



International
Global Centre for Nursing Executives

Elevating the Patient Experience

Advancing Towards Person-Centred Care

Global Centre for Nursing Executives

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Available Within Your Global Centre for Nursing Executives Membership

In recent years, the Global Centre for Nursing Executives has developed numerous resources to assist nursing leaders improve the patient experience. Select resources are shown here. All resources are available in unlimited quantities through Global Centre for Nursing Executives.

Elevating the Patient Experience



The Patient Experience Toolkit *Empowering the Frontline to Achieve and Sustain High Patient Satisfaction*

- Cultivating Caregiver Empathy
- Overcoming Universal Process Barriers to a Patient- and Family-Centred Experience
- Diagnosing Institution-Specific Process Barriers



The Family as Patient Care Partner *Leveraging Family Involvement to Improve Quality, Safety, and Satisfaction*

- Understanding the Family Perspective
- Hardwiring Family Involvement
- Enfranchising Clinical Staff
- Fostering Care Collaboration

To access these resources, visit:

[advisory.com/gcne/
PEToolkit](http://advisory.com/gcne/PEToolkit)



[advisory.com/gcne/
FamilyCarePartner](http://advisory.com/gcne/FamilyCarePartner)



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In addition to the resources available through the Global Centre for Nursing Executives membership, The Advisory Board Company offers a variety of leadership development services through our Talent Development programs.

Build Culture, Expand Capacity, and Elevate Outcomes

Through our Service Performance Acceleration program, the Advisory Board's Talent Development division mobilises staff to meet executive-defined patient experience performance objectives, and we equip participants to move beyond one-off success and achieve meaningful, sustainable long-term results. To date, we have collaborated on more than 4,000 employee-led improvement projects.

Cultivate Service Excellence

Having a fundamental appreciation of patients' actual experience can help hospital staff identify opportunities to better meet patients' physical or emotional needs. We provide participants in our Service Performance Acceleration series with the tools and skills to truly "walk in the patient's slippers."

We help participants map the patient experience to understand not just patients' interactions with hospital staff but their entire encounter with the health system—when they are alone, uncomfortable, frightened, or confused. This patient map becomes the starting point from which participants design a project to improve the patient experience.

We focus on service skills that staff need to make their projects successful, as well as organisational barriers that could threaten the long-term viability of the improvement. Finally, we help participants make sure that morale and motivation do not undermine service excellence, particularly in the clinical setting, where compassion fatigue can be an issue.

Moving Beyond Metrics—Creating Exceptional "Five-Star" Experiences

Too often, service improvement efforts focus solely on boosting satisfaction survey scores. While that is important, we help participants take a more expansive approach to service excellence—one that actually anticipates, and often exceeds, the patient's expectations, rather than just reacting to service failures. We help push participants beyond the usual thinking to design improvement projects aimed at delivering "five-star" experiences that drive the ultimate indicator of satisfaction: patients who would recommend the hospital to friends and loved ones.

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3,100⁺

Serving an unparalleled membership of 3,100+ hospitals and health care organisations

1,750⁺

Employing 1,750+ health care professionals

1,200⁺

Leading provider of performance technologies, now in 1,200+ hospitals

RESEARCH AND INSIGHTS	PERFORMANCE TECHNOLOGIES	CONSULTING AND MANAGEMENT	TALENT DEVELOPMENT
<p><i>Memberships Offering Strategic Guidance and Actionable Insights</i></p> <ul style="list-style-type: none"> • Dedicated to the most pressing issues and concerns in health care • 300+ industry experts on call • 200+ customisable forecasting and decision-support tools 	<p><i>Global Peer Collaboratives Powered by Web-Based Analytic Platforms</i></p> <ul style="list-style-type: none"> • Millions of admissions flow through our technology platforms • 1.1 million user sessions annually • Key challenges addressed: surgical efficiency, supply costs, and emergency department efficiency 	<p><i>Seasoned, Hands-On Support and Practice Management Services</i></p> <ul style="list-style-type: none"> • 1,800+ years of “operator” experience in hospital and doctor surgeries • Principal practice areas: hospital-doctor alignment, care transformation, surgery department optimisation • Range of engagements from strategy/diagnostic to best practice installation to interim management 	<p><i>Partnering to Drive Workforce Impact and Engagement</i></p> <ul style="list-style-type: none"> • Impacted the achievement of 69,000+ executives, doctors, clinical leaders, and managers • 16,000+ outcomes-driven workshops tailored to partners’ specific needs <p><i>Survey Solutions</i></p> <ul style="list-style-type: none"> • Customised strategies for improving employee and doctor engagement
<p>140,000⁺ health care leaders served</p>	<p>\$500⁺ million in realised value per year</p>	<p>1,150⁺ engagements completed</p>	<p>5,000⁺ employee-led improvement projects</p>

