
   d. JCAHO Accreditation, Standards, RM, IM
   e. Health Insurance Portability and Accountability Act of 1996 (HIPPA)

VII.   CROSS REFERENCES:
   Health Information: Access, Use and Disclosure
   Confidentiality of Protected Health Information
   HIV Testing
   Health Information, Patient Access

VIII. ATTACHMENTS:
   f.   Authorization for use or Disclosure of Medical Information
   g.   Coronado Hospital, Patient Comment/Addendum Form

IX.   APPROVALS:

   A.   Department of Clinical Care
   B.   Planetree Committee
   C.   Medical Executive Committee

	PAGE 3 OF 3		DEPARTMENT GUIDELINE
SHARP	ORIGINAL ISSUE DATE 11/04	CURRENT EFFECT DATE 10/04	
	TITLE: PATIENT ACCESS OPEN RECORD		
	SUBJECT: Protected Health Information		
	KEYWORD(S): HIPPA, PRIVACY, COMPLIANCE; AMENDING MEDICAL RECORD		

X.   **REPLACES:** N/A

XI.   **HISTORY:** N/A

F:\My Documents\P&P 2004\Open Record Review 12 08 04.doc

B. *Sharp Coronado Hospital's Guidelines for Open Medical Record*

OPEN MEDICAL RECORD PROCESS OUTLINE

PATIENT REQUEST TO REVIEW THEIR RECORDS DURING HOSPITALIZATION

The medical record is the property of the hospital, patients have the right to inspect and/or receive copies of their medical records. Release of patient's identifiable information will be carried out only as authorized by law/regulation. The patient is required to complete an "Authorization for Release of Confidential Information". In the event the patient is a minor or incapacitated a signed authorization from parent, legal guardian or executor is required. In the case of HIV test results and/or Psychiatric Records, there are special requirements that must be followed. Refer to Policy 12009.99 for Psychiatric records and Policy #38301 for HIV records, or contact the Health Information Management department for assistance.

Upon receiving a request from the patient to review their open medical record:

1   Ask the patient to complete an "Authorization for Release of Confidential Information".
2   As a courtesy inform the patient's primary physician of patients request. Records containing psychological, psychiatric or chemical abuse information should be reviewed by a physician prior to patient review.
3   Arrange for a date and time that a nurse will be available to observe the patient during review of the record. Sharp Healthcare requires that a member of the staff be in attendance during the inspection process.
4   A patient who inspects their medical record has the right to provide a written addendum. The addendum must be limited to 250 words and documented on the "Patient's Comments/Addendum Sheet". Neither the patient nor his/her representative may remove any documents or write in the medical record.
5   Once the patient has completed the review of their record, give them a copy of the signed release and their written comments. Place the original release and the original comment/addendum sheet in the progress note section of the medical record. Document on the release, any copies you may have made for the patient.
6   If there are any questions regarding the release of information to the patient you are instructed to call the HIM department at extension 3716.

CONSENTS/FORMS

1.   "Authorization for Use or Disclosure of Medical Information", MR205 (5/97)
2.   "Authorization for Disclosure of the Results of the HIV Test", California Healthcare Association
3.   "Patients Comment/Addendum" Form
4.   "Patient Access Open Record" *Pending approval*
5.   "Health Information request for Amendment", Policy #01964.99

C. Sharp Coronado Hospital's Patient Progress Notes Form

ADDRESSOGRAPH

SHARP CORONADO HOPSITAL
PATIENT COMMENTS/ADDENDUM

DATE: _____

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_____ Patient Signature

This is a permanent part of the Patient's Medical Record. PLEASE FILE UNDER
PROGRESS NOTES, IN DATE ORDER.

12/03
5/25/04
UR/MEDREC/PLANETREE

FAMILY INVOLVEMENT

> *"Regardless of how great the care is, you really need someone by your side 24/7. That care partner thing could be really great because my husband really knows me."* (patient quote)

Hospitals that are committed to being responsive to consumers' needs and expectations understand the invaluable role of "family"—however "family" is defined by the patient. These are the people who know the patient best and those who, simply by their presence, can help to reassure patients in times of uncertainty, anxiety or vulnerability. Patient-centered hospitals welcome family members by not only lifting many of the restrictions that have historically limited their involvement, but also by actively encouraging their participation as members of the care team.

As health care institutions, we treat thousands of patients with cancer, heart disease and other chronic and terminal illnesses every year. Many of these patients are elderly or critically ill and may undergo difficult medical treatments that require lengthy and/or frequent hospital stays or outpatient visits. During their treatment, family caregivers are often a critical source of care for their loved ones. Family caregivers can offer providers a valuable source of help as well as information about the patient's history, routines, symptoms and more. For these family members, participating in this manner is essentially an extension of the ongoing caregiving role they play at home, both before and after hospitalization. The practices in this section represent ways that hospitals are involving family and friends to provide optimal patient care.

The Patient Perspective:

"I think being a family member with older parents that there is a lot of stuff that is going on while they are in there that isn't communicated to us. He may have wanted to tell me but didn't have the details, so it would be good to have staff tell you."

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"I was here visiting my wife and father when they were here. They were easy going, and showed me how to operate some of the equipment. They showed me how to adjust things because they knew I would have to do this at home. They explained things to me. I was more comfortable during her recovery experience. They passed on their knowledge, they took the time."

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"I had a double mastectomy, and it would have been nice to know that my daughters could have learned to do the dressing changes while they were here and before I went home. We went home and it was trial and error."

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"My husband stayed and tried to help out. He didn't have to, but he wanted to and they were good with him."

"I was in ICU. I had tubes in my throat and in my stomach and in my other end. One nurse shoved my family out of the room and told me to go to sleep. She was really nasty. I asked her to bring my husband in and she kept saying, 'You don't need anybody. You are OK.' I started screaming, 'Will you get my son?' and she wouldn't."

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"At some point, [my husband] had a test result and they didn't know why and I knew it to be a reaction to medication… I've taken care of him for ten years with his Parkinson's and I know a lot and she didn't want to listen to me. She put him through two spinal taps and at that point, I said, 'No,' and I became loud and she said she was going to call psychiatric… How dare she say that I am hysterical. Of course I am! The person I love is in a very bad situation."

***

"I went home with a catheter and lots of drains and the nurses took hours to help him learn how to take care of everything. I got to go home because they took the time to teach him how to take care of me."

The Leadership Perspective:

"The biggest untapped resource in health care is the patient and their family. We systematically exclude patients and family members from helping to redesign care to be more effective and don't communicate that their knowledge is essential to improve outcomes. We can't afford to do that anymore." (Donald M. Berwick, M.D., Institute for Healthcare Improvement)

PATIENT-CENTERED APPROACHES FOR ENCOURAGING THE INVOLVEMENT OF LOVED ONES:

Patient-Directed Visitation

As Donald Berwick, M.D. of the Institute for Healthcare Improvement referenced in his article *Restricted Visiting Hours in ICUs: Time to Change*,[10] a study that examined the benefits of unrestricted patient visitation, 88% of families stated it had a positive benefit to their overall experience and decreased their anxiety by 65%. Despite clear evidence that patient-directed visitation is what patients and families prefer, hospitals continue to struggle with the transition from traditionally restrictive visiting policies to patient-directed visitation. Concerns range from spread of infection, family members posing as impediments to clinicians' ability to provide care, and that open visiting hours may keep family members from getting a much needed break from the bedside. Patient-centered hospitals have addressed and successfully overcome these barriers in order to implement patient-directed visitation.

Patient-directed visitation is defined as an unrestricted visiting environment in which the patient (or in situations in which the patient lacks capacity, the patient's health care proxy) establishes visitation parameters that best suit the individual circumstances. The ultimate goal is to meet the psychological and emotional needs of the patient and those who comprise the patient's support system through open visitation. A visitor is defined as anyone who the patient determines is significant to their well-being and whose presence would enhance their hospitalization. Typically, the primary caregiver establishes a dialogue with the patient upon admission to discuss who the patient/proxy identifies as essential to visit. Ideally, these patient-directed guidelines should be documented in the patient's record. The primary caregiver will discuss the

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[10] Berwick, D, Kotagal, M (2004). "Restricted visiting hours in ICUs: time to change." <u>JAMA</u>, 292: 736-737.

need to balance visitation with patient rest periods and educate visitors about their responsibility to maintain a quiet, healing environment along with proper infection control procedures. These guidelines are also applied in ICU and Emergency Department settings. An exception is behavioral health units which, with the need to limit interruption of therapeutic modalities, typically continue to specify visitation hours.

Northern Westchester Hospital's Recommendations for Implementing Patient-Directed Visitation:

Step 1:   **Educate staff and physicians**. Many studies have been conducted and articles written about the positive effects for both families and clinicians when restrictions on visitation are lifted. Reviewing the evidence-base may be helpful in establishing consensus. Medical Boards and Hospital Infection Control Committees also serve as pivotal committees for discussion, guidance and support.

Step 2:   **Identify physician and nursing champions**. These champions serve a vital role as credible subject matter experts and meet with departments to listen and respond to concerns with the ultimate goal of moving the institution toward adoption.

Step 3:   **Conduct a pilot study**. Identify a specific area(s) that is willing to pilot patient-directed visitation for a specified period of time. Use the experience of these pilot areas to refine the practice, develop appropriate policies, and educate other departments. Interview patients, families and staff during this period to obtain feedback. Document perceptions and lessons learned for educational purposes.

Step 4:   **Establish a time frame for house-wide implementation and finalize visitation policies**. Use the feedback from pilot sites and, whenever possible, have staff from pilot areas accompany champions to new areas to discuss their experiences. Use newsletters, communication boards, etc. to publicize feedback from patients and families about how being with their family, whenever they wanted to, benefitted them.

Step 5:   **Publicly recognize your champions for their participation as pilot starters**. Recognition of staff who step out on a limb to support these patient-centered practices is important for acknowledgment and empowerment of staff to embrace and lead other patient-centered initiatives.

Griffin Hospital's policy for patient-directed visitation is included on pages 152-153 as a resource.

Family Presence During Procedures or Resuscitation:

> *"I was initially very resistant to this concept. My feeling was family can be around, but when it really counts, everyone has to get out so we can do our jobs. Then we let a wife be with her husband as we did CPR on him. She did not get in the way and she stayed quietly by his side, whispering loving and reassuring messages. He didn't make it, but she turned to me and*

hugged me and said, 'Being here let me see how you did everything to save him and it also let me say goodbye. Thank you for not throwing me out.'" (ICU Nurse)

Historically, when a patient is having a bedside procedure or is in need of CPR, family is ushered out of the room. Family presence enables the family a choice of being present to support their loved one during this particularly stressful and frightening hospitalization period. This approach has a number of benefits including providing family with a sense of control, better comprehension of the patient's condition or status, assisting in medical decision making and, when appropriate, providing loved ones an opportunity for closure that facilitates the grieving process.

Many hospitals that remove this barrier and enable the family to be present appoint a staff member to act as a **family facilitator**. Staff members can include nurses, physicians, a chaplain, social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other appropriate health care professional. The family facilitator is assigned to be present with the family, explain the procedure, provide support, and ensure safety and comfort. After the procedure or code, the facilitator escorts the family to a comfortable area, addresses concerns, provides comfort measures, and addresses any other psychosocial needs that may have emerged. *The family presence policy in place at Northern Westchester Hospital is included on pages 154-156 as a resource.*

Patient/Family Initiated Rapid Response Teams

"When you are in the hospital, feelings of intense powerlessness come over you. It was a comfort to know that this team is available to me. What impressed me most is that after I called [the rapid response team], my nurse came in and said, 'I'm glad you felt comfortable calling the rapid response team. No one knows your body better than you— and you should feel comfortable and safe calling for help.'" (patient comment)

Staff initiated rapid response teams, considered "pre codes," are common in today's hospitals. Staff initiated teams empower any hospital staff member to signal a rapid response team when they see signs indicating that a patient's condition is deteriorating, such as difficulty breathing or a change in heart rate or rhythm.

Patient/family initiated rapid response teams take this quality initiative one step further, encouraging patients and their families to be actively involved by providing a mechanism for alerting the care team to a noticeable clinical change in the patient's condition. To ensure patients' and families' awareness of the program, information about it is presented upon admission. Signs about this team are posted in patient rooms and brochures about the program are available throughout public areas. Patients and families call a dedicated line, manned 24/7, and a rapid response team is immediately dispatched to the patient's bedside.

Shands Jacksonville Medical Center in Jacksonville, Florida themed the educational materials about its patient- and family- initiated rapid response team (RRT) with the phrase, "*You know your loved one better than anyone else*." Patients and families are educated about RRT and the summoning process in a variety of ways, including at the time of admission and with informational signs that are posted in all patient rooms. In addition, phones are labeled with

instructions for accessing the "4CARE Hotline," and patients and families are instructed that "calling for RRT is like calling 911 for help from home."

See pages 157-161 for Northern Westchester Hospital's Rapid Response Team Policy. See pages 162-166 for the training tools used by Shands Jacksonville Medical Center to educate staff, patients and families about the patient- and family-initiated rapid response team. Also included as a resource on page 167 is the signage posted in patient rooms at the University of North Carolina Children's Hospital to communicate about its pediatric rapid response team.

Care Partner Programs

Patient-centered hospitals recognize the important role caregivers play in the lives of their loved ones, and discuss with family caregivers the role they would like to play in helping to provide care to their loved one while in the hospital. Some family caregivers see hospitalization as a respite of sorts from their daily responsibilities, while others want to retain their active role. Care partner programs provide this vehicle. The goal of a care partner program is to meet the personal, emotional, spiritual, physical and psychosocial needs of the patient by allowing and encouraging his or her support system to be involved in his or her care, while at all times, protecting and respecting the patient's sense of dignity and independence. A care partner may be a spouse, significant other, family member or friend of the patient who is identified by the patient as a person supporting his/her hospital and/or home care and wellbeing.

Shortly after admission and with approval from the patient, the primary nurse discusses the routine care activities that are required and establishes the caregiver's interest. The nurse is typically responsible for providing the necessary education about the care and monitors the caregiver's progress and comfort level with any new skills. It is important to state that care partnering is not to be seen as a replacement for nursing care, but rather as an adjunct or enhancement to care. The purpose is to give caregivers the opportunity to learn or enhance their knowledge related to caring for their loved one both in the hospital and after discharge. More importantly, care partner programs enable institutions to acknowledge the pivotal role the caregiver plays in the patient's comfort, security and adherence to their plan of care.

Examples of routine care activities that may be provided by care partners include, but are not limited to:
- Personal care – bathing, backrubs, hair care
- Meal assistance – feeding, menu selection, encouraging, recording
- Ambulation assistance – wheelchair use, encouraging, monitoring
- Monitoring fluids
- Diversional activities – reading, writing, companionship
- Treatments – mouth care, dressings, exercises
- Catheter/drain care
- Safety measures
- Suctioning

See pages 168-169 for Alegent Health's Care Partner Program brochure.

An excellent way to acknowledge care partners is to provide recognition for their participation. Some institutions, such as Sharp Coronado Hospital, provide official care partners with a pin, clearly identifying them as care partners to all members of the health care team. The hospital also encourages care partners to take a break by offering them coupons to the cafeteria for a complimentary meal.

Caregiver Support Programs
As the number of family caregivers grows, so too do the burdens they face. Informal care of family members requires a great deal of time, dedication and perseverance. For those caregivers employed outside of the home and those with children, their burdens are further complicated by having to juggle work, family and caregiving obligations.

The Family Caregiver Alliance[11] reports that:

- 31% of those caring for persons 65 and older describe their own physical health as "fair to poor."

- Caregivers experience mental or emotional strain and elderly spousal caregivers have a 63% higher risk of dying than non-caregivers.

- About 40-70% of caregivers show signs of clinical depression as a result of caregiving and take more prescription medications, including those for anxiety and depression, than others in their age group.

- Stress associated with family caregiving has resulted in increased risks of infectious disease, such as colds and flu, and chronic diseases such as heart disease, diabetes and cancer.

Accordingly, in its 2003 report *Ensuring the Health and Wellness of our Nation's Family Caregivers,* the U.S. Department of Health and Human Services stressed the importance of encouraging the health and well being of the nation's family caregivers:

> "Family caregivers are less likely than peers of the same age to engage in health-promoting behaviors that are important for chronic disease prevention and control. Given that the demands of caring for a loved one may compromise caregiver health and functioning and increase caregivers' risk of developing physical health problems, there is a pressing need to encourage family caregivers to engage in activities that will benefit their own health, well-being and longevity."

This pressing need was addressed by Northern Westchester Hospital with the establishment of the **Ken Hamilton Caregivers Center**, a wellness and resource center located right off the hospital's main lobby. It is a sanctuary for family caregivers—away from the bright lights and hospital personnel—but still close enough to allow them to be physically close to their loved ones. The Center offers a variety of services including a comprehensive library of caregiver

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[11] The Family Caregiver Alliance. Caregiver Health. [www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=1822], Accessed: September 5, 2008.

resources; educational and spiritual materials; and healing arts such as m-technique, Reiki, aromatherapy, journaling and caregiver support groups. The Center has computer and Internet access, telephones, a small kitchenette, and a massage chair with a repertoire of guided imagery meditation CDs that is widely used. The Center serves as a quiet, peaceful area for reflection, reading and rest.

A crucial component of the Caregivers Center is the availability of emotional support and counseling provided by both the Center's professional social worker as well as volunteer coaches. Volunteer coaches are community members who have had a personal experience with caregiving and who understand the stress and demands of balancing one's personal life with that of caregiving. In fact, the support component of the program was in place 18 months prior to the physical Center being built. Coaches round on patient floors, meet with family members and gently encourage them to take a break from the patient unit.

> *"The care you give to yourself is the care you give to your loved one. The minute I walked into the Center, I could finally take a breath. The coach welcomed me and told me this place is for you. We talked, I cried, I vented, I drank a delicious cup of herbal tea with organic peanut butter on a biscuit. I was renewed. The Center has been there for me throughout my loved one's hospitalization and after. What a blessing for all caregivers to have this resource."* (family member comment)

Family Accommodations
With policies and programs in place to encourage family involvement, it is essential that the physical environment and any and all communications to patients and families reflect these messages that loved ones are welcomed. *See Section VII.F., Environment of Care, page 170, for more details on creating an environment that is welcoming of family members' presence and involvement.*

IMPLEMENTATION TOOLS:

A. Griffin Hospital's Visitation Policy, *pg. 152*

B. Northern Westchester Hospital's Family Presence Policy, *pg. 154*

C. Northern Westchester Hospital's Rapid Response Team Policy, *pg. 157*

D. Shands Jacksonville Medical Center's Rapid Response Team Training Tool Kit, *pg. 162*

E. University of North Carolina Children's Hospital Pediatric Rapid Response Team Signage, *pg. 167*

F. Alegent Health's Care Partner Program Brochure, *pg. 168*

Tool A: Griffin Hospital's Visitation Policy

THE GRIFFIN HOSPITAL
STANDARD OPERATING POLICIES

SUBJECT: VISITOR POLICY

EFFECTIVE DATE: 3/2008   **SUPERCEDES: 9/2005**

RESPONSIBLE DEPT: Administration/Nursing   **APPROVED BY:**

Administrator

PURPOSE:

To provide an open policy for visitation on the patient units <u>except</u> where defined in policy below.