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HEALTH CARE EXECUTIVE BOARD <i>Serving Chief Executives, Strategy and Business Leaders</i>	<i>Strategy and Business Leadership for Enduring Success</i> Research and insights for chief executive officers and other senior executives to support their efforts to guide their organisations to sustainable excellence and prosperity. <ul style="list-style-type: none"> • Strategy and planning amid disruptive change • Maximising value from clinical innovations • Strengthening financial management • Marketing to doctors and patients • Increasing staff productivity and engagement • Providing leadership for organisational performance
GLOBAL CENTRE FOR NURSING EXECUTIVES <i>Serving Chief Nursing Executives and their Senior Teams</i>	<i>Building the World Class Nursing Organisation</i> Research for an international network of nursing executives charged with leading the largest and most critical element of the health care workforce in a time of great challenges. <ul style="list-style-type: none"> • Achieving excellence in care quality and safety • Improving the patient experience • Recruiting and retaining high quality nurses • Managing nursing diversity and culture • Developing next-generation nursing leaders • Enhancing nursing staff efficiency and productivity
GLOBAL eHEALTH EXECUTIVE COUNCIL <i>Serving Chief Executives and Chief Information Officers</i>	<i>IT Strategy and Planning</i> Research and analysis to help hospital information technology (IT) departments effectively plan and implement key initiatives and achieve organisational strategic IT goals. <ul style="list-style-type: none"> • Improving governance and management of IT • Leveraging IT to improve care quality • Achieving return on IT investments • Engaging doctors in IT adoption • Analysing vendors, applications, and industry trends • Optimising business intelligence and executive data strategy
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About this Publication

Also Available Online

This research is also available in a web-based format, which you can access by visiting **advisory.com/gcne/patientexperience**. For your convenience, links to specific practices, tools and related resources are embedded throughout this publication.

You may also view the online version of the study on your mobile device at any time by scanning the image below.



A Guide to Tactic Grading

To assist our members in prioritising implementation of the best practices profiled in this publication, the Global Centre for Nursing Executives research team has evaluated each practice along the two vectors described below:

- Practice Impact** refers to the potential for the strategy to elevate the patient experience.
- Hospital Effort** refers to the degree of resource investment (financial, time or otherwise) required for implementation.

For a brief explanation of how each of these grades is determined, reference the key below.

Practice Impact	Hospital Effort
A – Very high impact	A – Minimal resource investment
B – Moderately high impact	B – Moderate resource investment
C – Relatively low impact	C – Significant resource investment

QUESTIONS?

To obtain more information about this research, or for any other questions regarding the Global Centre for Nursing Executives please do not hesitate to contact us at any time at **gcne@advisory.com**.

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Executive Summary

A Growing Focus on Patient-Centred Care

While delivering patient- and family-centred care has long been a priority in nursing, there is now widespread interest in the topic across health care delivery systems around the world. Rising consumer expectations, significant demographic shifts and an increase in health care performance transparency are driving this ambition to the top of the hospital and health system executive agenda. Yet despite renewed resource investment and interest in this area, many institutions find meaningful, sustainable improvement difficult to achieve.

Current Efforts Falling Short

Global Centre research reveals that institutions often adopt one of two targeted approaches to elevating the patient experience: focusing on specific patient experience survey domains where the organisation is performing poorly, or directing resources to underperforming wards or clinical areas. This largely reactive approach to performance improvement fails to take into account significant barriers preventing staff from consistently delivering a high-quality, holistic patient and family experience in the current environment. As a result, organisations achieve marginal gains in specific survey domains or on specific wards, but these advances are difficult to sustain over time. Overall, leaders who pursue this targeted approach typically witness no long-term net change in the quality of patient and family experience within their institutions.

Embracing a Proactive Strategy

In contrast to targeting efforts at specific areas of weakness, developing a culture of inclusive, compassionate, patient- and family-oriented care equips the organisation to not only provide high quality patient experiences right now, but prepare itself for truly partnering with patients, families and the public into the future.

The Global Centre recommends that executives start to build this culture by embracing a proactive strategy aimed at addressing the most significant barriers to patient-centred care delivery. This requires focusing organisational effort in a select few areas:

- 1. Reinventing Compassionate Caregiving:** Provide tools to support nurses in fulfilling their duty to deliver empathetic, compassionate, respectful care despite the demands of the current environment.
 - Set Patient-Centred Expectations: Prompt frontline staff to articulate what patient-centred care looks like in their local areas to establish a standard of behaviour and help nurses hold themselves and their peers accountable to that standard.
 - Connect Nurses to Patient Perspective: Cultivate caregiver compassion and empathy by providing consistent opportunities for staff to better understand the patient experience and develop relationships with their individual patients.
- 2. Promoting Patient, Family and Consumer Involvement:** Ignite the culture shift necessary to achieve true partnership with patients by actively involving patients, families and consumers in all levels of decision making.
 - Structure Participation at the Bedside: Ensure patients and families have ample knowledge and opportunity to take an active role in their care across the continuum.
 - Embed Consumers in Organisational Planning: Invite consumer participation in decision making at the highest echelons of the institution.



Global Centre for Nursing Executives Essay

The Shifting Paradigm

Ensuring a positive experience for patients and families has always been a priority for nursing leaders. But in recent years, the concept of patient- or person- centred care has been receiving broader and more intense international attention.

The proliferation of articles, books, and conferences on patient-centred care demonstrate a heightened level of interest in this issue among stakeholders across all health care settings and disciplines.

A Groundswell of Interest in Patient-Centred Care

Australian Healthcare Collaboration
The GREAT Healthcare Challenge: Achieving Patient-Centred Care

European Network on Patient Empowerment
European Conference on Patient Empowerment

Institute for Patient and Family Centered Care
5th Annual International Patient and Family-Centered Care Conference

The King's Fund
Transforming Patient Experience Annual Conference

Planetree
Planetree Annual Conference: the Longest Running International Conference on Patient Centred Care



The Future of Health Care Delivery

"Hospitals that respond to their consumers with personalised care, high-quality care and service excellence are poised to thrive in this era of health care consumerism. In essence, they differentiate themselves by building a brand identity around a patient-centred approach to care that proactively addresses health care consumers' increasingly high expectations."

Charmel and Frampton, 2008

While there is no single, internationally recognised definition of patient-centred care, literature analysis does reveal a consensus around the drivers of a positive patient experience.

This, in turn, informs the parameters around which an organisation's ability to *deliver* a positive patient experience depends.

The dimensions of patient-centred care listed here can be considered widely applicable to a range of patient conditions as well as to both acute and non-acute sectors. The act of delivering care in line with these six dimensions—consistently and to every patient in every interaction—is what this study will refer to as patient- or person-centred care.

Defining the Person-Centred Ambition

Institute of Medicine Dimensions of Patient-Centred Care

- | | |
|---|---|
| 1 Respect for patient values, preferences and expressed needs | 4 Information, communication and education |
| 2 Coordination and integration of care | 5 Emotional support, relieving fear and anxiety |
| 3 Physical comfort | 6 Involvement of family and friends |



Framework Universally Applicable

"We know 'what matters most' to the majority of patients from a combination of a wide-range of existing studies...A generic framework can be applied to a wide range of conditions and treatments; for example, both the Institute of Medicine and Picker frameworks are broadly appropriate for 'what matters most' to patients in both acute and non-acute sectors."

Robert and Cornwell 2011

Source: Charmel and Frampton, "Building the Business Case for Patient-Centred Care," *Healthcare Financial Management* March 2008; Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, D.C.: National Academies Press, 2001); Robert & Cornwell What Matters to Patients? *Developing the Evidence Base for Improving and Measuring Patient Experience*, NHS Institute for Innovation and Improvement 2011; Global Centre for Nursing Executives interviews and analysis.

The current high degree of interest among health care leaders in delivering patient-centred care comes as no surprise given the numerous benefits associated with this approach. Beyond improving patient and family satisfaction, literature supports a number of economic, operational, quality and workforce-related advantages to the successful practice of patient-centred care.

To view a full list of references supporting the benefits of patient-centred care, access the study Appendix.

In addition to widespread recognition of the economic and care quality benefits of patient-centred care, there are three major trends driving this priority to the top of the organisational agenda.

First is rising consumer expectations. Consumers in today's society are accustomed to a certain level of service and a high degree of power in deciding what they want and how they want it. Unlike their more passive predecessors, modern patients enter health care interactions armed with a great deal of information.

Furthermore, they are unwilling to accept the "clinician knows best" approach of the past. Overall, patients (and perhaps more importantly, their families) are becoming increasingly vocal and demanding about the standard of care.

Seemingly Undeniable Advantages

Benefits of Patient-Centred Care Delivery



Enhanced Operational Efficiency

- Length of stay decreased
- Improved care coordination, discharge planning



Staff Retention

- Staff engagement, satisfaction increased
- Improved ward culture, teamwork



Improved Quality and Safety Outcomes

- Reduction in adverse events
- Decreased mortality rates
- Increased quality of life post-discharge



Appropriate Resource Utilisation

- Lessens demand for specialty services
- Reduction in readmission rates



Not Just Platitudes

"The elevation of the patient to partner is not a ceremonial title bestowed for a 'feel good' moment, but has significant implications for the quality and safety of patient care."

The Joint Commission, 2008

Trend #1: Rising Consumer Expectations

Patient/Family Characteristics

Past

- Passive, placing high degree of trust in caregivers' judgment
- Limited understanding of their condition, treatment options, other aspects of care
- Grateful for health care services provided
- Unlikely to complain, hesitant to voice needs, requests

Present and Future

- Seeks involvement and enfranchisement in decision-making
- More educated about condition, options and looking for additional information
- Seeking high quality services, interactions in health care
- Vocal, willing to raise concerns



Consumerism Shaping Health Care Industry

"The current health care consumer is better educated and the best informed it has ever been. Consumers demand that the service industries accommodate their busy lifestyles and fulfill their need for information. Health care organizations must address those aspects of service that consumers most readily appreciate...Without a doubt, consumerism will have a significant impact on shaping the health care industry as it has had on all other aspects of business."