POLICY:

A. <u>General Hospital</u>

In concert with the Planetree Model of Care, Griffin Hospital has an open policy regarding visitation on all patient units with the <u>exception</u> of the Psychiatric Unit. Visiting is allowed at all times unless contraindicated by the patient's condition or the patient/physician requests visiting restrictions.

Physicians who implement visiting restrictions for medical reasons must inform the staff on the patient unit and make appropriate notation in the patient's record.

Visiting during the hours of 7:00 pm to 7:00 am are considered the "quiet hours" for all units. During this time, it is expected that all departments will maintain a quiet environment. Action steps that should be implemented to maintain that environment include:

- Keeping voices low
- Keeping electronic equipment such as TV's and radios at low volume
- Being mindful that doors may be noisy and not allowing them to slam
- Educating visitors of "quiet hours" and asking them to keep voices low
- Dimming the hallway lights to signify "quiet hours"
- Utilizing the partial closing of doors or complete closing of doors when necessary and safe to do so to provide a quieter environment

B. <u>Psychiatric Unit</u>

Visiting hours are: Weekdays (M-F) from 4:00 pm to 9:00 pm; Saturday and Sunday from 1:00 pm – 9:00 pm; and Holidays from 1:00 pm to 9:00 pm. Visitors may use the Seymour Avenue entrance which enters directly into the Psychiatric Unit. Visitors must request entry into the unit from department staff.

**THE GRIFFIN HOSPITAL
STANDARD OPERATING POLICIES**

SUBJECT: VISITOR POLICY

C. Exceptions/Other Provisions

Temporary changes to this policy including restricted hours or visiting either for individual patients or for the hospital may be implemented. Changes are authorized by hospital administrative nursing staff and will be posted at the Information Desk and/or at Patient Care Units.

Reviewed: 5/2001; 8/2004; 9/2005; 6/2006
Reviewed/revised: CPIC - 3/2008

Tool B: Northern Westchester Hospital's Family Presence Policy

Northern Westchester Hospital
Patient Care Services

Subject: Option of Family Presence (FP) During Resuscitation Events

Policy Number: Page 1 of 3
Effective Date: June 4, 2007   Issued By: Patient Care Services
Reviewed: Distribution: Patient Care Services Policy
Revised: and Procedure Manuals
Supersedes: N/A

POLICY: Family members will be permitted, when appropriate, in the patient care area during a resuscitation intervention procedure.

PURPOSE: To acknowledge the needs of patients and families regarding the delivery of patient healthcare that is consistent with the Planetree philosophy of family centered care. The potential benefits of FP to family members are the ability to:
- be able to provide comfort to the patient
- gain a sense of control
- help comprehend the condition/status
- assist in medical decision making regarding patient
- maintain connectedness of family
- provide an opportunity for closure and/or facilitate the grieving process.

DEFINITIONS:
Resuscitation: A sequence of events, including invasive procedures, which are initiated to sustain life and/or prevent further deterioration of the patient's condition (e.g. emergency endotracheal intubation, CPR).
Family Member: A relative of the patient or any person (significant other) with whom the patient shares an established relationship.
Family Facilitator: A staff member (nurse, physician, chaplain, social worker, clinical nurse specialist, nurse practitioner, physician assistant, and healthcare team member) assigned specifically to initiate interventions that assist the family and provide emotional and psychosocial support.

PROCEDURE:
The option of family presence (FP) at the bedside during an emergency resuscitation intervention procedure will be offered to the family/significant other(s) providing the following criteria are met:

A. The patient and uninterrupted patient care will remain the priority.

B. A member of the health care team will assess the patient's family/significant other (family) for appropriateness of family presence.
1. Members of the health care team shall participate with the family facilitator in evaluating whether families are suitable candidates for bedside presence.
2. Before the FP option is offered, families will be assessed for appropriateness of age, appropriate levels of coping and the absence of combative behavior, extreme emotional instability, and behaviors consistent with altered mental status.

C. The physician in charge/direct care provider is informed of and is in agreement with the option of FP.

Northern Westchester Hospital
Patient Care Services

Subject: Option of Family Presence (FP) During Resuscitation Events

Policy Number:
Effective Date: June 4, 2007
Reviewed:
Revised:
Supersedes: N/A

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D. The family will be offered the option of FP. Family members who do not wish to participate will be supported in their decision.

E. A maximum of two family members may be present at the bedside at any given time. When prioritizing family member participation in the FP option and determining the next of kin the following priority order should be considered.
   1st Spouse
   2nd Son, daughter 18 years or older
   3rd Either parent
   4th Adult brother or sister
   5th Guardian

F. Before entering the room, the facilitator should prepare the family for bedside presence. He/she will describe the patient's appearance and condition, procedures being performed, and the importance of their supportive role. He/she will explain that the patient and patient care is the priority.

G. The facilitator will provide the family with personal protective equipment as appropriate. The health care team will instruct the visitors where to stand and what they may or may not touch to prevent contaminating the patient or equipment.

H. The facilitator will escort the family to the bedside and remain with the visitors during the bedside presence until, upon collaboration with the team, it is appropriate for him/her to depart.

I. When in the room the facilitator will;
   1. Provide comfort measures, such as chair or tissues
   2. Provide an opportunity for the family to ask questions
   3. Facilitate opportunities for the family to see, touch and speak to the patient

J. If a family member becomes faint, overwhelmed, and sick or exhibits disruptive behavior at the bedside, the facilitator will immediately escort the person from the area and arrange for appropriate supportive care.

K. After completing the patient bedside visitation, the facilitator will escort the family to a comfortable area, address their concerns, provide comfort measures, and address any other psychosocial needs.

REFERENCES: Emergency Nurses Association. Presenting the Option of Family Practice, 2nd ed, Park Ridge, IL, Emergency Nurses Association, 2001.
Mason, Diana RN, PhD, American Journal of Nursing, 'Family Presence', May 2005
Mangurten,J. et.al. American Journal of Nursing, 'Family Presence: Making Room',

Northern Westchester Hospital
Patient Care Services

Subject: Option of Family Presence (FP) During Resuscitation Events

Policy Number: Page 3 of 3
Effective Date: June 4, 2007   Issued By: Patient Care Services
Reviewed: Distribution: Patient Care Services Policy
Revised: and Procedure Manuals
Supersedes: N/A

May 2005, volume 105, Number 5, pp. 40-48

APPROVALS: Family Presence Option Workgroup 4/11/07
                         Patient Care Standards Committee 4/23/07
                         Policy and Procedure Committee 5/02/07
                         Medical Board 6/04/07

Tool C: Northern Westchester Hospital's Rapid Response Team Policy

Northern Westchester Hospital
Patient Care Services

Subject Rapid Response Team

Policy Number:	Page 1 of 5 Pages
Effective Date: May 5, 2008	Issued By: Patient Care Services
Reviewed:	Distribution: All Department Policy and
Revised:	Procedure Manuals
Supersedes:	

POLICY: Northern Westchester Hospital's (NWH) Rapid Response Team (RRT) may be summoned to evaluate and initiate treatment in response to a patient's clinical deterioration or condition.

PURPOSE: To provide a team of clinical specialists (RRT) trained to respond to a patient's clinical deterioration or condition by assessing and stabilizing the patient thereby providing improved safety, better patient outcomes, decreased need for cardiopulmonary resuscitations, unplanned Critical Care Unit admissions and reduced mortalities.

RESPONSIBILITY:

    I. **Clinical Staff RRT Request**: The RRT available to immediately respond to a Clinical RRT request will consist of the following health care professionals:

        a. Critical Care Nurse
        b. Hospitalists (NWH and MKMG)
        c. Respiratory Therapist
        d. Administrative Supervisor

    II. **Patient/Visitor RRT Request (Patient/Visitor Emergency Help Line)**: The RRT available to immediately respond to a patient/visitor RRT request regarding patient will consist of the following health care professionals who may contact the appropriate response team to initiate treatment:

        a. Administrative Supervisor **AND**
        b. Patient Advocate

GUIDELINES: If a clinical staff member has concerns regarding a patient's clinical deterioration or condition the following guidelines may be considered, but are not limited to, in requesting and/or initiating the RRT.

- **Acute sustained changes** in SBP less than 90 or greater than 185 mmHg
- **Acute sustained changes** in heart rate less than 45 or greater than 140 BPM
- **Acute sustained changes** in respiratory rate less than 10 or greater than 30 BPM
- Chest pain
- Altered mental status (e.g. increase lethargy, seizures, syncope, decreased level of consciousness)
- **Acute sustained changes** in oxygen saturation less than 90% with Fi02 greater than 50%

PROCEDURE:

Northern Westchester Hospital
Patient Care Services

Subject Rapid Response Team

Policy Number: Page 2 of 5 Pages
Effective Date: May 5, 2008   Issued By: Patient Care Services
Reviewed: Distribution: All Department Policy and
Revised: Procedure Manuals
Supersedes:

NWH CLINICAL STAFF RRT REQUEST STEPS

1. Prior to contacting the RRT, every effort should be made by the nurse and the Care Manager/designee to contact the attending physician to address the patient's condition by using SBAR communication tool. If concerns persist the RRT may be called.

2. An RRT request may be initiated by notifying Telecommunications and stating need for RRT:

    - A telephone call on the 1212 phone
    - A staff member via the Nurse Console
    - The activation of the Code Button in a patient's room

3. The members of the RRT, after receiving report from the patient's nurse and assessing the patient within the scope of their practice, will initiate the appropriate interventions in treatment of the patient's clinical situation.

4. Documentation:
    A. Nurse will document:
        - In the 'Notes' option of the Hospital Information System (HIS) the reason

KEY POINTS

1. SBAR communication consists of
    Situation
    Background
    Assessment
    Request/ Recommendation

    Refer to policy - Patient Care Communication

2. Telecommunications will initiate the RRT call through the beeper text message system (Refer to telecommunication's policy: Rapid Response Team Procedure)

    A RRT request will NOT be announced via the overhead paging system.

3. The team will work with the patient's attending physician whenever possible. However, if the patient's attending physician is not available the team will initiate treatment within their scope of practice.

    The RRT does not assume the care of the patient, but assists in the evaluation, assessment, treatment to stabilize and the disposition of the patient. The overall care and treatment of the patient remains the responsibility of the patient's physician.

4.

Northern Westchester Hospital
Patient Care Services

Subject Rapid Response Team

Policy Number:
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Revised:
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for initiating the RRT, performed interventions with response, post-RRT outcome and disposition of patient.

- Each member of the RRT will document in the HIS on their appropriate documentation tools their evaluation, assessment, interventions initiated, and outcome(s) achieved.

5. The RRT Evaluation Form (available on paper or in HIS) is a confidential tool used for quality improvement, surveillance and for meeting The Joint Commission Standard should be completed post RRT. The RRT evaluation tool is forwarded to Quality Improvement

   RRT should be included in the Daily Administrative Report.

5. This is the responsibility of the patient's nurse and/or Administrative Supervisor.

   The RRT Evaluation Tool is **not** part of the permanent medical record.

PATIENT/VISITOR RRT REQUEST STEPS

1. An RRT response for a patient/visitor's concern may be initiated by notifying Telecommunications via:

   - A telephone call via the patient's phone - dial   HELP (4357) which is answered by telecommunications.
   - A staff member via the Nurse Console

KEY POINTS

1. Telecommunications will initiate the RRT call through the beeper system (Refer to telecommunication's policy: Rapid Response Team Procedure)

   A RRT request will NOT be announced via the overhead paging system.

Northern Westchester Hospital
Patient Care Services

Subject Rapid Response Team

Policy Number:
Effective Date: May 5, 2008
Reviewed:
Revised:
Supersedes:

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2. The Administrative Supervisor and, if available, the Patient Advocate will immediately respond to the patient's room to evaluate and address the patient's concern.
   a. The Administrative Supervisor is responsible for making the clinical assessment and initiating the response (e.g. calling the physician, calling clinical staff initiated RRT)
   b. The Patient Advocate will address patient, family, visitor issues. In the absence of the Patient Advocate the Administrative Supervisor will act as the designee.

3. Documentation of the Administrative Supervisor and Patient Advocate's response to the RRT request, evaluation of the situation and actions taken will be completed in MIDAS.

4. Follow steps #3, #4, and #5 under the NWH Clinical Staff RRT request.

2. The responding Administrative Supervisor and Patient Advocate will speak with those initiating the call, patient's nurse and, if appropriate, the attending physician.

REFERENCES: 2007 VHA Research Series   "Rapid Response Teams: A Bridge Over Troubled Waters".
Baldesseri, M.R., MD. Rapid Response System: Have they made a difference? " Critical Connections" Society for Critical Care Medicine (SCCM) 2006 June, Vol 5, Number 3.
Joint Commission 2008 National Patient Safety Goal 16 'Improve recognition and response to a deteriorating patient'.
Jolley,J., Bendyk, H. et al "Rapid Response Teams: Do they make a difference?" Dimensions of Critical Care Nursing Nov/Dec 2007, Vol 26, No 6.

ATTACHMENT(s): Rapid Response Evaluation Tool

Northern Westchester Hospital
Patient Care Services

Subject Rapid Response Team

Policy Number: Page 5 of 5 Pages
Effective Date: May 5, 2008   Issued By: Patient Care Services
Reviewed: Distribution: All Department Policy and
Revised: Procedure Manuals
Supersedes:

APPROVALS: Rapid Response Team Committee 1/10/08
                  Patient Care Standards Committee 2/7/08
                  Policy and Procedure Committee 4/16/08
                  Medical Board 5/05/08

Tool D: Shands Jacksonville Medical Center's Rapid Response Team Training Tool Kit

Training Tools

Partners In CARE

4-CARE (4-2273)

Patient & Families

&

Rapid Response Team

Script for staff to communicate with patient and family during room orientation/admission

- I want to share information with you about a service "**Partners in Care & the Rapid Response Team**."

- The Rapid Response Team is a group of highly trained hospital staff that can be called if it appears that you or your loved one is getting sicker very quickly. The team works with your caregivers as an expert set of eyes and ears to address your concerns.

- Of course the RRT is not intended to replace the EXCELLENT staff on (this unit). But when you notice a serious medical change, you can call the team. In short, if you fear something is seriously wrong and you can't get help another way, call the team.

- To call the team, you just **dial 4-CARE (4-2273)** using the hospital phone system.   It is like calling 911 from home for an emergency.

- We also have the phone number posted on this sign. (Show sign above white board). And there is a sticker on your phone with the number.

- Shands Jacksonville prides itself in providing EXCELLENT CARE.

- We are "Partners in Care with you, your family, & the Rapid Response Team!"

- Do you have any questions?

"Partners in Care"
&

In an Emergency Call 4-CARE (4-2273)

Script for staff training

One year ago, Shands Pavilion launched a rapid response team (RRT) program to provide staff members with access to a specially trained, multidisciplinary team that responds immediately and helps evaluate and treat a deteriorating patient.

Meeting with the hospital's goal of providing patient-centered nursing care, the program is being expanded to patients and families beginning October 5, 2007 in Shands Pavilion. This program is being called **"Partners in Care Program & the Rapid Response Team"** *that has a designated phone number for patient/family activated RRT 4-CARE (4-2273) available by using hospital phones not cell phones*

For the purposes of this program, the definition of family published by the National Consensus Project for Quality Palliative Care is adopted: "Family is defined by the patient or in the case of minors or those without decision making capacity by their surrogates. In this context the family may be related or unrelated to the patient. They are individuals who provide support and with whom the patient has a significant relationship" (National Consensus Project for Quality Palliative Care, 2004).

Other hospitals that already have expanded their programs, or are in the process of doing so, can provide a glimpse of what will happen when families have access to the RRTs. One example is a hospital in Pittsburgh, Pennsylvania. Patients and families have had access to the RRT since May 2005. Approximately 2-3 calls are received from families each month. Program leaders at Shadyside report that families take the privilege very seriously, "They don't call for frivolous reasons. They see it as a sort of '911' for the hospital."

Family education will emphasize the importance of discussing concerns with bedside providers first. Families will be told about the RRT by nursing staff when admitted to the unit. In addition to the sign in their room, they will receive a fact sheet on how and why to call the RRT.

Please note: As staff, if you are in a patient's room and need to activate the Rapid Response Team use the RRT # 226-4582 pager number. Do not use the "4-CARE #"
Also, underline continue to use the 42222 to call a Code Blue.

Employees with questions about the RRT program can call Venerre Hall RN at 4-8801.

"Partners in Care"
&

In an Emergency Call 4-CARE (4-2273)

Fast Facts for Managers

Cynthia Gerdik, Director Surgical/Trauma Nursing, answered questions about how the rapid response team (RRT) program is doing:

Why was the program launched? Isn't an RRT just another "Code Team" with a different name?

Research shows that before patients experience full cardiac or respiratory arrest, there are typically warning signs present for several hours before the arrest. RRTs are designed to provide immediate help to patients who are deteriorating but have not yet crashed. Research shows that RRTs significantly reduce the number of cardiac arrests, respiratory arrests, and deaths in hospitals.

Who does our RRT consist of and what do they do?

The Clinical Center and Pavilion each have their own RRT consisting of a critical care nurse who is dedicated to the team and a Respiratory Therapist who responds to RRT calls. They have been an excellent tool for helping us see patterns when the staff need help with high risk patients and what issues need to be addressed. This RRT is proactive in assessing high risk patients and providing training to staff.

How long has the program been in place and what has happened so far?

The RRT program was launched in the Pavilion October 2006 and in the clinical center July 2007. Since then, the team has answered over 300 calls in the Pavilion. Most have been generated by the bedside nurses but also the by ARNPs and the nurse managers.

How are we defining family?

For the purposes of this program, the definition of family published by the National Consensus Project for Quality Palliative Care is adopted: "Family is defined by the patient or in the case of minors or those without decision making capacity by their surrogates. In this context the family may be related or unrelated to the patient. They are individuals who provide support and with whom the patient has a significant relationship" (National Consensus Project for Quality Palliative Care, 2004).

"Partners in Care"
&

In an Emergency Call 4-CARE (4-2273)

Partners In CARE
4-CARE (4-2273)

Patient and Families
&

Rapid Response Team

KNOW THE WARNING SIGNS OF AN EMERGENCY

Shortness of breath	Chest pain	Severe shakiness or seizure
Uncontrolled bleeding	Sudden changes in vision	Any sudden or severe pain
Sudden, excessive perspiration (sweating)	Sudden confusion or drastic change in behavior	Unable to wake up
When something just does not look or seem right *No one knows your loved one like you do!*		

Calling the 4-CARE hotline
is like calling 911 from home.

Tool E: University of North Carolina Children's Hospital Pediatric Rapid Response Team Signage

Tool F. Alegent Health's Care Partner Program Brochure

Notes or Questions For My Healthcare Team

_____

_____

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Alegent Health

1-800-ALEGENT
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by Catholic Health Initiatives and Immanuel Health Systems.