S.S. Wadhwa, "Customer Satisfaction and Health Care Delivery Systems: Commentary with Australian Bias"
Internet Journal of Health, 2002

Source: S.S. Wadhwa, "Customer Satisfaction and Health Care Delivery Systems: Commentary with Australian Bias," *Internet Journal of Health*, 2002; Global Centre for Nursing Executives interviews and analysis..

The second trend relates to patient demographics. Populations in developed countries worldwide are getting older and sicker. The World Health Organization reports that the number of people aged 80 years will almost quadruple to 295 million between now and 2050.

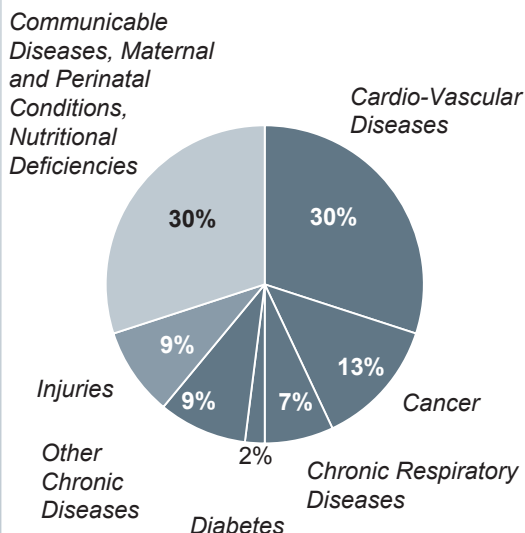
Probably even more important is the rise of chronic disease related not only to ageing but also to advances in medical care, with many patients now presenting with not just one, but often two or more comorbidities.

Health care leaders are increasingly recognising that the system in its current form, with an emphasis on acute care and weak capacity for supporting long-term condition management, is simply not equipped to address this burden without significant changes to care delivery.

Trend #2: Patient Demographic Shifts

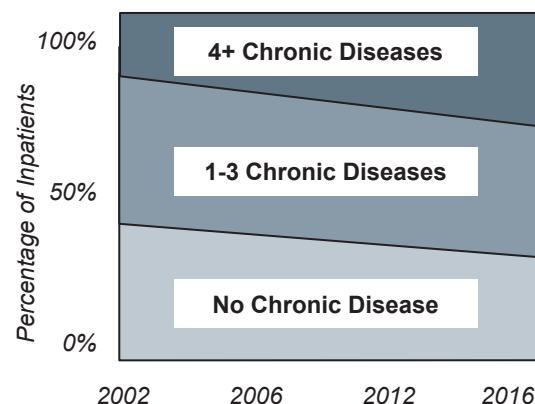
Chronic Disease a Global Phenomenon

Projected Main Causes of Death Worldwide
All Ages, 2005



Comorbidity Breakdown of US Inpatient Admissions

2002–2016



The complex patient is at the centre of an intricate array of interventions within the current acute-focused and disparate delivery system.

Effectively managing these patients will require a different approach to care on the part of each individual provider within this web.

Health systems' ability to meet the needs of older, sicker patients with limited resources also means that patients themselves have to assume greater responsibility for their own care. Organisations will thus increasingly be required to centre care around individual patients, taking into account their unique needs, coordinating their care and preparing them to manage their conditions.

New Patient Demands New Care Model

Patient well connected with community services to support self-management

Specialist coordinates with primary care doctor, sees patient annually for preventive treatment, diagnostic tests

Home health nurse assesses compliance with medication recommendation, determines patient ability to self-manage care

GP creates customised care plan for patient based on mix of chronic diseases to reduce acute episodes

Discharge education provided near conclusion of inpatient episode ensures comprehensive understanding by patient, family of patient self-care instructions

Pharmacist explains side effects of lifestyle medications, tracks patient utilisation

Patients and carers understand self-care to allow for continued living at home

Source: Ekinci O, "Getting to the Heart of Things", 20 Aug 2010, *European Hospital*; World Health Organisation (WHO), "Preventing Chronic Diseases: A Vital Investment," 2005; Thorpe K, Howard D, "The Rise in Spending Among Medicare Beneficiaries: The Role of Chronic Disease Prevalence and Changes in Treatment Intensity," *Health Affairs*, September-October 2006, w378-w388; Innovations Center Futures Database; Global Centre for Nursing Executives interviews and analysis.

Finally, all of these changes are occurring in an environment where hospital and health care performance is under more scrutiny than ever before. Both the media and government stakeholders are taking a closer look at indicators of quality, safety and efficiency in the health sector.

Information on hospital performance against these indicators is becoming increasingly transparent to the public through the media and other sources.

Trend #3: Increased Scrutiny on Hospital Performance

The New Zealand Herald
Doctor made patient feel like 'a piece of rubbish'

Flanders News
Wrong diagnosis cost hospital 400,000 euros

The Telegraph
'Cruel and Neglectful' care of one million NHS patients exposed

Selected National Hospital Quality Indicator Projects

Country	National Quality Indicator
Australia	National Indicators of Safety and Quality
Canada	Canadian Hospital Reporting Project
England	NHS Choices
Germany	Deutsches Krankenhaus Verzeichnis
Netherlands	Zichtbare Zorg
New Zealand	National Quality Improvement Programme
United States	Hospital Compare

Governments Incorporating Patient-Centrism into Policy and Targets

This broader trend toward greater transparency in health care is contributing to a growing focus on patient experience measurement and reporting around the world.

In some countries, governments are taking this specific priority a step further, actively promoting this priority by establishing incentive structures related to performance on patient-centred care evaluations. In the US and the UK, for example, hospital performance on patient experience surveys is tied to financial reimbursement schemes. In other countries, patient-centred care is increasingly being incorporated into accreditation requirements for health care organisations.

UK: NHS England Operating Framework: informs CQUIN¹ targets; financially rewards high performance related to patient experience measures

US: Affordable Care Act: value-based purchasing provision ties public reimbursement to HCAHPS² scores

Scotland: National Quality Strategy: prioritises three overarching quality ambitions: person-centred, safe and effective care

Finland: Health Care Act 2011: promotes quality, safety in health care, health promotion and consumer choice; Empowers patients to make informed choices about their health care providers

Netherlands: Health Care Market Regulation Act 2006: Increases consumer choice in health care market; drives measurement of consumer assessment of care through CQI⁵

New Zealand: HQSC⁴ Partners in Care program provides guidance for involving consumers as partners in health policy, planning, and services

Australia: ACSQHC³ 10 National Safety and Quality Health Service Standards include "Partnering with consumers" standard; health care providers required to meet standards for accreditation; recent creation of National Health and Hospitals Performance Authority

1) Commissioning for Quality and Innovation
2) Hospital Consumer Assessment of Healthcare Providers and Systems
3) Australian Commission on Safety and Quality in Health Care
4) Health Quality and Safety Commission New Zealand
5) Consumer Quality Index

Source: Lundy, S. "Doctor makes patient feel like 'a piece of rubbish,'" *The New Zealand Herald*, 2 April 2012; Smith, R. "Cruel and Neglectful" care of one million NHS patients exposed," *The Telegraph* 27 August 2009; "Wrong diagnosis costs hospital 400,000 euros" *Flanders News* 9 December 2010; UK Department of Health, www.dh.gov.uk; Hospital Care Quality and Information from the Patient Perspective, <http://www.hcahpsonline.org/home.aspx>; Australian Commission on Safety and Quality in Health Care, <http://www.safetyandquality.gov.au/>; Health Quality & Safety Commission, <http://www.hqsc.govt.nz/>; Global Centre for Nursing Executives interviews and analysis.

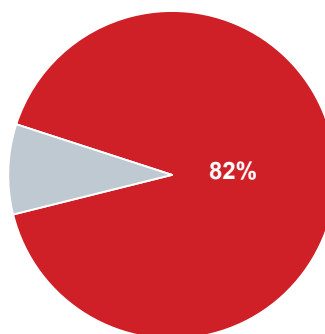
These three trends—rising expectations on the part of consumers, ageing populations and growing prevalence of chronic disease, and increased performance scrutiny and transparency in health care—have resulted in the topic of patient experience rising in importance for health care organisations around the world.

Results from the Global Centre's 2012 Patient Experience Research Survey indicate that for 82% of nursing leaders surveyed, improving patient experience was one of the top three strategic priorities for their organisation. For over one-third of respondents, improving the patient experience was the number one priority.

Rising to the Top of the Organisation-wide Agenda

Percentage of Global¹ Nursing Leaders Reporting Patient Experience Top Three Strategic Priority for Their Organisation