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**Alegent Health
Care Partner Program**
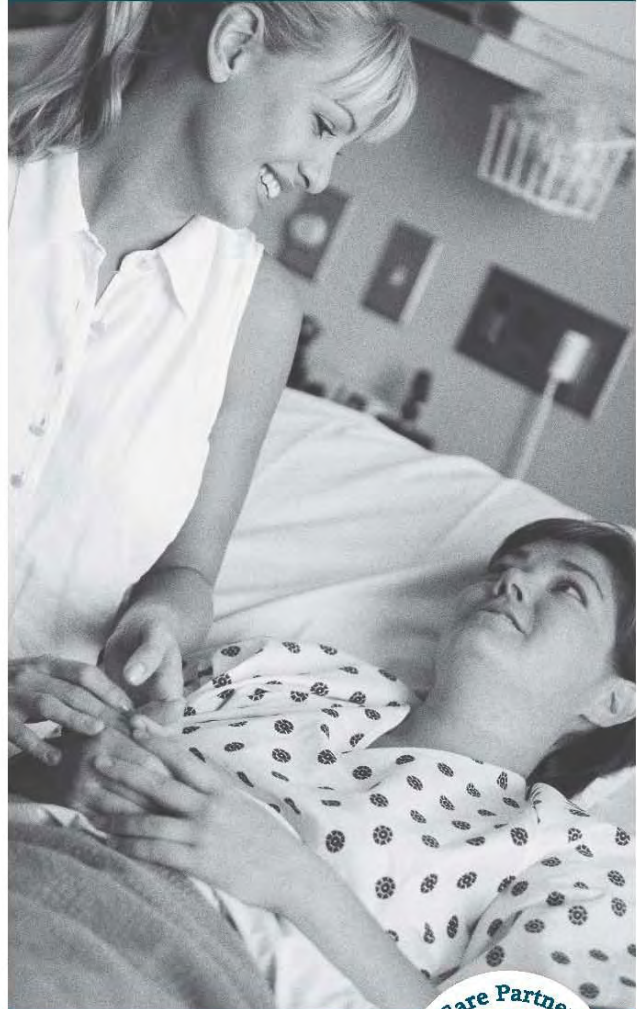
Alegent Health
This is your healthcare

Care Partner

Patient-Centered Care At Alegent Health

At Alegent Health we put you, the patient, at the center of our care by listening to your personal needs. The Care Partner program is designed to make your hospital stay as comfortable as it can be. After all, this is your healthcare.

What is a Care Partner Program?

A Care Partner Program encourages you – the patient – to select a family member or close friend to assist you while you are in the hospital. The Care Partner can assist the caregiving team by participating in any number of ways. Common examples include:

- Communication and Education
- Emotional and Spiritual Support
- Cultural and Religious Support
- Patient Safety
- Physical Care Support

The Care Partner program was designed with you and your family in mind. We heard from patients, just like you, who told us that they want to have their family and friends involved in their care while in the hospital. We know that being kept informed about your situation and possible treatment options is important to you and we recognize that you expect to have your needs known and respected.

On the opposite page of this form is a more specific checklist you and your designated Care Partner(s) can review and discuss. Use this list to determine where your Care Partner can be of most assistance to you. Once you have completed the form, discuss your decisions with your nurse and other primary caregivers. Your Care Partner will then be integrated into your care team.

** Should your condition require extended care at home beyond this hospital stay, our healthcare team can teach your care partner basic care, including bathing, feeding and toileting.

Ways Your Care Partner Can Assist You

Communication & Education Advocate
o Share progress with family and friends.
o Help keep a list of questions to ask the doctors and nurses and their responses.
o Participate in planning for care and discharge with other healthcare team members, including daily discharge rounds
o Learn about medications and treatments
o _____

Patient Emotional and Spiritual Support
o Help complete My Story.
o Coordinate visitors, including pets if appropriate
o Communicate spiritual needs with patient's own spiritual support or the Chaplains here
o Coordinate entertainment activities (e.g. reading out loud, choosing television programs, selecting music, and doing puzzles.)
o _____

Cultural and Religious Preferences Expert
o Share cultural needs or preferences with care team members
o Share spiritual or religious needs or preferences with care team members (for example, dietary restrictions, language needs and rituals)
o _____

Safety Advocate
o Report safety concerns to care team
o Help prevent patient falls
o Report changes in condition or other concerns
o _____

Physical Care Support
o Assist in personal care (e.g. nail or hair care)
o Provide comfort measures (e.g. hand or foot massage, filling water/ ice, moistening lips)
o Encouraging therapies as appropriate (for example, breathing exercises and exercises such as walking)
o Assist in menu selection, snacks.
o _____

Name of my care partner(s)
o _____
o _____

ENVIRONMENT OF CARE

> *"I woke up in ICU and it was so demoralizing…I look out and you don't see anything in that room to make you feel alive. You couldn't see any sky; the windows they did have were up against a brick wall."* (Patient Comment)

Patients often enter the doors of a hospital with heightened feelings of stress, anxiety and vulnerability. The environment that meets them has the potential to profoundly exacerbate, or conversely, to profoundly assuage these states of mind, either way often leaving an indelible impression that persists long after the patient has left the hospital. The environment of care is not limited to physical surroundings and aesthetics. It encompasses the totality of the atmosphere of the organization—the sights, sounds, and smells, certainly, but also the attitudes and accommodations made around patient privacy, dignity, comfort and peace of mind.

A patient-centered environment of care is one that is safe and clean, and that guards patient privacy. It also engages all the human senses with color, texture, artwork, music, aromatherapy, views of nature, and comfortable lighting, and considers the experience of the body, mind and spirit of all who use the facility. Space is provided for loved ones to congregate, as well as for peaceful contemplation, meditation or prayer, and patients, families and staff have access to a variety of arts and entertainment that serve as positive diversions. At the heart of the environment of care, however, are the human interactions that occur within the physical structure to calm, comfort and support those who inhabit it. Together the design, aesthetics, and these interactions can transform an institutional, impersonal and alien setting into one that is truly healing.

The Patient Perspective:

"I hate it when you come in and don't know where to go…The front desk is quite a ways from the door when you come in, and they aren't always paying attention to you. It would be so nice if they could help me get to where I want to go."

***

"When they take you in the wheelchair down to x-ray it is a very poor arrangement. It is a place that is like the catacombs…It is impersonal and you are just left there. You get your x-ray and then you sit there by yourself and you feel abandoned."

***

"My only problem with privacy is the way the hospital is laid out. I had to cross it on a gurney and I really felt like people were seeing me in a hospital gown on a gurney."

***

"We came to ER, triage checked me—I was in so much pain but I had to sit in the waiting room. My husband got so mad. There were a lot of people sitting there staring at me because I was in so much pain I was panting. It would have been nice to have a room where I could go and have some privacy."

"We couldn't have too much family up there because we were stuck in one of the smallest rooms they had. We had people in the hallway taking turns to come in. They didn't show us any other space we could go."

***

"I had to wait for my husband, and the chairs were so uncomfortable. It was 8 am, and the gift shop wasn't open, and I wasn't hungry. There were a few magazines. I finally went outside and laid down on a bench and fell asleep."

***

"The rooms are so noisy...You can't just close your door. You can hear everyone outside. The nurses are flying down the hall. It is hard to get a good night's sleep here. It is a big issue—patients are so fatigued. I would just fall asleep and I would hear the isolette coming down the hall. I brought my sound machine with me."

***

"One night the IV popped out of my arm all over everything and I am trying to hold it close. That was Friday night. I didn't realize it until I went home Sunday morning that I had the same stained pillow case. The same sheets for two and a half days."

The Staff Perspective:

"I used to work in a city hospital, and when I first came here, the piano was playing in the lobby, a maintenance man helped me find my way, you could feel the warmth. I immediately said 'I want to work here, this is what it's all about.'"

***

"The artwork, the pet therapy, room service...it's a wonderful experience here now."

The Leadership Perspective:

"How I want to spend my time as a leader is walking around and listening... I want to hear the sounds of laughter, I want to hear the sounds of conversations between staff and patients, I want to see physicians engaged in conversations with the nurse, with the environmental management person, the person pushing the broom down the corridor with the dietician coming up...We have gotten ourselves so carried away with all the rules and regulations that the patient has become secondary. And so I have invited employees into the tent. We let them go to our yoga, we let them go to massage therapy, we let them go to humor therapy, we let them have aromatherapy, we have sessions of spirituality for our employees who can go and talk...My time as a leader is going to be spent ...making the place a quality place you want to work at. A place of healing, not a place of abuse." (Kenneth Mizrach, VA New Jersey Healthcare System)

PATIENT-CENTERED APPROACHES TO THE ENVIRONMENT OF CARE:

First Impressions

The warm, welcoming environments of many patient-centered hospitals can often come as a surprise to those entering the doors for the first time. The domestic aesthetic feels far from the cold, bleak and sterile atmosphere that many expect to find in a hospital. Art work adorns the walls, natural light is abundant, and comfortable seating is arranged to meet the preferences of both those seeking privacy and those looking for social interaction.

The design of patient-centered hospitals anticipates and strives to alleviate the stressors that patients and visitors may encounter when they arrive. For hospitals where parking is limited, **valet parking** offers families the peace of mind of knowing that they will not have to start off

their visit hunting for an elusive parking spot. Visible and **clearly distinguished entryways**, **music piped in overhead** in the parking lot, and **golf carts to transport patients** to and from their cars can also reduce anxiety and create positive first impressions.

Recognizing that patients in wheelchairs and on gurneys have unique vantage points, routine evaluations are conducted in patient-centered hospitals to view the hospital from these points of view, with pieces of visual interest (decorative ceiling tiles, etc.) installed to enhance their view as they travel down hospital corridors. At Valley View Hospital in Glenwood Springs, Colorado, artwork of a nature scene on the ceiling above the CT scanner provides a welcome distraction for patients undergoing the often anxiety-filled experience of an imaging procedure.

Many patient-centered hospitals complement these design considerations with **greeters** whose friendly smiles contribute immensely to the healing environment. Stationed at entryways and busy or confusing intersections throughout the hospital, greeters can also assist with wayfinding, oftentimes personally escorting someone to where they need to go. At Valley View Hospital, **Patient Care Associates** are strategically posted throughout the hospital in high traffic areas such as the lobby and the emergency department. Easily recognized by their distinct uniforms, they are available to assist patients with any concerns they may have before the concerns become complaints. At Stamford Hospital in Stamford, Connecticut, the environment of the emergency department was transformed when the security guards' traditional uniforms were replaced with blue blazers, and their role was broadened out to encompass more of a customer service focus. Training and scripting were provided, and they now assist patients and visitors with finding their way, obtaining wheelchairs when necessary, and other tasks, while still maintaining a security presence. The facilitation of a snack and amenities cart in the Emergency Department allows for increased interaction to ensure an appropriate blend of security and customer service.

Wayfinding
Patient-centered hospitals use a variety of techniques to help patients and visitors navigate through the facility. The path that a patient takes to arrive at their destination, however, begins at home. Clear directions, given either over the phone or on the hospital's website, can assist patients and visitors in finding their way. In addition, the path taken from the parking areas should be clearly marked and identified, with safe pathways to the entrance of the facility. Within many patient-centered hospitals, traditional signage is complemented by distinct architectural elements or artwork that can serve as landmarks, e.g. "follow the corridor to the tree mural, then take a left." Recognizing that levels of literacy and English proficiency vary among patient and visitor populations, the language and tone of signage is considered thoughtfully, and signage often features easily identifiable icons to assist in comprehension. Wayfinding can also considerably be enhanced by greeters or ambassadors who are equipped with user-friendly maps to provide to visitors, or better yet, who personally escort visitors to their destinations.

Guarding Privacy
The patient comments at the beginning of this section underscore that consideration of patient privacy is a paramount concern. **Quiet rooms** or spaces set aside for private consultation allow patients and families to have sensitive conversations out of view and out of earshot of others. Many patients also report feeling exposed by the traditionally thin, open-back gowns provided to them. While the openness of these traditional patient gowns may be practical for providers, they

have long left patients themselves feeling on display. Today, alternative patient attire options such as **side-tying gowns** provide greater coverage for patients without compromising caregivers' abilities to do their jobs. The provision of blankets to patients when they are being transported down public corridors in wheelchairs or on gurneys further preserves their dignity.

Elimination of Physical and Symbolic Barriers

Architecture and design can also serve to cultivate partnerships between patients and the hospital staff. Consider the messages sent by the traditional centralized nursing station where half walls or glass partitions physically block staff from those they treat versus the symbolism of small and **open decentralized clusters of nurse work stations** or "team centers." The open, inclusive designs of these spaces encourage interaction between patients and families with those providing their care. Situated in close proximity to patient rooms, these decentralized stations minimize the amount of time nurses and other team members need to be walking down corridors, thereby maximizing their time at the bedside.

Noticeably absent in many patient-centered hospitals is the clutter so characteristic of today's space-deprived facilities. At Griffin Hospital in Derby, Connecticut, **clutter corridors** were incorporated into the design of the North Tower addition built in the early 1990s. These tucked away corridors allow staff easy access to equipment they may need while keeping it out of view (and out of the way) of patients and visitors. **Nurse servers** in every patient room at Northern Westchester Hospital can be accessed both from the corridor outside the room and from within the room. The units are stocked routinely with frequently used items by techs from the corridor outside each room, providing nurses with easy access to such items right from the room. Many hospitals are also now using **artwork on the walls or decorative cabinetry in patient rooms to conceal intimidating medical equipment** while keeping it readily accessible to clinicians.

Design that Encourages Family Participation

Of all the comforts of home that can be offered in health care settings, perhaps the most powerful is the presence of friends and family. Round-the-clock, patient-directed visitation is enhanced by a variety of spaces where visitors can comfortably congregate—both at the bedside of their loved one and throughout the hospital. Patient-centered hospitals accommodate visitors with **family lounges** furnished with comfortable seating and diversionary activities (magazines, puzzle books, television) and nourishments (coffee, tea, a microwave). **Overnight accommodations** enable loved ones to remain close through the night, and range from **pullout couches, cots or recliners** rolled into the room to **hotel-like rooms** set aside in the hospital.

Views and Access to Nature

Gardens, fountains, fish tanks, rooftop gardens, and water features can connect patients, families and staff with the relaxing, restorative aspects of nature. Furniture and equipment are oriented to take fullest advantage of these nature views. At Loma Linda University Medical Center's East Campus, patient rooms have access to their own private outdoor patio that can be utilized for visiting with family and friends as well as for rehabilitation therapy that may be required throughout their stay.

The Auditory Environment

In patient-centered hospitals, the sounds of overhead pages and incessant beeping are often replaced by **soothing music**, perhaps piped in overhead or provided courtesy of a **live musician** sharing his or her talents with passersby. A common practice among patient-centered hospitals is to develop protocols aimed at **eliminating overhead paging**. Instead, staff members carry beepers or phones, and pages are used only as a last resort or in emergent situations.

A common patient complaint is the noise associated with cleaning, which often takes place during hours when patients are trying to rest. Patient-centered hospitals strive to balance the practical considerations of vacuuming and performing other routine maintenance tasks during less busy times with patients' need for quiet at night. **Quiet campaigns** can elevate staff's awareness of noise levels. Tools such as the stoplight-style "Yacker Tracker" are also available to monitor decibel levels and alert staff when they exceed an acceptable level. The provision of **white noise machines** and **headsets for watching television or listening to music** allows patients some control over their auditory environment. Other options include providing patients with items such as **earplugs**, **sleep masks**, or **soothing aromatherapy** that may aid their sleep. **Carpeted corridors** can also help to reduce the ambient noise of cart traffic in hallways adjacent to patient rooms.

Piping in a familiar **lullaby** through the facility's overhead sound system is a way of announcing and celebrating the arrival of a new life. This simple program can have a profound effect on patients, visitors and staff alike.

The Olfactory Environment

Unlike typical unpleasant hospital smells, in patient-centered hospitals, the smells of **freshly baked cookies** or muffins may evoke comforting thoughts of home. **Aromatherapy** offered via atomizers can further enhance the healing environment while having a calming effect on patients, visitors and staff. Many patient-centered hospitals also opt to replace noxious cleaning products with others with less-offending odors.

Gathering Spaces

The design of a patient-centered facility provides patients and families with spaces for both solitude and social activities, and includes **libraries**, **kitchens**, **lounges**, **activity rooms**, **chapels**, and **gardens**. It is also important to include spaces for the staff to gather, in addition to their locker room or break area. This may be in the form of a **restoration room** or **outdoor garden** where staff can decompress when necessary.

Therapeutic Enhancements

Part of creating a healing environment is providing nourishment for the body, mind and soul. Positive distractions such as roving musicians, clowns, humor carts, book carts, and visits from therapy dogs can help to lift patients' spirits, calm their nerves, and may serve as welcome diversions for patients and families alike. *The pet therapy policy in place at Fauquier Hospital in Warrenton, Virginia is included on pages 176-178 as a resource.*

Staff Support and Work Areas

It is just as essential to create healing environments for staff as it is for patients. Physicians, nurses and ancillary staff are very much affected by their working environment. It is very hard to help patients heal and recover in inhospitable, cold and impersonal spaces. The provision of lounges and sacred space for staff is an important component in the creation of a healing environment, and soliciting employee input into the design of the staff areas—including the artwork that will adorn the walls—can be a meaningful and effective way of engaging staff in the creation of a healing environment of care.

IMPLEMENTATION TOOLS:

A. Fauquier Hospital's Pet Therapy Policy, *pg. 176*

Tool A: Fauquier Hospital's Pet Therapy Policy

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THE FAUQUIER HOSPITAL, INC.
ADMINISTRATION

POLICY NUMBER 831-519

PET THERAPY

</div>

DEFINITION AND PURPOSE:

To provide guidelines and specific standards for pet visitation or therapy in the hospital settings as related to the pet and the volunteer responsibility.

POLICY:

All pets will meet specific grooming and health criteria prior to hospital visitation.

All pets must be on a leash the entire time they are visiting and must be under control of the pet's owner/handler.

No pets will be permitted in Maternity, OR, Radiology, Central Supply, Storeroom, Laboratory, Dining areas, Respiratory and Vascular Rehabilitation areas, Emergency Department.

Employee's pets are not permitted in the hospital or other off campus facilities unless participating in Pet Therapy.

The animal's comfort needs will be attended to prior to visitation.

Certified Pet Visitation may include canine species only.

PET THERAPY ANIMALS:
Criteria for companion animals:

REQUIREMENTS:

The following steps must be completed to become a therapy animal prior to being permitted in the hospital.

1.   Must be a certified companion animal
2.   Must like people, accept strangers, enjoy children
3.   Must adhere to the grooming requirements prior to each Pet Therapy Session
4.   Must behave around other animals
5.   Must be friendly and outgoing
6.   Likes to be hugged

7.   Must be healthy and free of disease and pass a Vet Screening
8.   Must be stable, mature, housebroken
9.   Must be under control at all times
10.   Must pass a formal basic obedience and temperament evaluation test administered by certified animal evaluators before being admitted to the Pet Therapy Program.

STANDARDS:

All animals must complete the following steps to be allowed into the hospital.

1. Steps to becoming a therapy animal.
    a. Completion of an obedience training course
    b. Completion of a veterinary screening that includes proof of vaccinations. Veterinary checks must be performed annually and include dates of vaccinations
    c. Provide proof of current rabies vaccination
    d. Pass a temperament evaluation/test conducted by certified evaluators from Fauquier Hospital.
    e. Complete a series of training sessions, at least three without incident, in Fauquier Hospital.

2. Animals must be accompanied by their owners/handlers, who are trained pet therapy volunteers at Fauquier Hospital.

3. Animals must be bathed within 24 hours of the visit to the hospital. Animals must be neatly groomed and free of all parasites. Visual inspection by the handler will be performed with attention to cleanliness of the animal prior to entrance to hospital.

4. Animal must wear ID badge specified by the hospital and be on a 4 foot lead while visiting in the hospital.

5. Visitation sessions will be conducted in specified area only, as previously identified in Policy.

6. A member of the Pet Therapy Team will be present with the patient at all times during the sessions.

7. Those patients not appropriate for visitation include:
        Patients will allergies to dogs
        Patients with fear of dogs
        Agitated or violent patients
        Patients with illnesses which may be transmitted to animals
        Patients with open wounds
        Patients with a tracheotomy may be seen only if covered with oxygen or capped

8. All animals must relieve themselves prior to visiting in the hospital.

9.   If the animal demonstrates any aggressive action towards patient, visitor, or any person within the hospital, the animal will no longer be used for visitation.

10. Incidents must be immediately reported to the Pet Therapy Facilitator and an occurrence report completed.

11. A copy of all records for the animals will be kept in the appropriate department.

12. All certified Pet Therapy animals are covered by the insurance policy of Fauquier Hospital.

SPIRITUALITY

> *"Here I find that they treat you mind, body and soul. I thought I was going to lose my leg and needed to see someone. That was a very important part of my treatment plan."* (Patient Comment)

Spirituality is our own internal ability to find meaning and connectedness in life, and is not limited to religious traditions. Patients and families interacting with hospitals and health care institutions are often in the midst of challenging times or significant life events. Feelings of vulnerability, anxiety and fear abound. Patient-centered hospitals recognize the wide range of patient and family needs, and are implementing unique programs geared toward supporting the mind, body and spirit.

The Patient Perspective:

"There should be a program in which they ask you if you want a minister. There should be a minister on call or on staff. I think they have one during the day, but they should also have one at night. People should know that there's someone there who they can talk to."

***

"On the last day, someone asked me if I'd like communion. I'd have liked to have it every single day, and I think they should ask you on your first day what your spiritual needs are."

***

"Someone came to see me— I think it was the chaplain—what a nice break that was. She was sympathetic and understanding."

***

"I spent many hours in that space where I could think when my mom was in the hospital."

PATIENT-CENTERED APPROACHES TO SPIRITUALITY:

Blessing of the Hands
This brief ceremony, conducted in many patient-centered hospitals, acknowledges the sacred work of the health care team. The ceremony can be done annually or more often if desired. For many hospitals, the Blessing of the Hands ceremony is a meaningful additional to traditional Hospital Week celebrations. One hospital team has adopted a morning blessing as part of shift report. This allows each team member to refocus their own mind, body and spirit toward the intention of healing and providing the best for patients each day.

Spiritual Assessments
Many patient-centered hospitals have expanded their initial patient assessment to include a spiritual component. This includes a short series of questions related not only to one's religious practices and traditions, but also to exploring the patient's relaxation practices and/or other

sources of inspiration. This allows the health care team to proactively address spiritual needs in the broadest sense and to customize the plan of care to the patient's preferences and past practices. *See pages 182-183 for the spiritual assessment used by Northern Westchester Hospital.*

View from the Bridge
As a way of emphasizing the hospital's commitment to caring for mind, body and spirit, the chaplain at Sharp Coronado Hospital outside of San Diego, California began writing a short newsletter entitled "*A View From the Bridge*." This newsletter is reflective, inspirational and motivational for the patients, families, community members and staff of the hospital. *A sample newsletter is included as a resource on page 184.*

Prayer Shawls
At Valley View Hospital in Glenwood Springs, Colorado, volunteers create shawls for newly diagnosed cancer patients. These shawls, created with loving intentions for the receiver, are distributed to patients in an effort to provide comfort during a time of extreme stress.

White Rose Program
This program is a way of honoring the death of a patient. After a death, a white silk rose is placed on the patient's pillow, privacy curtain, or door out of respect for the patient and as a means of communicating to other caregivers that a death has occurred. The rose is then given to the family as a keepsake.

Memory Bears
At Sharp Hospice Care, a group of volunteers hand-stitch Memory Bears. Family members who have lost a loved one are encouraged to send in clothing and accessories for use in creating the treasured keepsakes. Using the clothing, hats, scarves and other such items to make a bear in honor of their lost loved one has provided endless comfort during a time of extreme grief and loss.

Quilts for Hospice Patients
At many hospitals, community volunteers donate quilts for Hospice patients. The quilts brighten the hospital room and bring comfort to family and patients dealing with the stresses of end of life care.

Ecumenical Services for Cognitively Impaired Patients
With the sensory stimulation of music, feathers, cotton balls, flowers and essential oils, cognitively impaired patients have demonstrated a renewed spiritual energy that has enhanced their quality of life.

Prayer Hotline
Setting up a Prayer Hotline is as easy as designating a dedicated phone number that patients, family members and staff may call with their personal prayer requests. The requests are then regularly forwarded on to a hospital chaplain and/or a corps of volunteers who ensure each prayer request is granted.

Volunteer and Formal Non-Denominational Pastoral Care Services
The structure of pastoral care services at patient-centered hospitals varies depending on the size and budget of the institution. For sites with limited financial resources, an all volunteer program is a viable option, and can be developed through community networking.

Sacred Spaces
Sacred spaces in patient-centered hospitals may include traditional non-denominational chapels, but they are not limited to such defined areas. Sacred spaces are areas within the building and on the campus that foster peace and serenity. They include meditation rooms, reflection rooms, sanctuaries and other such spaces that are welcoming to visitors of any faith tradition, and can be a setting for quiet contemplation or communal worship. Healing gardens with benches for sitting or walking paths provide access to the restorative effects of nature. Outdoor **labyrinths** may be used for meditation purposes, and for hospitals for which outdoor labyrinths are not a viable option, handheld labyrinths are also available.

IMPLEMENTATION TOOLS:

A. Northern Westchester Hospital's Spiritual Assessment,
    pg. 182

B. Sharp Coronado Hospital's Sample "View from the
    Bridge" Newsletter, *pg. 184*

A. Northern Westchester Hospital's Spiritual Assessment

Northern Westchester Hospital **Patient Care Services**

Subject: Spiritual Assessment

Page 1 of 2

Effective Date: 11/21/07   Issued By: Patient Care Services
Reviewed: Distribution: Patient Care Services P&P
Revised: Manual
Supersedes: N/A

POLICY: To outline the process by which health care providers can identify a patient's
                   spiritual needs pertaining to their medical care.

PURPOSE: Evidence in the medical literature strongly suggests a relationship between
                   spirituality and medicine in that spiritual health is important to physical health and
                   well-being. A complete assessment of the whole person should include a spiritual
                   assessment as part of the overall medical assessment.

                   A spiritual assessment involves asking specific questions, listening carefully and
                   observing nonverbal cues. The HOPE mnemonic is a tool that should be used
                   during the assessment interview to determine whether spiritual factors may play
                   a role in the patient's illness and recovery. This tool, HOPE, aids in organizing
                   questions covering the topics of **H**ope, **O**rganized religion, **P**ersonal spirituality
                   and practices, and **E**ffects on medical care and end-of-life issues.

                   The patient's spiritual beliefs and needs should be addressed in the patient's
                   treatment plan.

PROCEDURE:

                   As part of the multidisciplinary admission assessment completed on all patients
                   admitted to Northern Westchester Hospital the following HOPE questions should
                   be considered when conducting the spirituality part of the admission assessment.

                   **H - HOPE Sources of hope, meaning, comfort, strength, peace, love and
                   connection**
                         What are your sources of hope, strength, comfort and peace?
                         What do you hold on to during difficult times?
                         What is there in your life that gives you internal support?
                         What sustains you and keeps you going?
                         For some people their religious and spiritual beliefs act as a source of
                         comfort and strength, is this true for you?

                   O - ORGANIZED RELIGION
                         Do you consider yourself as part of an organized religion?
                         How important is religion, or your religion, to you?
                         What aspects of your religion are helpful? Not helpful?
                         Are you part of a religious community? Does it help you?

P - PERSONAL SPIRITUALITY AND PRACTICES

Do you have spiritual beliefs that are independent of organized religion? What are they?

Do you believe in God? What kind of relationship do you have with God?

What aspects of your religion or spiritual practices do you find most helpful or comforting? (eg prayer, meditation, music, hiking, communicating with nature, church etc)

E – EFFECTS ON MEDICAL CARE AND END-OF-LIFE ISSUES

Is there anything we can do to help you access things which help you spiritually?

Are there any concerns about your religious or spiritual beliefs and your medical care or your stay here at Northern Westchester Hospital?

Would it help to speak with, or do you wish to speak with, the hospital chaplain or another spiritual leader?

Are there any specific practices or restrictions that we should know about in providing your medical care? (eg dietary, blood products)

The nurse will use the HOPE mnemonic to identify the patient's religious/ spirituality needs and document any specific and relevant religious/spiritual information received on the Admission Assessment Intervention. The nurse does not need to document responses to all questions only those answered and appropriate to the patient's care needs.

Initiate and document referrals as appropriate (eg Chaplain, Dietary) .

ATTACHMENTS:
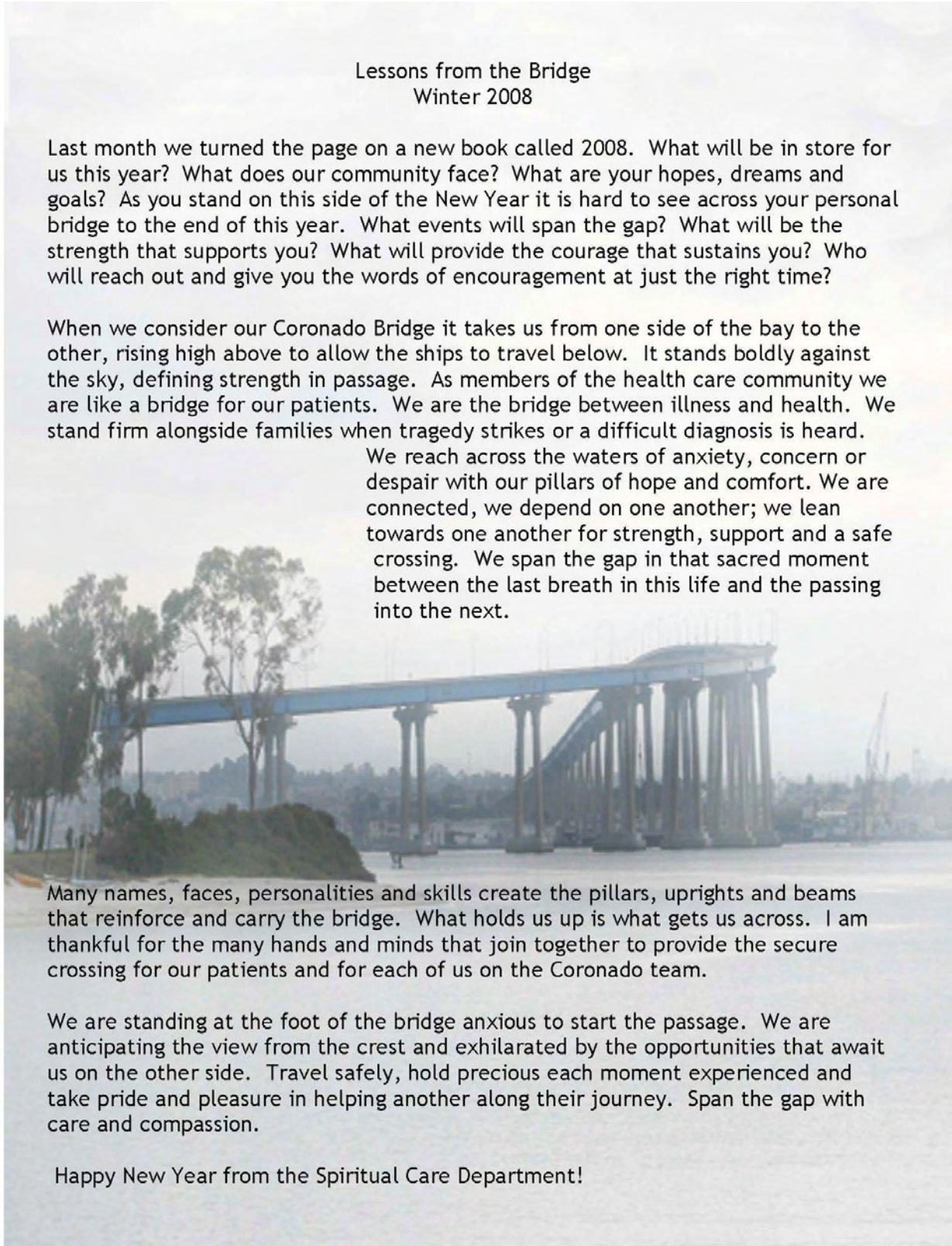
REFERENCES:
Evaluating your Spiritual Assessment Process. Joint Commission: The Source, February 2005, Volume 3, Issue 2. The Joint Commission on Accreditation of Healthcare Organizations.

Anadarajah, G., Hight, E: Spirituality and Medical Practice: Using the HOPE questions as a practical tool for spiritual assessment. American Family Physician 63(1): 81-88, 2001.

APPROVALS:

Patient Care Standards Committee 11/1/07
Policy and Procedure Committee 11/21/07

Tool B.   Sharp Coronado Hospital's Sample "View from the Bridge" newsletter

Lessons from the Bridge
Winter 2008

Last month we turned the page on a new book called 2008. What will be in store for us this year? What does our community face? What are your hopes, dreams and goals? As you stand on this side of the New Year it is hard to see across your personal bridge to the end of this year. What events will span the gap? What will be the strength that supports you? What will provide the courage that sustains you? Who will reach out and give you the words of encouragement at just the right time?

When we consider our Coronado Bridge it takes us from one side of the bay to the other, rising high above to allow the ships to travel below. It stands boldly against the sky, defining strength in passage. As members of the health care community we are like a bridge for our patients. We are the bridge between illness and health. We stand firm alongside families when tragedy strikes or a difficult diagnosis is heard. We reach across the waters of anxiety, concern or despair with our pillars of hope and comfort. We are connected, we depend on one another; we lean towards one another for strength, support and a safe crossing. We span the gap in that sacred moment between the last breath in this life and the passing into the next.

Many names, faces, personalities and skills create the pillars, uprights and beams that reinforce and carry the bridge. What holds us up is what gets us across. I am thankful for the many hands and minds that join together to provide the secure crossing for our patients and for each of us on the Coronado team.

We are standing at the foot of the bridge anxious to start the passage. We are anticipating the view from the crest and exhilarated by the opportunities that await us on the other side. Travel safely, hold precious each moment experienced and take pride and pleasure in helping another along their journey. Span the gap with care and compassion.

Happy New Year from the Spiritual Care Department!

INTEGRATIVE MEDICINE

> *"You know some of these [complementary modalities]*
> *when people have concerns, they might be more*
> *confident if it were done in a place like this. I would*
> *try acupuncture if they offered it here because I would*
> *trust them to do it right."* (patient comment)

A fundamental aim of patient-centered care is empowering patients with the knowledge, support and resources they need to make informed decisions and to manage their health and wellness. One way that patients are increasingly meeting their own health care needs is through the use of complementary and alternative medicine (CAM). Creating programs that support patients' interest in and use of CAM modalities enhances patient choice and allows mind, body and spirit healing to be maximized. Top performing patient-centered hospitals are integrating CAM programs in both inpatient and outpatient settings.

The Patient Perspective:

"I have used complementary therapies before, like acupuncture and massage therapy. I think they should offer these to patients in the hospital."

***

"I use some things now. It's just meditation. I don't talk [about it] with my doctor, because it really has no medical implications."

***

"I take natural things instead of prescriptions and I don't think that was appreciated or supported by the doctors."

***

"M.D.s look at you like you are nuts when you use alternative things."

***

"I use integrated medicine and I see doctors. I was taking a homeopathy cure because it can't hurt. I didn't tell anyone. It didn't come up."

The Staff Perspective:

"The idea of [patient-centered care] is very active in pediatrics, including integrative services. We have some on staff who pooh pooh it, but as they have seen patients react positively they have softened."

***

"The more relaxed and accepting approach of the staff now to using complementary therapies has improved patient care."

The Leadership Perspective:

"I remember asking [this group of staff], 'What is it about this place that makes you want to come in, day after day, and do what you do?' And one of the staff members said, 'We have created an atmosphere of love in this organization'...And they started to talk about the

healing touch that goes on in the organization. It's become just a part of the way they care for one another." (Susan Frampton, Planetree)

PATIENT-CENTERED APPROACHES FOR INTEGRATING COMPLEMENTARY APPROACHES TO CARE:

Expanding the options of what is available to patients to include some of the complementary modalities described below can be an effective way to respond to growing interest in such approaches while ensuring the safe and effective integration of clinical and complementary modalities in a patient's plan of care. In addition to providing access to complementary modalities, patient-centered hospitals are health care environments where information on such CAM treatments is readily available, systems for referrals to CAM practitioners are in place, and where conversations about CAM modalities are ones that patients can enter into without fear of being disparaged.

Aromatherapy
Essential oils from flowers, leaves, bark, branches, rind or roots of plants are mixed with a carrier oil (often almond oil) and gently rubbed on the skin, or the oils are placed on a cotton ball for the patient to smell. The oils are not consumed, but are absorbed through the nose or through the skin into the bloodstream, where they can affect the whole body and promote healing. Nurses, pharmacists or other licensed health care providers may be trained in the use of essential oils for clinical aromatherapy. *Sharp Coronado Hospital's clinical aromatherapy guidelines are included on pages 188-191 as a resource.*

Massage Therapy
Massage therapy improves functioning of the circulatory, lymphatic, muscular, skeletal, and nervous systems and may improve the rate at which the body recovers from injury and illness. Massage involves holding, causing movement of soft tissue, and/or applying pressure to the body. Swedish and gentle stroke massage has been demonstrated to effectively reduce pain and anxiety. Certified massage therapists may be formally hired or brought in to the hospital through a contracted service arrangement. Trained volunteers may also be used to implement such a program, and students of local massage therapy schools may be a particularly viable group to engage on a volunteer basis. In addition, nursing and other personnel may be trained in the use of bedtime massage and/or back rubs.

Healing Touch and Reiki
Two forms of complementary and alternative medicine based on the belief that a vital energy flows through the human body are healing touch and Reiki. This energy is said to be balanced or made stronger by practitioners who pass their hands over a patient's body. Healing touch and Reiki may be used as an intervention for the relief of pain, anxiety and stress. Formal training programs are available in both modalities.

Guided Imagery
Guided imagery is a technique in which patients use their imagination to visualize improved health, or to "attack" a disease. Some studies indicate that positive thinking can have an effect on disease outcome. Audio tapes or CDs can be made available for purchase, or can be provided to patients for use with personal listening devices.

Music-Thanatology

Music-thanatology is a field whose practitioners provide musical comfort, using harp and voice at the bedside of patients near the end of life. The service at the bedside is called a music vigil and is delivered by one or two highly trained music-thanatologists. Its purpose is to lovingly serve the needs of the dying and their loved ones with prescriptive music. Mid-Columbia Medical Center in Oregon has a renowned music-thanatology program.