n = 407

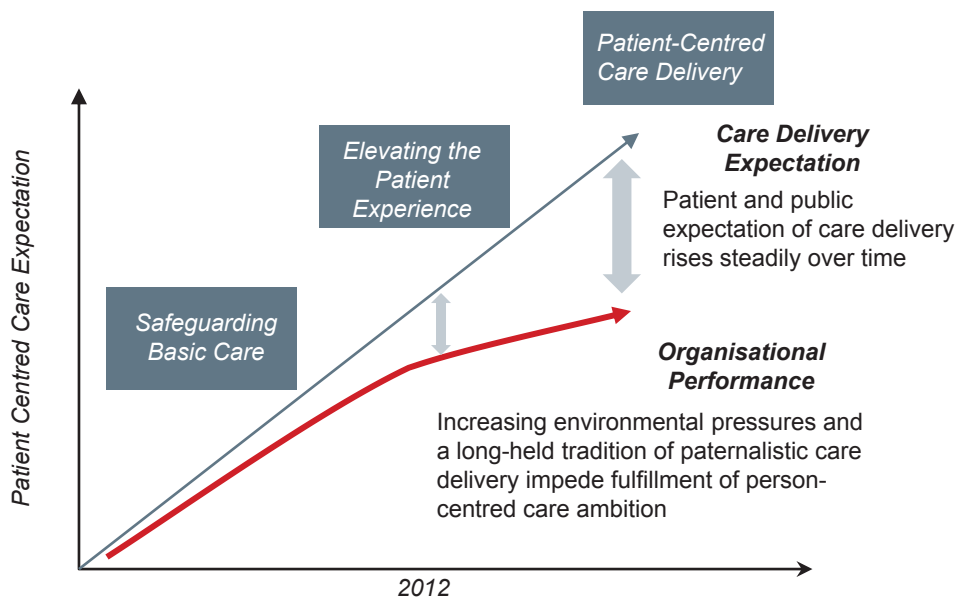


While the imperative to elevate the patient experience falls largely on nursing's shoulders, the gap between expectations and performance only appears set to widen.

The nature of the modern care delivery environment, characterised by lean staffing levels, high patient acuity and low length of stay inhibits frontline staff from consistently delivering a holistic, high-quality experience for all patients.

As a result, many organisations struggle to keep pace with *current* standards regarding a positive patient experience—let alone feel equipped to meet the expectations of the future. As these expectations continue to rise and the care delivery environment becomes increasingly complex, the gap will widen between the demand for high-quality patient experiences and organisations' ability to deliver.

The Task Ahead



1) Member responses from Europe, United Kingdom and Australasia.

Source: Global Centre for Nursing Executives 2012 Patient Experience Survey; Global Centre for Nursing Executives interviews and analysis.

To close this gap, health care organisations typically take one of two targeted approaches to improvement.

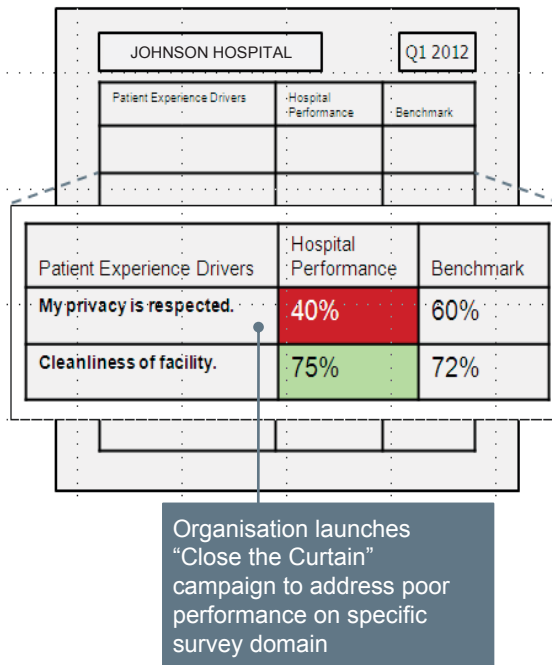
First, for those who are consistently measuring patient experience, many target a specific domain of their measurement tool where there is an identified problem. An example of a tactic commonly used in response to poor survey results in the domain of patient privacy, for example, could be having nurses always say aloud, "I am closing this curtain for your privacy," each time they close a curtain.

The second approach is to identify the *wards or units* that are not performing well and target them for improvement. This often involves the development of task forces and increased education, as well as general enhanced scrutiny on that particular ward's performance.

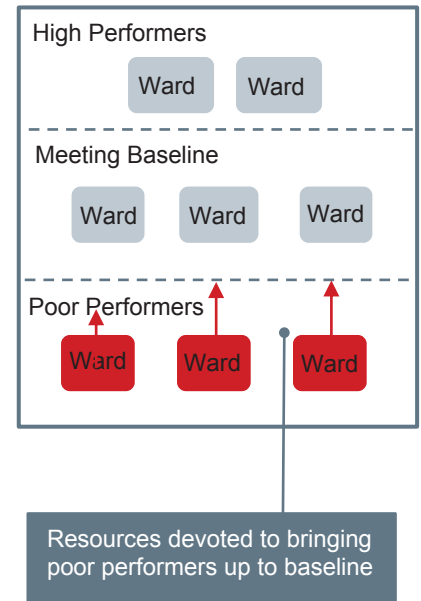
While these approaches appear efficient from a resource utilisation standpoint, many organisations are finding they do not yield long-term, sustainable improvements. Performance often advances in the short term, but progress inevitably wanes as processes return to normal and staff continue to face the same challenges that impede high performance in the first instance.