Integrative Therapy Cart

A mobile cart containing CDs for guided imagery, essential oils for aromatherapy, music for relaxation, massage oils and other such support materials can be an easy way for sites to facilitate and encourage staff use of such modalities.

Holistic Nursing Council

Hospital-wide councils allow nurses who share an interest in CAM therapies to support one another and the hospital. Northern Westchester Hospital in New York has succeeded in developing such a core group of motivated professionals.

IMPLEMENTATION TOOLS:

A. Sharp Coronado Hospital's Clinical Aromatherapy
   Guidelines, *pg. 188*

A. *Sharp Coronado Hospital's Clinical Aromatherapy*
   Guidelines

	SECTION #:		DOCUMENT #:
	ORIGINAL ISSUE DATE	CURRENT EFFECT DATE	**Department Guideline**
	06/03	06/03	

AFFECTED DEPARTMENT:	ENTITY(S):
Hospice Department Emergency Department	Sharp Coronado Hospital

TITLE:
Aromatherapy: Guidelines for Use

I.   **PURPOSE:**

To recommend the following course of action relative to the use of essential oils in patient care.

II.   **DEFINITIONS:**

III.   **TEXT:**

A.   All essential oils should be stored as follows:

   Locked up in med room;
   Out of the reach of children;
   In a cool place;
   In a tightly closed container;
   Away from food, drink;
   Away from heat;
   Away from flames.

B.   All bottles containing essential oils should be clearly marked with:

   Labels that are indelible and stay on;
   The full botanical name;
   Relevant safety phrases;
   The quantity of oil;
   The company name and address.

C.   All essential oils should be packaged:

   In colored glass bottles;
   With an integral dropper of 20 drops per ml;

D.   Essential oils shall only be used in the hospice unit & emergency room by an LVN or RN who have successfully completed the Clinical Aromatherapy Course including post-test.

E.   Whenever possible, essential oils should be used in enclosed areas to prevent the aromas from spreading (i.e. close the patients room door).

F.   All essential oils used in nursing should be documented within the Interdisciplinary Plan of Care.

G.   The positive and negative effects of the essential oils should be evaluated and noted in the Interdisciplinary Plan of Care.

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	SECTION #:	DOCUMENT #:
	ORIGINAL ISSUE DATE 06/03	CURRENT EFFECT DATE 06/03	**Department Guideline**
	AFFECTED DEPARTMENT: Hospice Department Emergency Department	ENTITY(S): Sharp Coronado Hospital
	TITLE: Aromatherapy: Guidelines for Use	

H. Only a 1 to 3 percent dilution should be used, except in specific situations as recommended by safety guidelines. NEVER USE UNDILUTED ESSENTIAL OIL ON THE SKIN

I. The following low risk essential oils may be used in the Hospice Unit and the Emergency Room:

Cananga odorata	Ylang Ylang
Citrus bergamia	Bergamot
Cymbopogon citrates	Lemongrass
Elettoria cardamomun	Cardamom
Lavendula angustifolia	True lavender
Melaleuca alternifolia	Tea Tree
Mentha piperita	Peppermint
Origanum majorana	Sweet marjoram
Zingiber officinale	Ginger

IV.   PROCEDURE: **RESPONSIBILITY:**

A. Obtain a written or verbal MD order for use of aromatherapy (i.e. Aromatherapy prn per Department Guidelines)   RN/LVN/Rx

C. Review the monograph on the individual oils selected prior to use on patient for any patient specific precautions or contraindications.   RN/LVN/Rx

D. Check for allergies to plants, fragrances, or oils.   RN/LVN/Rx

E. Allow the patient to smell the oil prior to application.   RN/LVN/Rx

F. Conduct a patch test in sensitive or immunocompromised patients.   RN/LVN/Rx

G. Select an application method: RN/LVN/Rx
    Air Mister Method
    Bath Method
    Cotton Ball Method
    Diffuser Method
    Emmolient/Lotion Method

H. Follow specific application method as described below: RN/LVN/Rx

"Air Mister Method":

1. Use only pure essential oil(s) mixed with water in a 1-3% dilution.
    1% =1 drop Essential oil in 5 ml. water
    2% = 2 drops Essential oil in 5 ml. water
    3% = 3 drops Essential oil in 5 ml. water
2. Spray high in the air, not directly over the patient.
3. Spray 3-6 times for odor control or to scent the room.
4. Spraying may be repeated every 5 minutes up to three times.

SHARP®			PAGE 3 OF 4
	SECTION #:		DOCUMENT #:
	ORIGINAL ISSUE DATE	CURRENT EFFECT DATE	**Department Guideline**
	06/03	06/03	
	AFFECTED DEPARTMENT: Hospice Department Emergency Department		ENTITY(S): Sharp Coronado Hospital
	TITLE: Aromatherapy: Guidelines for Use		

"Bath Method":

1. Essential oils may be used in bath water, compresses, foot bath or sitz bath in a 1% to 3% solution.
2. Place essential oil in carrier oil or milk in one of the following amounts:
   1% =1 drop Essential oil in 5 ml. Carrier Oil or milk
   2% = 2 drops Essential oil in 5 ml. Carrier Oil or milk
   3% = 3 drops Essential oil in 5 ml. Carrier Oil or milk
3. Conduct a patch test for sensitivity. Apply small amount of the mixed oil preparation to patient's forearm, wait 15 minutes and note any reaction. If any reaction (redness, itching, burning) is noted, wash oil preparation to patient's forearm, wait 15 minutes and note any reaction. If any reaction (redness, itching, burning) is noted, wash area with soap and water, remove essential oil from patient's room and document reaction. If no reaction, proceed with bath or compress.

"Cotton Ball Method":

1. Place 2-4 drops of an appropriate essential oil on a cotton ball and place it in a plastic medication cup.
2. Place the medication cup containing the scented cotton ball at the patient's bedside. It may be held by the patient, if desired, or placed inside their pillow case.
3. The cotton ball can be used up to 24 hours.
4. If the patient finds the scent disagreeable, remove from room and discard.

"Diffuser Method":

1. Diffusers are not recommended in direct patient-care areas.
2. Diffusers used in departments (e.g., waiting areas, offices) are the responsibility of the unit Director.
3. Diffusers must be inspected by Engineering prior to installation.
4. Diffusers must be turned off when not in use, or when no one is in the department or area.

"Emmolient/Lotion Method":

1. Essential oils may be added to carrier oil or lotion to be used on a patient's hands, feet, back or other areas of the body. Preparations should be clearly labeled with name of oil, dilution and date. Avoid getting oil/lotion in eyes, face and mucous membranes.
2. Place essential oil in lotion in one of the following amounts:
   1% =1 drop Essential oil in 5 ml. lotion
   2% = 2 drops Essential oil in 5 ml. lotion
   3% = 3 drops Essential oil in 5 ml. lotion
3. LVN's or RN's who have successfully completed the Clinical Aromatherapy Course including post-test may apply oil or lotion to patient after conducting a patch test for sensitivity. Apply small amount of lotion to patient's forearm, wait 15 minutes and note

			PAGE 4 OF 4
	SECTION #:		DOCUMENT #:
	ORIGINAL ISSUE DATE	CURRENT EFFECT DATE	**Department Guideline**
	06/03	06/03	
	AFFECTED DEPARTMENT:		ENTITY(S):
	Hospice Department Emergency Department		Sharp Coronado Hospital
	TITLE:		
	Aromatherapy: Guidelines for Use		

any reaction. If any reaction (redness, itching, burning) is noted, wash area with soap and water, remove essential oil from patient's room and document reaction. If no reaction, proceed with topical application of lotion.

    I.   Document use of essential oil and patient response on the   RN/LVN/Rx
        Interdisciplinary Plan of Care. Include:
            Which essential oil(s) were used.
            Dilution properties and any carrier solution used.
            Indication for use of essential oil(s).

    J.   Reassess patient within 30 minutes of treatment and document   RN/LVN/Rx
        patient's response on the Interdisciplinary Plan of Care.

V.   **REFERENCES:**
Buckle, J. (1997). Clinical Aromatherapy in Nursing.

VI.   **CROSS REFERENCES:** N/A

VII.   **ATTACHMENTS:** N/A

VIII.   **APPROVALS:**

    A.   General Medicine Supervisory Committee 5/1/03
    B.   Medical Executive Committee 5/19/03
    C.   Sharp Coronado Hospital Villa Coronado Medical Director – 5/13/03
    D.   Sharp Coronado Hospital Emergency Medical Director – 5/19/03

IX.   **REPLACES:** N/A

X.   **REVISIONS:** N/A

CARING FOR THE COMMUNITY

*"There is something to be said for having a
hospital that is community conscious."*
(patient comment)

Many hospitals have adopted a broader charge beyond caring for the sick and injured, focusing concurrently on promoting wellness, prevention and safety—not only for patients, but also for staff and the community-at-large. Patient-centered hospitals are increasingly providing their communities with access to prevention programs such as educational health seminars, safe driving classes, health fairs, opportunities to meet with professionals who can assist with advance directives, planning for your healthy future, and more. These community offerings all contribute to a patient-centered approach by reaching out beyond the walls of the hospital to meet the health care needs of the entire community. Included in this section are some innovative approaches in reaching out to, educating, and caring for the community.

Block Buddies Program
The Block Buddies Program at Sentara Williamsburg Regional Medical Center is a program that was created to provide information and improve access to health services for residents in low to middle income neighborhoods. At the core of the model are individual champions recruited from within each neighborhood to rise to the challenge of assisting the community health department as the neighborhood's health resource contact. As a specially trained Block Buddy volunteer, each of these individuals communicates with their neighbors about general safety precautions, first aid, immunization, disease prevention, medication safety, and other issues important to their communities.

Patient Navigators
In many hospitals, the role of patient navigators is to help patients find their way through the health care system by providing assistance in making appointments, receiving financial assistance and accessing interpretation services. Their role can be expanded, though, to also help meet the needs of underserved populations by serving as a liaison to patients who are uninsured and require assistance with access to care.

Parish Nurses
Griffin Hospital's Parish Nurses serve as coordinators between the clergy, parishes and other resources in the community, such as hospitals and other social service agencies. Parish Nurses are health educators, and as such, organize health screenings, discussion groups, classes and other events to help congregations recognize the interrelationship of mind, body and spirit. Parish Nurses may also serve as health counselors, making themselves available for personal consultations for parishioners in the home, hospital or other facilities. It is important to note that this program can be applied to any spiritual denomination.

Mini Med School
Griffin Hospital's Mini Med School is a ten-week course about the human body and common disorders specifically designed for the layperson with little or no medical background. Offered to the community free of charge, the program provides a unique opportunity for participants to gain a greater understanding of anatomy, insights into common disorders of the various organ systems, as well as information about disease prevention. Each weekly session is divided into two 50-minute sessions provided by volunteer physician lecturers, with time for questions and answers at the end of each session. The program is designed to be comprehensive and the knowledge base cumulative so that those who attend all sessions will gain the most benefit. Topics covered include: Anatomy and Physiology; The Role of Primary Care; Cardiology; Endocrinology; Orthopedics; Pulmonary Disease; Gastroenterology; Nephrology; Neurology; Oncology and Hematology; Otolaryngology; Ophthalmology; Gynecology; Urology; Rheumatology; Dermatology; and General Surgery. The Mini Med School "semester" concludes with a graduation ceremony, recognizing participants who have successfully completed the curriculum.

The President's Junior Leadership Council (PJLC)
This unique program at Northern Westchester Hospital (NWH) empowers teens to become an active "voice" for important health issues affecting young people in their community. Made up of 27 high school students (grades 9-12), PJLC members work together to improve the health, safety, and well-being of adolescents and young adults in their region. As a "hands on" working group, the Council meets twice a month for presentations and work sessions. The Council's mission, as developed by the students, is to act as liaisons and serve as a "voice" between community youth and hospital administration and staff, as well as to support, advise, and assist NWH administration and staff in their efforts to promote health and wellness. The Council identifies and prioritizes key health issues affecting young people, and develops and implements programs to address these issues. The PJLC participates in school health fairs and community events and for the 2007/2008 academic year, identified teen and adolescent stress as a key health factor impacting themselves and their peers. The students researched the topic for national trends and information and developed a comprehensive health display as a means of educating the community.

Teddy Bear Clinic
Open to the public, these clinics are designed to alleviate children's natural fears about going to the doctor or the hospital, as well as to convey important health and safety information. Children are invited to bring their favorite teddy bear or doll for a "check up" by hospital staff. The toys are registered and given ID bands, and each child is provided with a medical record in which they can place stickers distributed at each of a series of stations. At the examination station, the toy is weighed and measured, and its temperature and blood pressure is taken. The medication station provides education about medication and the importance of children never taking anything without checking with their parents. At another station, suturing is done for the toy, with assistance from the child. At the splint and cast station, the toy gets a cast put on and the child is given instructions regarding cast care. As the children visit each station and equipment is demonstrated to them, they are encouraged to ask questions. Once they have visited each station and the medical record has been populated with all of the stickers, the child is eligible to enter a drawing for a teddy bear. By creating an opportunity for families to visit the hospital and

interact with professional caregivers when they are well, such programs can help to demystify many hospital procedures.

New Driver Car Control Clinic
With a focus on promoting safe driving habits among its community's newest drivers, this program in place at Fauquier Health System in Warrenton, Virginia is a twice-annual, hospital-sponsored program for teen drivers. The curriculum focuses on defensive driving skills, and includes two hours of classroom instruction, followed by four hours of behind-the-wheel training. The driving instruction is outsourced, and participants pay a modest fee. For many parents facing the trepidation of handing over the car keys to their newly licensed teen, though, the value of the program is priceless.

Patient-Centered Care Awareness Month
Patient-Centered Care Awareness Month is an international awareness building campaign celebrated annually in October to commemorate the progress that has been made toward making patient-centered care a reality and to build momentum for further progress through education and collaboration. A variety of suggestions for how to celebrate the month, as well as a complimentary toolkit, are available on the Planetree website (www.planetree.org).

CARE FOR THE CAREGIVER

> *"We take better care of ourselves and each other, and this then extends to our patients."* (staff comment)

Providing patient and family-centered care requires staff to give tremendous amounts of themselves—both physically and emotionally. Acknowledging and being responsive to the experience of staff, and the multi-faceted demands placed on them every day, is fundamental to patient-centeredness. Patient focus group comments underscore that when staff do not feel cared for and supported, when they feel stressed and burdened, these feelings are palpable to patients. So, despite efforts to understand and be more responsive to patient concerns and comfort, what we hear from patients is that it is *they* who are considering care from the *perspective of staff* who they perceive as over-worked, stressed and burdened for time. This translates into patients hesitating to request assistance or ask for information, and presents a sizeable barrier to providing patient-centered care.

Patient-centered hospitals not only strive to meet the full range of patient and family needs, but also those of staff. This includes putting in place a comprehensive system of reward and recognition to acknowledge staff's dedication to putting patients and families first. Equally as important as a culture of recognition is a defined culture that encourages employee wellness and provides professional caregivers with outlets for stress reduction and work-life balance.

The Patient Perspective:

"They were doing their best to care when there are a lot of people needing care."

***

"One of the nurses was positively insulting. I asked her about getting a pain medication. She responded in a rude manner, 'You didn't have that pain med'—I gave them the benefit of the doubt that they were having a bad day; that they were overworked and doing more than they have to do."

The Staff Perspective:

"The niceness of the nurses really has an impact, the happier they are, the more it feeds on itself."

***

"I love the tea cart. It's a smile on wheels. It says thank you. It makes you feel like someone cares about you."

***

"We use the healing techniques on each other, a hand massage, aromatherapy. If someone is having a tough day we try to help."

The Leadership Perspective:

"As our job gets harder, we don't want to put the patient in the position of having to say, 'Well, I know those caregivers don't have the resources they need, there are all of these things being imposed on them, so I have to lower my expectations.' I think we really fail if that's the outcome of all of this—[if] our response to what patients need is forcing patients to lower their expectations." (Patrick Charmel, Griffin Hospital)

PATIENT-CENTERED APPROACHES TO REWARD AND RECOGNITION:

Whether they occur as part of formally developed programs or in a more informal, impromptu fashion, recognition of a job well done, acknowledgement of challenges faced, and expressions of gratitude are all part of a culture of patient-centered care. Responsibility for recognition is not limited to managers and supervisors, and it is not a "to do" item to be checked off a list. In a patient-centered culture, *everyone* has the opportunity to participate in reward and recognition: staff across the organization, physicians, leadership, and patients and families.

Healing Cart
Stocked with herbal teas, fresh fruit, nuts and other healthy snacks and escorted by friendly volunteers, the Healing Cart travels to all areas of the hospital, and staff is encouraged to help themselves to one of its nourishing goodies and to take a much needed break. Adding essential oils, in the form of "the oil of the day" can be another way to expand upon the cart's offerings. The oil is placed on a small cotton pad and its medicinal value explained—peppermint to refresh or invigorate, or lavender to quiet or calm. Another function of healing carts can be information sharing. Information that needs to be communicated will be placed on the cart to get the word out throughout the organization. Having the CEO or other senior executives within the organization visit departments with the cart can further enhance its value as a vehicle for recognition, interaction and the exchange of information.

Pay It Forward Cards
Peer-to-peer recognition can be particularly meaningful, and having various ways for staff to acknowledge one another helps to create a staff-championed recognition culture. When the Employee Congress of Northern Westchester Hospital was discussing ways in which staff could recognize each other for the random acts of kindness they bestow on each other, a member referenced the book *Pay It Forward* by Catherine Ryan Hyde. The theme of the book inspired the development of Pay It Forward Cards. A staff member fills out the top part of the card, thanking their colleague. The second part is a duplicate blank card to encourage the receiver of the thank you to *pay the recognition forward.* The cards have a monetary value and can be used in the hospital's cafeteria or gift shop. One employee shared that the cards enabled her to feel the joys of both receiving and bestowing recognition: "The card came to me and I felt great. I turned around and recognized another co-worker on the spot. We both went down and had a cappuccino together using our cards!"

Planetree Kindness Tokens
Planetree has developed a program to celebrate the power of individual acts, big and small, to make a difference in the lives of patients, families and staff, and how collectively these individual acts create a community that is transforming health care. Inspirational tokens are

available for distribution to individuals who are making a difference. The individual receiving the token registers it on a website and then passes the token on to another individual who is making a difference. More information about the kindness token program is available at www.planetree.org.

Department-to-Department Recognition Cart
Another example of a pay-it-forward program is a Department Recognition Cart. The cart is decorated and stocked by one department to bestow on another in the spirit of cultivating inter-departmental connections. The items on the cart can either be useful or fun and can represent a variety of themes such as an upcoming holiday. Delivery of the cart can be part of the celebration. The recipient department enjoys the items for a month, and then "pays it forward," working together to select the next recipient, and decorating and stocking the cart accordingly.

Professional Recognition Days Calendar
Weeks and months designated for a variety of professional recognition celebrations provide optimal opportunities for acknowledging the unique contributions that various departments make to the hospital. A monthly calendar listing each of the departments celebrating national recognition in that month promotes department to department recognition.

Thank You Notes
A personalized and hand-signed thank you note sent to an employee at home may seem like a small gesture.   The simplicity of the act, though, belies its potential for making a tremendous impact on staff.   In the words of one grateful recipient: "It meant so much to my family to hear about why I stay at work late and sometimes missed baseball games. My son was so touched when the card came from the CEO stating how I touched the lives of a family in crisis and made their pain just a little more bearable. My son said, 'I'm proud of you Mom, you are a great nurse.'"

For many staff, the most meaningful recognition they can receive is from the patients and families they care for. Many patient-centered hospitals have implemented systems by which patients and their loved ones can formally acknowledge their care providers. **Drop boxes or mail boxes with slots for cards** are a simple way to promote an organization-wide attitude of gratitude. For maximum effect, the purpose of boxes should be clearly identified ("*Please take a moment to acknowledge our staff for the first class care they provided you.*") and the boxes themselves placed in high visibility areas of the hospital, such as waiting rooms and elevator landings. Volunteers can be used to collect the cards from the drop boxes and distribute them to departments so that patients' kind words can be shared.

Manager Rounding
Rounding by managers is another vehicle for immediate feedback from patients about staff they would like to acknowledge. Providing patients or family members the opportunity to single out those on staff who have provided them exceptional care is immediately gratifying for both patient and caregiver.

Midnight Runs
For an organization that operates 24/7, recognition cannot be limited to a 9 to 5 function. At Northern Westchester Hospital, Midnight Runs have been an effective way to recognize night staff personnel. Senior staff members deliver nutritious boxed meals to the night shift to thank them for their service. Along with the food delivery, hand massages with aromatherapy are provided to the staff by members of the Holistic Nursing Council. Midnight Runs are also routinely conducted for staff working on holidays.

PATIENT-CENTERED APPROACHES FOR PROMOTING WORK-LIFE BALANCE:

Human beings caring for other human beings at times of great vulnerability can be considered nothing less than a calling. Health care professionals give so much of themselves in caring for patients and families, and the demands placed on them during the work day are great. Coupled with the demands placed on them outside of work, is it any wonder that many staff members report feeling stressed, pressed for time, and at times, overwhelmed? These feelings do not go unnoticed by patients. Patient-centered hospitals strive to alleviate some of these stressors that affect the attitudes of caregivers by anticipating and responding to what is causing them.

Concierge Programs
One approach for doing so is the development of a concierge program. These programs can be operated, based on a hospital's needs and available resources, by hospital staff and volunteers or by outsourced concierge companies. Common services provided by a concierge program include oil changes and car washes, flower purchases, food delivery, general information and directions, notary services, postal services, dry cleaning drop-off and pick up, and more. The easy accessibility of such services—and the hospital's recognition of the importance of work-life balance—can be powerful benefits to highlight in staff recruitment efforts as well.

Relax and Renew Sessions
At Mid-Columbia Medical Center (MCMC) in The Dalles, Oregon, employees benefit from *Relax and Renew Sessions*. Conducted by members of the hospital's Center for Mind and Body Medicine, these sessions for staff include ten-minute neck and shoulder massages and meditation sessions accompanied by the hospital's on-site music-thanatologist. In order to ensure staff's availability to "relax and renew," the sessions are conducted where staff are—on the patient care units and in hospital departments. A relax and renew rotation schedule ensures that staff from every department are included on a routine basis. When staff experience a particularly stressful event, the team makes itself available to come to the floor to help staff members release tension, sadness and stress.

Mid-Columbia Medical Center also offers additional forms of relaxation to both patients and staff by the use of a terrazzo stone **labyrinth** located outdoors in a beautiful natural setting adjacent to the hospital. The labyrinth is a replica of the ancient labyrinth built into the floor of France's Cathedral Notre-Dame de Chartres. Patients, families and staff use the labyrinth's walking meditation paths, winding inward to a center and back. For those unable to use the outdoor labyrinth, oak finger meditation labyrinths are located in the hospital chapel and quiet rooms. MCMC also offers a trained labyrinth facilitator, available to meet with patients and others upon request.

Post-Crisis Debriefing and Support

Patient-centered hospitals are attuned to the emotional toll on professional caregivers following a crisis. Individual and group **debriefing sessions** facilitated by a professional social worker can restore and sustain staff in the wake of a difficult patient care experience. **Drumming and meditation circles** can also provide a therapeutic environment for stress release. Mid-Columbia Medical Center's music-thanatologist collaborates with the pastoral care team to offer staff and families who had a loved one pass at the hospital the opportunity to participate in an annual memorial service honoring the lives of those they lost. This program, with its communal and therapeutic spirit, provides families with an opportunity to reunite with the team who cared for their loved one.

Sick Bay

The demands of being in a business that is 24/7 and very resource-dependent can pose many challenges to hospitals and their staff. One of the work-life challenges staff face is what to do when their child is under the weather, and not well enough to go to school or daycare. This type of situation often results in the parent taking the day off, leaving the department either short-handed or in the difficult position of needing to find adequate coverage. A sick bay can help to alleviate these stresses by allowing staff to bring their sick child with them to work. The child remains under the supervision of pediatric nurses, and stays on the pediatric unit. The children have access to the playroom, video games and other pediatric services, and the parent can visit whenever they want. As one nurse said, "This program is so great. I can come to work and I know my child is being well taken care of, even a little spoiled. When I come to take them home, they don't want to leave."

On-Site Day Care

When feasible, on-site day care programs provide another source of comfort and convenience for staff. A unique program at Mid-Columbia Medical Center in The Dalles, Oregon is the Great 'n Small Child Development Center. The Center's motto is "work without worry." With quality, affordability and proximity at the top of the list in the search for child care, Mid-Columbia offers all three to their employees. Opened in 1982, the Great 'n Small Child Development Center is an on-campus, licensed facility staffed with teachers who are dedicated to the care, nurturing and education of Mid-Columbia employees' children. Children also serve the patients at the hospital by dressing up and parading through the hospital on holidays, staging singing recitals and making get well cards for patients. The program accommodates children from newborn through middle school with arrangements made with local schools to transport the children to the daycare for after school care.

PATIENT-CENTERED APPROACHES FOR PROMOTING EMPLOYEE WELLNESS:

Fitness Centers

On-site fitness centers are a commonly requested employee perk, but are sometimes hard to implement due to limited resources and physical space. Sharp Coronado Hospital in Coronado, California overcame these barriers through the creation of a **Motion Center** within their Rehabilitation Department. The Motion Center is an outpatient and inpatient resource for Coronado residents with sports-related and other injuries. The Motion Center fitness area is open to the public for private workout sessions with a fitness trainer, low-cost memberships, weight-training programs and fitness classes. Staff members are also able to use the Center to meet their

wellness goals. As one patient at the Center remarked, "I love being able to come here and work out. I also get the opportunity to meet the great people who work here and we support each other through our grueling work outs!"

Wellness Staircase

A simple way to promote employee wellness is to encourage walking and taking the stairs (versus the elevator) through the creation of a wellness stairwell. A commonly used stairwell can be painted and decorated to inspire its use and to encourage fitness. Signs posted by nearby elevators can encourage everyone to use the stairs.

Promoting Healthy Eating Habits

Recognizing the importance of healthy eating habits to overall wellness, many hospitals have begun examining the food and snack offerings available to patients, visitors and staff. By offering wholesome foods that are tasty, nutritional *and* well-balanced, these hospitals are reinforcing their health-promoting missions. **Posting nutritional information** about food options in the cafeteria can enable patrons to make informed choices, and **healthy vending machines** stocked with a selection of drinks, snacks and replacement meals that are low in sugar and carbohydrates and high in protein and fiber offer a healthier alternative to the candy, chips and sodas that typically populate vending machines.

Ensuring access to healthy and satisfying food during late night hours means that the food options for staff who work the night shift are not relegated to snack foods and take out. In some hospitals, the kitchen prepares a variety of healthy meals that are **ready for night staff to eat —when they want to eat.** Some hospitals have taken this concept a step further. Night shift can call in their request from a select menu the night before their shift. The requests are prepared and easily accessible to staff the next night.

Going Smoke Free

Introducing a smoke free environment is another way that a number of hospitals have further enhanced their culture of wellness. Smoke free campuses are being implemented in hospitals across the nation with the question of how to best help health care workers *kick the habit*. A number of hospitals have introduced multi-faceted programs that include one-on-one counseling for employees with a trained respiratory therapist, nicotine replacement therapies, integrative approaches such as acupuncture and aromatherapy, and nutritional consults. Employees can be paired with a coach (typically a former smoker) who can offer support and guidance. Support groups are also provided, along with incentives for remaining smoke free.

Greening Your Hospital

Patient-centered hospitals have embraced the green movement in a variety of ways, such as **electricity utilization reduction programs** and **recycling policies** that stipulate the use of only recycled paper for correspondence, two-sided printing, and the recycling of plates and cups. Environmental services departments are switching to cleaning solutions that are environmentally friendly and effective, and hospitals are trying to create more green space on hospital campuses.

At Hackensack University Medical Center, in Hackensack, New Jersey, **The Deirdre Imus Environmental Center for Pediatric Oncology** educates the public about the carcinogens and

other environmental factors that too commonly affect our lives, and helps to shape policy decisions that impact our environment. A hospital-wide "Greening the Cleaning" initiative to replace potentially toxic cleaning products with more environmentally responsible products was developed and implemented. With the construction of the Sarkis and Siran Gabrellian Women's and Children's Pavilion, The Deirdre Imus Center evaluated the materials and practices involved in every aspect of the development of the building. As a result, the Women's and Children's Pavilion was named one of the Top 10 Green Hospitals in the nation by the *Green Guide* for building a truly environmentally responsible, sustainable health care facility.

Going "green" does not only have to pertain to facility changes. Encouraging and rewarding staff to take alternate means of transportation into work—to reduce gas use —is a green initiative. Programs can provide incentives for employees who **ride share**, bike or use other mass transit options. In addition, the food being served in hospital cafeterias and offered on patient trays is increasingly under scrutiny for its healthy attributes. Serving the **freshest foods possible** is a goal of food service departments in hospitals, and many have entered into arrangements with local farmers to provide fresh fruits and vegetables and protein sources with preparations being preservative free. Some have even extended such partnerships to include **farmers' markets** on hospital grounds for employees and other visitors, and others have **banned trans fats** from their facilities.

PATIENT-CENTERED APPROACHES TO DATA AND TECHNOLOGY

"I'm not a number.
I'm a person." (patient comment)

We would be remiss if we did not acknowledge the central role that both data and technology can play in enhancing the patient, family, and staff experience. We do so cautiously, however, for despite the promise that data and technology offer, they must be used with wisdom in order to achieve that promise. If misused, both data and technology can become barriers to patient-centered care.

The Patient Perspective:

"When I had my visit, and did the workups, the doctor printed out three pages of data on everything and he went over all of it with me."
***
"My doctor discovered a lump in my breast and sent me to the breast center for a mammogram and ultrasound. At the breast center, the tech told me the mammogram and ultrasound didn't show anything, but I never saw a doctor there and no one tried to feel the lump. They called me back later the same day to schedule an MRI. My doctor told me not to go back to the breast center and instead sent me to a surgeon who felt and removed the tumor."
***
"I have an MRI here every three months and I walk out with a disk"

The Staff Perspective:

". . . we have begun to focus on charts and graphs and performance measures, we are losing touch with the patient . . . We are too focused on paper and figures and data."
***
"It's a goal to retain staff, and they keep surveying us . . . They are not listening to us."
***
"A patient comes in and I have to ask so many questions and fill in so many boxes that when he leaves he has gotten nothing from me—no care. . . . We are just filling in the boxes. This keeps [us] from caring."
***
"To get a new form in CPOE is more difficult than to get elected President."
***
"I am not a measurement person . . . I focus on relationships. If the relationships are working well then that is enough for me. However, it isn't enough for the world in which I work and I need to create simple, easy ways to measure."

The Leadership Perspective:

"Imposing information technology, which we are telling everyone is going to have a real benefit in terms of patient safety, is really disrupting the relationship between caregivers and patients. And caregivers, especially those that haven't grown up with the technology, are trying to understand how to use that technology in a way that supports and fosters a positive patient relationship." (Patrick Charmel, Griffin Hospital)

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"I was in a meeting where there was a quality improvement person who was talking to people about how to improve their HCAHPS scores, and they were using this technique of saying to the patient 'I always did this for you,' because the scale on HCAHPS is never/always, always the high score. And that made me cringe." (Charles Darby, consultant, former CAHPS Project Officer, Agency for Healthcare Research and Quality)

***

"We put all these computer systems into it, and it has my doc sitting in primary care with his back turned to the patient putting in all of the information into the computer, and the patient is sitting there and saying, 'Could I talk to you?' You know, 'What are you putting in there?'" (Kenneth Mizrach, VA New Jersey Healthcare System)

USING DATA TO SUPPORT A PATIENT-CENTERED CULTURE:

"Data" is defined by Merriam-Webster as "1: factual information (as measurements or statistics) used as a basis for reasoning, discussion, or calculation;" and "2: information output by a sensing device or organ that includes both useful and irrelevant or redundant information and must be processed to be meaningful." The first definition's emphasis on quantitative data is widely reflected in health care, but the second definition is more important for patient-centered care. Patient-centered organizations recognize that data is broader than numbers and includes the qualitative perspective of patients, families, and staff. Patient-centered organizations also recognize that data is a tool to understanding relationships, but it is those relationships, not the data, that are important.

From Data to Information

Examining quantitative data is not enough; it is important to consider all data sources and put them in context to derive meaning. One way to think about this concept is to reframe it in terms of clinical care. If we evaluate only the quantitative data (the lab values, vital signs, etc.) outside the context of the patient's history and what is "normal" for that patient, we are likely to miss or misinterpret facts that have clinical significance. To effectively diagnose and treat, clinicians must wade through a mass of apparently unrelated "data" in order to develop a cohesive "picture" of the patient's illness. Similarly, patient-centered organizations know how to appropriately sift through the mass of data to identify what is meaningful, not only in treating patients' medical conditions, but in truly caring for patients as individuals. This broadening of focus from "what is the matter with the patient" to "what matters to the patient[12]" is at the core of patient-centered organizations.

This broader focus and commitment to considering data in an integrated fashion helps patient-centered organizations avoid the Whack-A-Mole game illustrated on the next page. Uncovering

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[12] Moore, L.G., & Wasson, J.H. (2006). An introduction to technology for patient-centered collaborative care. Journal of Ambulatory Care Management, 29(3), 195-198.

the meaning behind the data and using that as a guide to setting and maintaining appropriate organizational goals builds relationships; constantly changing priorities in response to the latest data reports undermines them by making staff feel either like the manager below chasing different items as fast as they can, or even worse, like the mole being "whacked."

Reprinted with permission of the illustrator, Michel Baudin

Patient-centered organizations also recognize that the manner in which the data is presented is important. Reports that focus purely on the latest quantitative data, without putting it in context or focusing on the people behind the numbers can be demoralizing to staff, who may perceive the organization as merely "chasing" HCAHPS scores or other metrics. Patient-centered organizations remain focused on using data as a tool for improving the patient experience, rather than "gaming" scores.

The Cleveland Clinic Office of Patient Experience has developed a **centralized dashboard** that synthesizes qualitative and quantitative information about the patient experience, along with other relevant metrics, such as employee engagement and staffing. The data is used to develop a

short list of system wide priorities, and a variety of structures are in place to **help employees use data effectively as a springboard for improvement**. The Office of Patient Experience recognizes that the goal is to transform the experience and data is only one part of their comprehensive efforts.

Spotlighting Success and Providing Tools

> *"I know our system works better in some areas than in others. The issue that I present is 'How do you leverage that? How do you elevate those really bright spots that exist everywhere?' And make that and replicate it?"* (Fred M. DeGrandis, Cleveland Clinic Regional Hospitals)

The review and interpretation of data provides opportunities to discover not only areas for improvement, but areas of excellence that can be shared and replicated throughout the organization. **Spotlighting excellence**, as well as **celebrating meaningful progress** toward a goal even if the goal has not yet been achieved, is essential. Managers confronted by data frequently express frustration about being held accountable for "fixing the scores," without being provided any guidance or tools to use to improve their performance. The areas of excellence, such as a high-performing unit, can **provide tangible, practical examples** of how to achieve success within the unique environment and pressures of each organization.

Coaching

Hackensack University Medical Center in Hackensack, New Jersey, has implemented an extensive program to **coach managers in effective use of data**. During the 12-week program, managers are provided with one-on-one education and training in how to effectively use patient satisfaction and employee survey data. The program begins with a needs assessment, which allows a coach from the Service Excellence Department to customize a plan for each manager. Meetings occur weekly for one hour per week. At the completion of the program, participants are awarded CEUs.

USING TECHNOLOGY TO SUPPORT A PATIENT-CENTERED CULTURE

> *"What patients want is not rocket science, which is really unfortunate because if it were rocket science, we would be doing it. We are great at rocket science. We love rocket science. What we're not good at are the things that are so simple and basic that we overlook them."* (Laura Gilpin, Planetree)

Although a patient-centered focus on human interactions is undoubtedly high-touch, it does not need to be low-tech. Patient-centered hospitals have developed innovative ways to utilize technology to support relationships. As the photograph on the cover of this Guide demonstrates, even the appearance of technology, which can be intimidating to patients, can be softened through creative design.

Technology to Promote Effective Communication

Patient-centered hospitals are using technology in a variety of ways to promote effective communication between and among patients, families, and staff, as well as to educate patients. Common practices include providing patients and families with **computer access**, either through dedicated terminals or the availability of **wireless Internet services** that can be accessed with a

laptop. Hospital television sets also can be enhanced to include **educational programming**, as well as **interactive opportunities to communicate** with staff, such as through the television quiz used at Sentara Virginia Beach General Hospital (*See section VII.D., Access to Information, page 138*).

Technology to Promote Continuity of Care
Many hospitals are using technology to promote continuity of care by providing patients with detailed information about their medical condition. Mid-Columbia Medical Center in The Dalles, Oregon has developed a home-grown web-based discharge system that generates a **patient-friendly printout** of important discharge information, including a summary of all medications. Other hospitals routinely provide patients with **printouts of test results** and/or **electronic copies of images** for the patients' reference and use in coordinating with other physicians. Some hospitals have broadened the information directly available to patients by implementing systems to provide patients with **Internet access to medical records**, such as the Cleveland Clinic, Aurora Health Care and the Veterans Administration.

Fauquier Health System in Warrenton, Virginia has developed an innovative approach to promoting medication safety through technology. The Rcopia AC system allows the hospital to **access community pharmaceutical records** of hospital patients, which facilitates more accurate medication reconciliation.

Technology to Support Family Involvement
Technology also can be used to enable patients to remain in close contact with their support network of family and friends. Many patient-centered hospitals offer the opportunity to **send an electronic message of support to a hospitalized patient**, which the hospital prints and delivers to the patient's room. Some hospitals also offer systems that enable patients to **post electronic updates about their condition**, which can help patients keep their extended support network informed without becoming overwhelmed by a large volume of phone calls.

Selecting and Implementing the Right Technology
In the strategies described above, hospitals have leveraged technology to promote effective relationships, but in the absence of careful planning technology can have the unintended consequence of impairing the same relationships it is intended to build. Electronic medical records are a good example. The benefits of transitioning to an electronic medical record have been extensively documented, but hospital staff members are increasingly expressing concern about the effect these systems are having on the relationship between patients and staff. Many staff members are uncomfortable using computers at the bedside because they focus on the computer, not the patient, or don't want patients to see them "hunting and pecking," so instead they document in the hall, which results in less time interacting with the patient. Staff also frequently express concerns about the reliability of mobile technology—if the battery life is not long enough to consistently allow in-room use without the device shutting down, staff will quickly lose confidence and develop work-arounds that leave the device plugged in outside of the patient room.