Common Approaches to Improving Performance

Focusing on Discrete Survey Domains

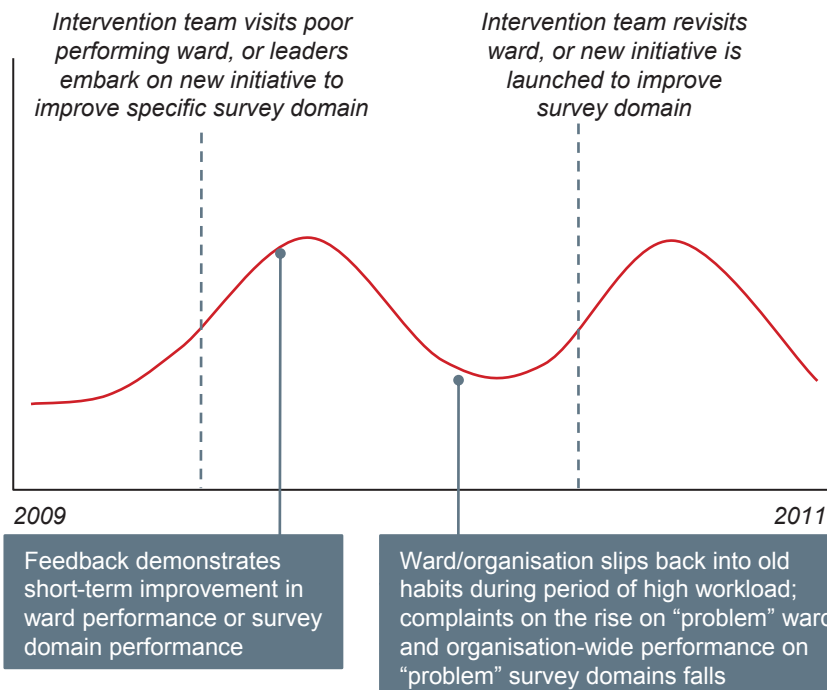


Isolating Poor Performers



Reactive Interventions Struggle to Make Lasting Gains

Typical Organisational Patient Experience Trend



Targeted approaches fail because they typically do not address two underlying barriers to progress that are impacting all clinical areas within an organisation. First, the nursing care environment is changing. High churn, a complex patient population, staffing reductions and evolving responsibilities of the modern nurse often drive nurses to become highly task oriented. In addition, these realities mean they are spending limited time interacting with patients at the bedside. This has negative consequences for our nurses' ability to treat patients with compassion and empathy, get to know them as individuals and respond to their non-clinical needs.

Second, the standard of involvement and partnership with patients and families currently demanded is, in many ways, relatively new for most care providers. A longstanding tradition of more paternalistic care delivery—driven by clinician needs, values, and opinions rather than patients'—inhibits organisations from inviting the level of participation from consumers that will be demanded in the future.

Facing Significant Barriers to Progress

Changes in Nursing Care Environment



- Reduced patient length of stay, increased “churn” of patients through ward environment due to advances in treatment, pressures to improve patient flow
- Ageing and increasingly acute/complex patient population
- Registered nurses taking on higher-level tasks
- Increasing protocolisation, evidence-based guidelines to improve quality
- Increased nursing documentation
- Lean staffing and skill mix adjustments



Nurse compassion, empathy towards patients getting lost in a highly protocolised, pressurised environment

Tradition of Paternalistic Care Delivery



- Involvement of patient and families seen as an additive burden to workflow
- Concerns raised about privacy, confidentiality
- Challenges tradition of paternalistic delivery, providers value “ownership of patient care”
- Lack of confidence in patients' ability to meaningfully participate
- Fear of excessive, unrealistic patient demands



Caregivers hesitant to involve patients and families on their own, need structured opportunities to do so

To make sustainable progress in this area, the Global Centre for Nursing Executives recommends that nursing leaders develop a proactive strategy aimed at directly addressing these barriers to improvement.

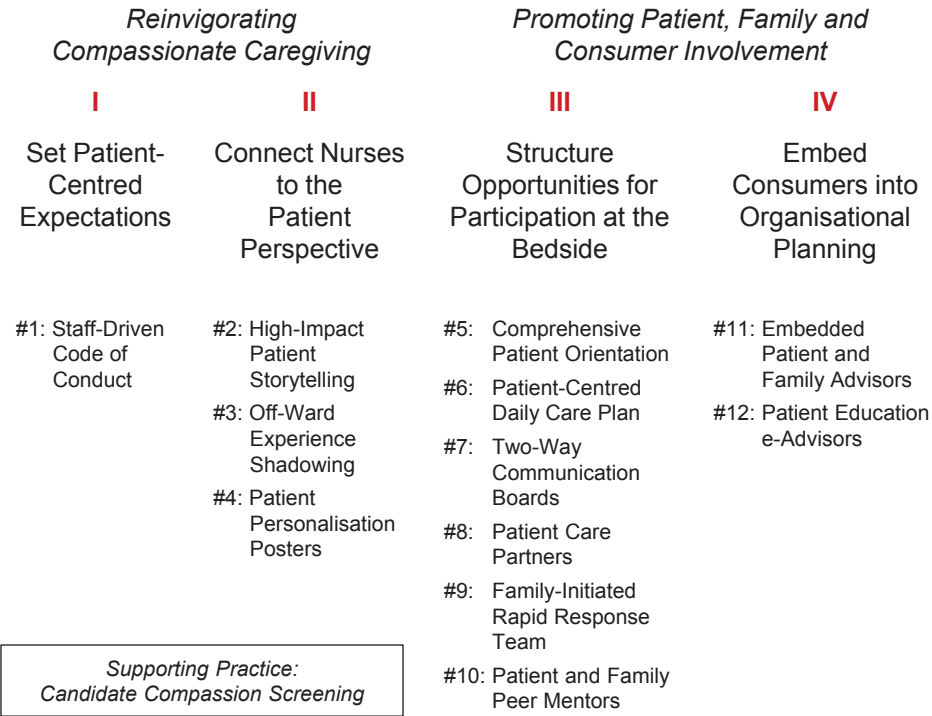
First, organisations must prompt nurses to display empathy and compassion in their interactions with patients and their families despite the day-to-day realities of the busy, complex nursing environment. To do this, organisations must set clearer expectations regarding patient-centred behaviour and enable frontline nurses to hold themselves and their peers accountable to this standard. Furthermore, providing opportunities for nurses to understand the patient perspective and get to know their individual patients helps frontline staff deliver care in a more compassionate manner.