Other examples of technology gone wrong include:

- Placing timers in patient rooms to remind staff to check-in with patients at regular intervals, when staff routinely come into the room and reset the timer without even making eye contact with the patient

- Using stoplights to monitor ambient noise levels when staff believes the monitors contain hidden microphones.

Organizations considering new technology routinely evaluate the financial resources, timeline, ability to meet organizational objectives, and usability of the technology from a human factors engineering perspective, but a patient-centered approach calls for an additional **evaluation of the effect that the technology will have on relationships** between and among patients, families, and staff. Technology should be implemented in a way that is respectful of and enhances these relationships. Even when new technology offers apparent patient safety benefits, it is important to take the time to consider the unintended consequences of the new technology.

Communication to staff and patients throughout a technology evaluation and implementation is an important part of a patient-centered approach to technology. Staff who will be using the technology should be involved in the decision making and also should play a significant role in creating the implementation plan. Engaging staff in the process early on will help to identify any implementation challenges and strategies to address them. Communicating with patients is also important. For example, in the absence of an appropriate explanation, patients may actually interpret a technological patient safety process, such as repeatedly electronically verifying the identification of the patient, as a sign that the staff isn't paying attention and doesn't remember the patient's name.

The lure of technology as a quick solution is powerful and pervasive, but technology itself is not the answer. Skillful use of the tool of technology can advance patient-centered care, but the technology must be designed and implemented to serve human needs, rather than in way that forces people to conform to the technology.

IMPLEMENTATION TOOLS:

A. Planetree Techniques for Using Data Effectively, *pg. 208*

B. Relationship-Based Technology Assessment, *pg. 210*

Tool A: Planetree Techniques for Using Data Effectively

ORDINARY USES OF DATA
Data is used as a way to measure compliance, promote standardized achievements, and evaluate effectiveness.

EXTRAORDINARY USES OF DATA
Data can provide a window into organizational culture and relationships, the building blocks for innovation, and an opportunity to discover and build on areas of excellence.

TECHNIQUES FOR USING DATA EFFECTIVELY

- **Prioritization**
    - Use data as a tool to help identify priorities
    - Avoid attempting to focus on everything at once
    - Avoid changing priorities constantly

- **Integration**
    - Integrate all data sources and types to gain a better understanding
    - Relate the data to organizational context and goals
    - Recognize that data cannot capture everything that is important

- **Identification of best practices**
    - Use data to help you identify what is already working well in your organization (e.g. high-performing units)
    - Identify successes not only based on top performance, but on improvements in performance
    - Use data as a way of evaluating the success of improvement strategies
    - Avoid measuring progress too narrowly
    - Avoid getting "trapped" in the data – data itself is not the objective

- **Communication**
    - Provide data in a format that is intuitive and actionable for users
    - Tell the stories behind the data
    - Be flexible and creative
    - Avoid providing data only, without interpretation or support for improvement
    - Avoid focusing only on the negative
    - Avoid concentrating on isolated incidents, as opposed to broader concerns

- **Comparison**
    - "Measure to improve, not to impress[13]"
    - Look at the bottom box scores, as well as the top box scores
    - Manage based on recent data, not older publicly-reported performance
    - Use trending to compare against yourself

- **Celebration**
    - Celebrate meaningful successes
    - Avoid overreacting to random variations in performance

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[13] Lee, F. <u>If Disney Ran your Hospital, 9 ½ Things You Would Do Differently.</u> Bozeman, MT: Second River Healthcare Press, 2004.

Tool B: Relationship-Based Technology Assessment

PLANETREE

RELATIONSHIP-BASED TECHNOLOGY ASSESSMENT

Technology Selection

- Who decides what technology is necessary?

- Who selects technology for the hospital?
    o Are frontline users involved in the selection process?
    o Are patients/families involved in the selection process?

- Are there opportunities to test different approaches before selecting a specific technology?

- Is the selected technology pilot-tested before full implementation in order to identify the unintended consequences?

- Is the impact on patient-centered care a key factor in identifying technology needs and selecting products?

Communication

- What is the objective of implementing the technology? (What do you hope to achieve with the technology?)

- Are the capabilities of the technology being communicated to and vetted with future users, patients and families?

- What processes are in place for frontline staff, patients, and families to provide feedback on the technology once it is implemented?

Patient-Centered Evaluation of New Technology

- How will implementation of the technology affect interactions between patients, families, and staff?
    o Will technology affect the location of the interactions? (e.g. bedside or outside patient room)
    o Will technology support or impede the provider's ability to communicate effectively with the patient/family?
    o What are the possible unintended consequences of implementing the technology?

- How will implementation of the technology affect interactions among staff?
    o What training is necessary and who will receive the training?
    o Will the technology work reliably in all areas of the facility or are there limitations on where it can be used?
    o What processes are in place to repair or replace the technology if it is not working effectively?

PERSONAL STRATEGIES: WHAT YOU CAN DO NOW

Note: This section draws heavily from previous work: Brady, C. and Frampton, S. "Breaking Down the Barriers to Patient-Centered Care" in Putting Patients First: Best Practices in Patient-Centered Care, San Francisco: Jossey Bass, 2008.)

"As a leader, the most important thing—I wish I had known it earlier—is that we are not alone.   Most of our health care workers and everybody on the team—the housekeeper on up—want to make a difference every day. How can you tap into that purposeful energy, and give them the empowerment and engagement and the authority to make a difference?" (Susan Stone, Sharp Coronado Hospital)

"Find the staff's personal mission and connect it to the organization." (Fred M. DeGrandis, Cleveland Clinic Regional Hospitals)

As children, we believe that we can do anything, but paradoxically as we age and our sphere of influence grows, we tend to lose faith in our ability to effect change. Even in situations when everyone acknowledges something is not working, individuals are reluctant to take on the challenge of fixing it. We may grumble about it, but we often conclude "that's just the way it is."

Whether you are a patient, family member, concerned citizen, or health care provider, you have more power than you think. Each of the organizations involved in creating this Guide was the product of one person's vision. Harvey Picker, founder of Picker Institute, and Angelica Thieriot, founder of Planetree, are two passionate individuals whose similar missions have helped shape health care. Although patient-centered care has since become a well-known concept, at the time they envisioned it, Harvey and Angelica's ideas were revolutionary.

There is no doubt that you too can change the world. Leaders of all kinds have been teaching the same message for generations:

"You must be the change you wish to see in the world."
Gandhi

"Go confidently in the direction of your dreams. Live the life you imagined."
Henry David Thoreau

"If you think you can do a thing, or think you can't do a thing, you're right."
Henry Ford

*"Not everyone is called to be a physician, a lawyer, a philosopher, to live in the
public eye, nor has everyone outstanding gifts of natural capacity, but all of us are
created for the life of social duty, all are responsible for the personal influence that goes forth
from us."*
Vittorino da Feltre

*"Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed,
it is the only thing that ever has."*
Margaret Meade

YOUR VISION FOR PATIENT-CENTERED CARE

What is your vision? Spend some time thinking about what you would do if you had the proverbial "magic wand" and could change things in an instant. At this stage, don't reject any idea as too crazy or unrealistic—after all, many of the practices discussed in this Guide, such as patient-directed visitation and open medical records, were once dismissed as impossible. Don't temper your expectations with reality. What would be the ideal health care experience for you as a provider, patient, family member? Write down your ideas.

Now take your vision and break it down into smaller parts. What can you do today that would help move toward that vision? Make a commitment to yourself and write that down. *"I will participate in making health care more patient-centered by _____ ."* The key is to believe that you can make it happen.

Some ideas are included as resources at the end of this section, but they are just a starting point. Just as a patient-centered culture must grow from within a health care organization, your personal commitment must be uniquely yours. Make it as specific as you can, such as by listing concrete behaviors, and include a timeframe.

We invite you to be part of this growing community of people dedicated to transforming health care. Individuals and organizations around the world are making the dream of patient-centered care a reality—you can too. Harvey Picker is with us in spirit and we can hear him saying to us all "Let's get on with it."

IMPLEMENTATION TOOLS:

A.   Personal Commitment Topic Ideas, *pg. 213*

B.   Vision Worksheet, *pg. 216*

Tool A:

Personal Commitment Topic Ideas

For Hospital Leadership

- Complete the self-assessment (*see page 9*) and use the results to highlight areas of excellence, as well as to identify opportunities for improvement.

- Identify one or more practices from the Guide that are aligned with organizational objectives and set a timeline for implementation.

- Actively engage the governing board in patient-centered care. Consider having board members round on patients prior to each board meeting.

- Make an explicit organizational commitment to patient-centered care and put systems in place to reinforce that commitment. Consider displaying and/or distributing the Proclamation for Patient-Centered Care (*see page 22)* and using the proclamation as part of the employee selection process and/or new employee orientation to reinforce that patient-centered care is an essential part of the organization. (To request a complimentary personalized copy of the Proclamation, please contact Planetree.)

- Recognize and reward staff members who are excellent role models for patient-centered care.

- Create a patient and family advisory council if you don't already have one.

- Invite patients or family members to join the hospital governing board or hospital committees.

- Distribute "I am an expert about me" stickers to patients and "I am listening to you" stickers to staff to reinforce that patients are respected partners (*see page 194*).

- Routinely share patient, family, and staff stories (positive and negative) with staff and the community, as well as information about suggestions that have been implemented.

- Host an open house for patients and families.

- Write a letter to the editor of your local paper describing your organization's commitment to patient-centered care and identifying the opportunities for patients and families to get involved.

- Determine how you can eliminate or mitigate barriers that are making it difficult for your staff to be the kind of caregivers they want to be.

- Incorporate a relationship assessment into the evaluation of any new technology.

- Evaluate your data collection and reporting systems and refine them if necessary to support development of a patient-centered culture.

- Consider whether Patient-Centered Hospital Designation is an appropriate goal for your organization (*see page 47*).

- Consider participating in Patient-Centered Care Awareness Month (*see page 194*).

For Hospital Staff

- Share the Proclamation for Patient-Centered Care (*see page 22*) with your colleagues and discuss how these principles could be exemplified in your unit or by your team. (To request a complimentary copy of the Proclamation, please contact Planetree.)

- Select one of more practices from this Guide that intrigue you and implement them.

- Encourage patients and families to ask for what they need. Whenever you can, say "yes" to patient and family requests. If you can't say yes, explain why, and see if you can identify an alternative way to meet the need.

- Share the positive. Hospitals have extensive systems for capturing and responding to complaints, but often the positive comments do not get shared. Remember to thank your colleagues, non-clinical and clinical, for the work that they do. If a patient or family member makes a positive comment, share it with the people involved. If you have a process that has been particularly effective for you or your team, share it with others in the organization who may be interested in replicating it.

- Think about why you chose health care as a field. Rekindle your passion for this work and commit to being the kind of professional that you intended to be.

- Recognize that your attitude is contagious and that what you do has an impact not only when you do it, but forever. Think about how your words and actions will be perceived by patients, families, and colleagues. Be present, smile, listen closely, and connect with others as individuals, not "to do" list items.

- If there are "rules" in place that limit your ability to effectively care for your patients, work with your colleagues to change the rules.

- Share your creative talents with the hospital (e.g. gardening, photography, art, music, etc.)

- If you need administrative support for something you would like to try, make the suggestion. If the answer is no, ask why, and work with your colleagues to overcome whatever barriers are identified. (Consult the evidence base document to be made available on the Planetree (www.planetree.org) and Picker Institute (www.pickerinstitute.org) websites for evidence to support the change.)

- Consider participating in Patient-Centered Care Awareness Month (*see page 194*).

For Patients, Family, and Community Members

- Contact your local hospital and ask how you can get involved. Offer to participate on a patient/family advisory committee, other committees, or in focus groups.

- Provide feedback to your hospital about your experiences (both positive and negative) and share your suggestions and dreams for what would make the experience better for you. Be creative and don't reject ideas just because they would be expensive or take time to implement. (If you find yourself rejecting ideas, keep in mind that that the innovative Ken Hamilton Caregivers Center at Northern Westchester described on page 150 was the vision of one family member, Marian Hamilton, whose leadership is transforming the healthcare experience for hundreds of caregivers.)

- Consider wearing "I am an expert about me" stickers when you interact with your health care providers to remind them (and you) that you are an essential partner in your care (please contact Planetree for complimentary stickers).

- Proactively take charge of your health so you are in a position to make informed decisions about your care. Many hospitals offer community education classes about particular medical conditions; consider taking one of the classes if you or a loved one has that condition. Create a list of your medications and keep it updated (*see page 114*). Keep a medical history file with key information including physician names, medical conditions, prior surgeries and hospitalizations, etc.

- If you have a choice of hospitals, review the list of questions to ask your hospital (*see page 76*), contact the hospitals to ask about the items that are important to you, and let the hospitals know that their answers will affect your decision.

- When you are hospitalized, don't assume things are not possible. Speak up and ask for what you need. For example, if you are hungry, don't wait for the next scheduled mealtime, ask for something to eat.

- Share the things that bring you joy with hospitalized patients as a volunteer. If you are a musician, offer to play your instrument at the hospital. If you are an artist, offer to do small art projects with patients. If you like to read, offer to read aloud to patients. If you are a gardener, offer to plant or maintain a healing garden at the hospital.

- Consider participating in Patient-Centered Care Awareness Month (*see page 194*).

Tool B: Vision Worksheet

PLANETREE

Your Vision for Health Care

If you had a magic wand, what would you change?

What would be the ideal health care experience for you…

As a provider?

As a patient?

As a family member?

Make Your Commitment:
Remember to include a timeframe and specific behaviors necessary to realize your personal commitment to transforming health care.

I will participate in making health care more patient-centered by _____

_____

_____

_____

APPENDIX A: PATIENT-CENTERED CARE AND HCAHPS

The HCAHPS survey is a nationally standardized survey that captures patients' perspectives of their hospital care. It allows consumers, for the first time, to compare hospitals based on measures of how effectively they are satisfying patients' needs and expectations. The survey's 27 questions look beyond clinical outcomes and technical capabilities of hospitals and focus instead on aspects of the care experience that are particularly meaningful to patients, including:

- Communication with doctors
- Communication with nurses
- Communication about medications
- Responsiveness of hospital staff
- Pain management
- Quality of discharge instructions
- Cleanliness of hospital environment
- Quiet of hospital environment

With hospitals' scores publicly reported by the Centers for Medicare and Medicaid Services on its Hospital Compare website (www.hospitalcompare.hhs.gov), accessible by consumers, competitors and media alike, sound performance on these measures is imperative. Indeed, the HCAHPS program has elevated the importance of hospitals paying attention to the patient experience, and consequently, has considerably fueled interest in patient-centered approaches to care.

By definition, patient-centered hospitals look to their patients and their communities to help define a positive and satisfying patient experience. However, while patient responses to HCAHPS survey questions ranging from "always" to "never" happens can provide useful input to hospitals about how well they are meeting patients' needs and can draw attention to aspects of care where improvements can be made, these responses alone do not address the full range of things patients and families desire in their interactions. Patient-centered organizations refrain from using changes in HCAHPS scores as the only measure of whether an intervention designed to improve the patient experience was beneficial, and instead combine the HCAHPS data with other qualitative and quantitative information about the patient, family and staff experience.

In this section of the Guide, we turn again to the voices of patients themselves for their insights about their experiences with hospital care. The source of the data that follows is an analysis of more than 90 patient focus groups (representing 645 patient voices) conducted by Planetree Inc. in hospitals across the United States over the course of three years. Patients were asked a series of questions about their hospital experience, including what went well and what could have been improved, and many of their comments have appeared elsewhere in this Guide. Whereas HCAHPS scores can tell us *where* we are satisfying patients' needs and where we are falling short, these patient comments shed light on the *how, why* and *what*, including how we, as an industry, can better communicate with patients and their family members, what their expectations are with regard to responsiveness, and why the environment of care is such an important aspect of the care experience.

These patient comments are followed by a simple grid identifying specific patient-centered practices that address key areas of the patient experience measured by the HCAHPS survey.

COMMUNICATION

- **When communication is effective and productive, it is much more than a transactional exchange of information; it is also an opportunity to convey caring and compassion, to reassure, to strengthen partnerships between patient and caregiver, and to forge a human-to-human connection based on courtesy and respect. From the patient perspective, how something is communicated is as important as what is communicated.**

    "They communicated with you. She told me everything before I went there. I was so nervous, and she could tell. I even overheard her saying to the next unit that I was coming over and I was a little nervous."

    "They are trained technically, but they don't all have the customer service behavior that would make you want to be here…before you even have your first test, the people you see beforehand are going to make you comfortable. If you see one person who fails to smile, it doesn't matter how great the treatment is. In your mind the quality of care goes down."

    "When I was in ICU there was a lady who was disturbed and made a lot of noise. The nurses told me that what I was hearing isn't bad but we would all hear it and they would try their best to do something about it. It felt good that they told me what was going on—I felt like part of the process."

    "When the doctor came back after I waited for a while, the doctor didn't even bother to come in. He just stuck his head in the room and told me I was fine. I thought that was rude."

    "I think nurses and doctors know their jobs so well that they forget that you don't. So even though they explain it, maybe the warmth isn't there because you don't know what to expect. Like 'you're going to get a pinch.' Well, what next? Maybe just a little more compassion."

    "People who come into the hospital are sick and harder to please—I think some of the people need training on how to deal with people and not be harsh with them. I think some people just get snappy."

    "The nurses [should] listen to the patients for a change and don't think we don't know what's wrong with us . . . [The nurses will] check under my sheets to see if I'm wet. I know if I'm wet . . . ASK ME! There's nothing wrong with my brain."

- **The common adage "knowledge is power" is particularly apt in the health care setting. Patients frequently express feeling overwhelmed, situated in unfamiliar surroundings, and feeling they have little control over their bodies, their routines and their well-being. Caregivers who carefully listen to questions and concerns, and provide thorough, clear explanations can considerably aid in restoring patients' sense of control. Conversely, when things are not well explained or information is withheld, that sense of powerlessness is compounded.**

> *"When my sister came, they really were very good to her including explaining things to her. At one point, I had a drug reaction and I was very disoriented. I just remember them taking my blood pressure and saying they couldn't give me anything for pain and they explained everything to her. They were really very good to her."*

> *"I think the information process goes well. They make a concerted effort to talk to you. From the time I came into the ER the processes were explained very well. The hospitalist explained what was going to happen and when, and it went very well. The nurses and techs also explained what they were doing and why."*

> *"It took them several hours to check me into my room, but I was okay with that because they told me what was going on and that ten other patients had come in at the same time, which I totally understood. When you're in a situation like that the communication is what soothes you. Not knowing scares you more."*

> *"When I came in Monday night they gave me a list of what's done every day. It said I have OT, but I didn't know what that means. They didn't explain. Just like no one explained that you had to pick up your own tray."*

> *"I came here 4½ months pregnant and I was bleeding. They said, 'It's a little clot, no big deal…if it continues you may miscarry,' but they didn't tell me what to look for…They wouldn't tell me anything during the ultrasound. They said you have to ask your doctor. They just would say, 'We can't give you any information.'"*

- **If patients feel that they are not being listened to, they will likely be less inclined to speak up, to make their needs known and to ask questions about their care; in other words to be actively involved in their own health care.**

> *"I have been here since the 7ᵗʰ and finally got a cup of coffee and my headache went away. The staff told me I should have told them and they would have given it to me right away."*

"I take a lot of medications. So when I was here, I went over the list and questioned a few things because I'm always afraid of reactions. The sense was that they were offended that I was questioning them."

"I felt like I was interrupting them when I asked for help."

"I would ring the bell and they wouldn't come. After I fell out of bed only then I got a lot of attention."

"There were four physicians who visited my wife. One of them was a hospitalist. That individual came in and asked some questions and we asked some questions and it was apparent that she had not read my wife's chart for that admission or the previous ER admission. She was quite upset with my questions and left saying that she had 30+ patients to see and does not have time. I didn't choose her profession and if she doesn't want to do it, she should walk out the door."

"My mother had a tumor. The doctor came out with all the big words and not explaining it so I can understand it. They wanted to operate right away and I told them I wanted a second opinion. The doctor brought in his own second opinion. If there had been a library on site I could have researched all the terms that he was using. I felt that we were rushed into it and had I known then what I know now, she wouldn't have had the operation."

- **For the time that patients are in our care, perhaps one of our most important jobs is equipping them with the information they need to confidently and competently manage their health on their own. This includes providing adequate discharge instructions and information about medications in ways that patients are best able to understand and absorb them. This requires being alert to the sheer amount of information being conveyed at any one time, providing alternative means of communication (verbal, written, experiential) to reinforce key pieces of information, and fostering environments where patients and family members feel comfortable speaking up with their questions and concerns.**

"It was great that the appointments I had to come to were written down."

"I had a ton of meds and they put them on a list at each time I was supposed to take a medication."

"I received great instructions. They took me into the OT kitchen to help me do the things that I would need to do at home."

"The care is great, and the service is outstanding. But sometimes I don't know what I should have asked. I go home and don't feel like I really know what's going on."

"It was total overload, too much at one time, I had to deal with two therapists, billing, my doctor…ten different people telling me ten different things in just 3-4 hours, I didn't remember anything."

"I got a call at home a few days after discharge, and asked why I had a burn on the inside of my wrist, and she never called me back with an answer to that."

"I think with being a family member with older parents there is a lot of stuff that is going on while they are in there that isn't communicated to us. He may have wanted to tell me but didn't have the details so it would be good to have staff tell you."

"The discharge instructions were not the ones reviewed by the doctor, so that the medications he reviewed were not the ones that were in the instructions. Even the pharmacists had different medications listed."

"You have to read the paperwork because I noticed they were supposed to send me home with medication."

"All of these drugs, they give you give you so many side effects that you forget what you are taking them for."

"If I have questions afterwards, it takes forever to get them answered. One of my best friends is a nurse so I call her to ask her what this means."

RESPONSIVENESS

- **Responsiveness to call lights, toileting needs and pain control—or lack thereof—sends powerful messages to patients who are dependent on caregivers to help them meet some of their very basic human needs. The feelings of powerlessness that often accompany illness, injury and hospitalization may be exacerbated when these basic needs are unmet, resulting in the feeling that one's dignity has been neither preserved nor prioritized. Call lights not answered in a timely fashion, even if for a non-emergent request, may suggest to patients that help may not be promptly provided when their need is, in fact, emergent. Furthermore, if patients feel that requesting help is a burden on staff, they will be less inclined to make their needs known and to ask questions about their care, considerably limiting our ability to partner with patients and provide optimal care.**

> *"They don't check on you enough. I wonder how people feel when no one checks on them for an hour or more. It seems like they gather at their station and stay there…I've noticed this a lot. Now they have a button in there that goes off every thirty minutes; someone comes in to press the button and then leaves. They don't check on you—they just leave the room."*

> *"There were two distinct parts to my hospitalization because after I went to my room it all changed. I had a horrible experience at night. There's no compassion, no attention to detail on this medical surgical unit...I felt like a number, and that they were just getting their job done. When they answered my calls, it took a long time and they just said, 'What do you want?' I felt I was annoying them every time."*

> *"I had to call for a bedpan and it took a long time. I said you must be busy and the nurse made a snide comment. These were my down experiences and it felt big at the time."*

> *"Sometimes between when you put your call light on and when they respond can take a while. Many times I had to wait 20-30 minutes to go to the bathroom. I had a hard time getting the help. Then I had to wait for someone to come and get me out of the bathroom. Procedures were done well, but after it was done, there was nobody there."*

> *"The last time I was here when I put on my call light and someone answered they didn't say anything to me, I just heard a click. I have seen a decline in nursing staff giving a rip."*

> *"She finally came and said, 'What do you need?' and I told her I needed to get to the restroom and I needed her to make the beeping stop. And it was like I was really putting her out."*

"I thought maybe I would feel better if I took my shower, so I called for her again and asked for someone to help me. She opened up the shower and threw a gown on the bed and left again."

"You are like a car; they park you here and someone will eventually come and get you."

"The only thing that is a problem is responding when you have to go to the bathroom. When I have to go, I have to go. I pressed the button and waited. That annoyed me."

"I was parched after surgery and lying in my bed and when I asked for something to drink, they gave me a 32 oz cup with a straw and they just left me on my back with the glass and straw and walked out of the room. It ended up dribbling all over me. I felt abandoned and set adrift alone."

"There is a shortage of nurses. I would say especially at night if you turn on your call light it can be 15 minutes before someone answers – between midnight and four in the morning. When you are hurt, even though it may not be a bad hurt, you want someone there to hold your hand. When they hit the call light you could have one person in the whole hospital to answer the call light and find out what the need is. That way you would get someone right away when you call…You would know they are coming and wouldn't just be laying there."

"During the day, the woman who took care of me was a saint. The ones at night were atrocious. They just wouldn't come. They were pumping me through with fluids so I had to go to the bathroom all the time but I couldn't get up so they had to bring a special bottle, and they just wouldn't come. I would watch the clock and it became a joke, when are they going to come. It could go anywhere from an hour to two hours. Whereas during the day, they'd come within two minutes."

"I was told that I was independent, that I had to go to the bathroom by myself. The toilets are too high. Only one time I asked for help and then I ended up wetting myself. I did not get good nursing attitudes."

"The aides aren't really good here. I have dentures and they never helped me brush my teeth. I was here for 3 weeks."

PAIN MANAGEMENT

- **Patients in pain want to know that their pain is being taken seriously, that a plan is in place to manage it, and that staff will adhere to the agreed-upon plan. Beyond being reactively responsive to patients' needs for pain control, patients are looking to staff to proactively manage their pain before it becomes unbearable.**

> *"They changed nurses and I didn't get any pain medication and I had to scream for it—and I have good insurance."*

> *"I don't know what the doctors are thinking sometimes. I'm in pain, but do they think my problem isn't that serious?"*

> *"[I had] to get out of my bed and go to the nurse's desk to ask for something for pain. She said you have to wait two hours and it had been two hours. Another nurse said it has been two hours but this nurse didn't seem happy to get up and get it for me."*

> *"I have an issue with pain medication. When I had my first child (C-section), I woke up numb and didn't realize I was in pain. When I woke up later, I was in terrible pain. On day one and day two after the C-section, I needed pain medication but was told I had to ask for it. The problem was, I was asleep a lot of the time and didn't realize I was going to be in pain when I woke up."*

> *"The pain medication wears off quickly and you don't always get enough. I was given two pills but took only one pill and saved the second knowing I would need it a couple of hours later."*

> *"I also didn't realize how much pain I would be in. I kept telling the nurse that I was in pain and had to keep telling her. After about thirty minutes, she said I needed ibuprofen. She got me some, but I had to keep asking for it every two hours—it wasn't offered to me without me asking."*

> *"The only thing that kind of went bad for me was when I came out from surgery. I have low tolerance for pain. I swear I had the whole floor up because I was yelling so loud. My daughter had been a nurse and they gave me the pain control pump, but it didn't go into me; it was leaking. That was why I was in such terrible pain. After I got my pills, I was fine. But I was so embarrassed because when I'm in pain, I have to yell."*

> *"It was really starting to cause me grief and by mid-afternoon I called her again and said, 'You've got to get me something.' She said, 'Oh…it will get better," and she left. After a while, I called again and told her it wasn't getting better; it was getting worse. She tried to pacify me with another Percocet."*

ENVIRONMENT OF CARE

- **For many patients, a clean hospital is considered a minimum expectation for care. When their expectations for a clean room, clean linens, and a clean bathroom are not met in an environment where hygiene, sterility, infection control and patient safety are paramount, patients are often left questioning the quality of their care.**

  "I had a surgery but it was not that bad. Then one night the IV popped out of my arm all over everything and I am trying to hold it close. That was Friday night. I didn't realize it until I went home Sunday morning that I had the same stained pillow case. The same sheets for two and a half days."

  "During that whole week, I didn't even have my teeth brushed, and even the bloody sheets weren't changed. Can you imagine being there and not feeling well and having that going on?"

  "I didn't get back to the room until 3:00 and the nurse got me up right after and I went into the bathroom and the wastebasket was filled to the top. There was a IV in the sink. I was petrified. That was not a good start."

  "For five days nobody washed my back and I laid in those dirty sheets."

  "I had an NG tube and all the garbage sat in my room for two or three days after they pulled the tube. That was awful. It made me feel ill to see it there in the wastebasket."

  "I think one of the plusses is that this hospital is very clean. That is important to me. That is a plus."

- **A night nurse deeply committed to the values of patient-centered care long before the term rose to prominence once expressed that her most important job was protecting the sleep of her patients. She knew well that rest was restorative, healthful, and in the best interest of her patients. Appreciating these benefits of rest, of course, hardly requires any specialized clinical expertise; patients, too, know inherently that rest is good medicine. Nonetheless, in many of today's hospitals, issues of practicality and convenience trump the benefits of quiet nights conducive to rest.**

  "I noticed the last couple of times I have been in here they have been buffing the floors at two or three in the morning—this was last July."

  "They were coming in and out of my room, and I heard them all night. The bathroom in my room was being used all night by the nursing staff! The toilet flushed, and the water ran all night. I didn't sleep at all. They would close the door only ¾ of the way. They didn't come over to see how I was doing."

"I know everybody who comes in your room comes in for a purpose but you really don't get any rest. They come in at the change of shift and turn on the bright lights to weigh you and get your labs at 5 am. Maybe turn on the lights on low and let you wake up a little bit so it is not so shocking."

"I was in for a catheterization and had quadruple bypass. The room was all right but the room was across from the nurse's station and I think they were playing cards. The door didn't shut all the way and they didn't fix it."

DISCHARGE INSTRUCTIONS

- **For patients, being prepared for discharge means not only being handed a packet of information about their condition and treatment plan, but also being able to plan for their discharge time in order to arrange for transportation, and having a streamlined discharge process in place that enables them to complete any necessary paperwork and have any final exams as efficiently as possible.**

    "I came here by ambulance at 4:00. I could go home the next day. The doctor left orders for someone to sign me out because she had to leave and I waited three hours for someone to come sign me out. My doctor said she was looking for someone to release me because they were waiting for one test to come back. Three times I went out to the nurses station to ask when I was going to go home. That was not a pleasant experience."

    "Discharge could have been better. I wanted to leave before the 24 hours because I wanted to be with my daughter and son at home. They could have had a lot of the discharge done ahead of time so all I needed would be the blood test. I could have gotten the blood test done at 11:30 at night but didn't go home until 1 a.m."

    "The only thing I have to say is when you get discharged it is hard. It is easy to get into the hospital but hard to leave. The doctor said I could leave at 11 in the morning and I didn't get out of here until the afternoon and all I could do was sit there and wait because of paperwork."

- **Of course, though, the information provided to patients upon admission is of the utmost importance. When it is clearly explained and efforts are taken to ensure comprehension, and when this information is conveyed during times when patients and family members are best poised to hear and absorb it, appropriate discharge instructions can be the difference between a patient being re-admitted and managing their care confidently on their own. Patients further confirm the value of discharge phone calls for reinforcing discharge instructions.**

"I received great instructions. They took me into the OT kitchen to help me do the things that I would need to do at home."

"Nothing was addressed for me until about a half hour before I went home and I was still groggy."

"You have to read the paperwork because I noticed they were supposed to send me home with medication."

"It was total overload, too much at one time, I had to deal with two therapists, billing, my doctor…ten different people telling me ten different things in just 3-4 hours. I didn't remember anything."

"At discharge a list of all the medicines I'm on should be given to me. I don't really know what I'm going home on. Maybe they could tell me what I was taking right as they gave it to me."

"I came in with salmonella and they sent me home with something and a day later they confirmed the salmonella and called me to tell me to take some medications. That was a follow-up."

"They made me feel important when they called me at home to see how I was."

PATIENT-CENTERED STRATEGIES FOR HCAHPS IMPROVEMENT

The grid below ties specific practices described in this Guide to specific domains of the HCAHPS survey. However as addressed in Section IV, individual practices, on their own, will not have a long-lasting effect. While short-term improvements in a hospital's performance on individual HCAHPS domains may occur as a result of implementation of these interventions, the improvement will be fleeting without an overarching organizational culture of patient-centered care that is supported by human resources practices, staff education, and leadership engagement.

HCAHPS DOMAIN	PATIENT-CENTERED APPROACHES	PAGE
COMMUNICATION WITH NURSES *HCAHPS Questions:* • During this hospital stay, how often did nurses treat you with courtesy and respect? • During this hospital stay, how often did nurses listen carefully to you? • During this hospital stay, how often did nurses explain things in a way you could understand?	Staff Retreats to sensitize staff to patient experience	44
	Standardized Shift Change	80
	Communication Guidelines	80
	Patient and Family Communication Boards	81
	Questions for Your Doctor or Nurse Notepads	81
	Multicultural Pointing Tool	96
	Plain Language Guidelines	115
	Patient Pathways	115
	Change of Shift Bedside Report	117
	Care Conferences	117
	Interdisciplinary Care Rounds with Family	117
	Hourly Rounding	117
	Shared Medical Record	137
	Patient Progress Notes	138
	Care for the Caregiver Initiatives	195
COMMUNICATION WITH PHYSICIANS *HCAHPS Questions:* • During this hospital stay, how often did doctors treat you with courtesy and respect? • During this hospital stay, how often did doctors listen carefully to you? • During this hospital stay, how often did doctors explain things in a way you could understand?	Physician Retreats	46
	Patient-Centered Care Physician Advisory Council	46
	Physician Aspirations for Practice and Conduct	46
	MD Coach	47
	Questions for Your Doctor or Nurse Notepads	81
	Plain Language Guidelines	115
	Patient Pathways	115
	Care Conferences	117
	Interdisciplinary Care Rounds with Family	117
	Hourly Rounding	117
	Shared Medical Record	137
COMMUNICATION ABOUT MEDICATION *HCAHPS Questions:* • Before giving you new medicine, how often did hospital staff tell you what the medicine was for? • Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?	Self-Medication Policy	92
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MARCH 26, 2008 PICKER/PLANETREE PATIENT-CENTERED CARE LEADERSHIP ROUNDTABLE PARTICIPANT LIST

Melinda Abrams, Senior Program Officer
The Commonwealth Fund

Carrie Brady, Vice President, Quality
Planetree

Patrick Charmel, President and CEO
Griffin Hospital (Derby, CT)

James Conway, Senior Vice President
Institute for Healthcare Improvement

Charles Darby, Former CAHPS Project Officer
Agency for Healthcare Research and Quality

Fred M. DeGrandis, President and CEO
Cleveland Clinic Regional Hospitals

Robert Devermann, MD, Regional Director
of Medical Operations for Central Region,
Aurora Medical Group (Milwaukee, WI)

M. Bridget Duffy, MD, Chief Experience Officer
Cleveland Clinic (Cleveland, OH)

Beth Feldpush, MPH, Senior Associate
Director, Policy
American Hospital Association

Susan B. Frampton, Ph.D., President
Planetree

Rosemary Gibson, Senior Program Officer
Robert Wood Johnson Foundation

Barbara Glickstein, RN, MPH, MS
Public Health Nurse and Broadcast Journalist
Producer and Host, *Healthstyles*, Pacifica Public
Radio; Health Reporter, Martha Stewart Living
Radio, Sirius Satellite

Sara Guastello, Manager, Designation and
Resource Development
Planetree

Richard A. Hachten II, President
Alegent Health (Omaha, NE)

Maria Hale,
Vice President, Patient Advocacy & Service Excellence
Northern Westchester Hospital (Mount Kisco, NY)

Marcia K. Hall, CEO
Sharp Coronado Hospital (Coronado, CA)

Lucile Hanscom, Executive Director
Picker Institute

Sheryl Horowitz, PhD, Director of Research &
Evaluation
Planetree

Sir Donald Irvine
Picker Institute

Beverley Johnson, President and CEO
Institute for Family-Centered Care

Ken Mizrach, Director
VA New Jersey Health Care System

Wendy Peche, Director
Employee and Organization Development
Aurora Health Care (Milwaukee, WI)

Joel Seligman, President and CEO
Northern Westchester Hospital (Mount Kisco, NY)

Dale Shaller, Principal, Shaller Consulting;
Managing Director, National CAHPS®
Benchmarking Database

Susan Bennett Smith, MSN, RN, CNA-BC
Interim VP of Human Resources
Director of Education/Staff Development
Planetree Coordinator
Fauquier Health System (Warrenton, VA)

Susan Stone PhD, RN, Chief Nursing Officer and
Chief Operations Officer
Sharp Coronado Hospital (Coronado, CA)

Raymond G. Troiano, MD, Vice President
and Administrator
Sentara Virginia Beach General Hospital
(Virginia Beach, VA)

Carol Wahl, Vice President of Patient Care
Services
Good Samaritan Hospital (Kearney, NE)

J. Mark Waxman
Picker Institute

PRACTICES AND IMPLEMENTATION TOOLS, AT A GLANCE

PLANETREE PROJECT TEAM

Susan Frampton
President
203-732-1365
sframpton@planetree.org

Sara Guastello
Manager, Designation and Resource Development
203-732-7171
sguastello@planetree.org

Carrie Brady
Vice President, Quality
203-732-1381
cbrady@planetree.org

Sheryl Horowitz
Director of Research and Evaluation
203-732-1379
shorowitz@planetree.org

PICKER/PLANETREE FELLOWS

Funded by the Picker Institute, the Picker/Planetree Fellowship was created as an opportunity to engage health care professionals with first-hand experience implementing patient-centered care in the development of this Improvement Guide. The three fellows were selected from among the most accomplished patient-centered hospitals in the country, as evidenced by their having been awarded Planetree's Patient-Centered Hospital Designation. The 2008 Picker/Planetree Fellows are:

Maria Hale
VP, Patient Advocacy and Service Excellence
Northern Westchester Hospital (Mount Kisco, NY)

Susan Bennett Smith, MSN, RN, CNA-BC
Interim VP of Human Resources
Director of Education/Staff Development
Planetree Coordinator
Fauquier Health System (Warrenton, VA)

Susan Stone, PhD, RN
Chief Nurse and Operating Officer
Sharp Coronado Hospital (Coronado, CA)