Second, leaders need to provide staff with the tools and opportunities to better inform and involve patients and families at all levels of health care decision making.

By structuring opportunities for patients and families to play a greater in a non-threatening fashion, leaders can start to acclimate their staff to a “partnership” approach to care. Furthermore, embedding patient, family, and consumer representatives into organisation-wide decision making reinforces the commitment to patient-centred care. Together, these strategies promote the culture shift necessary to achieve genuine partnership at all levels: from the bedside to the boardroom.

By implementing tactics to reinvigorate compassionate caregiving and promote patient, family, and consumer involvement within their organisations, health care executives will establish a strong foundation to meet the standard of care—both now and into the future.

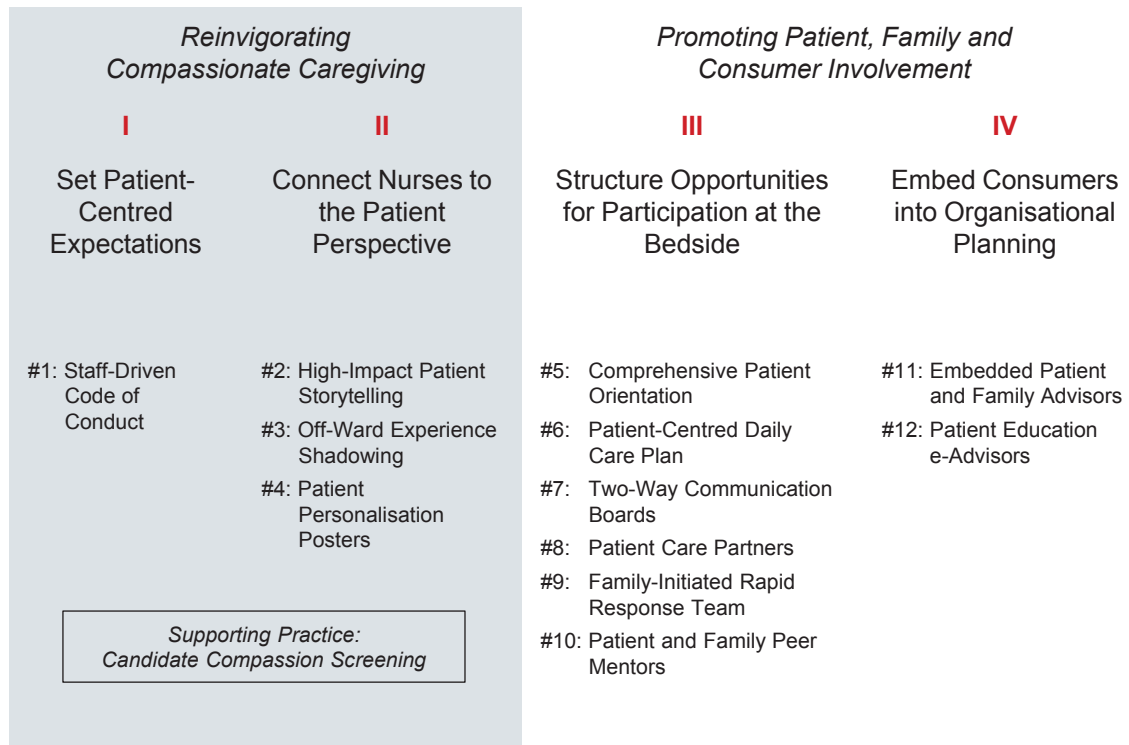
Elevating the Patient Experience: Advancing Towards Person-Centred Care



Source: Global Centre for Nursing Executives interviews and analysis.



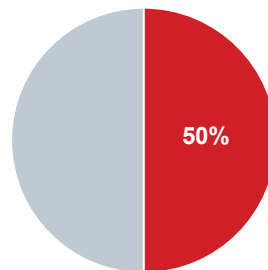
Elevating the Patient Experience: Advancing Towards Person-Centred Care



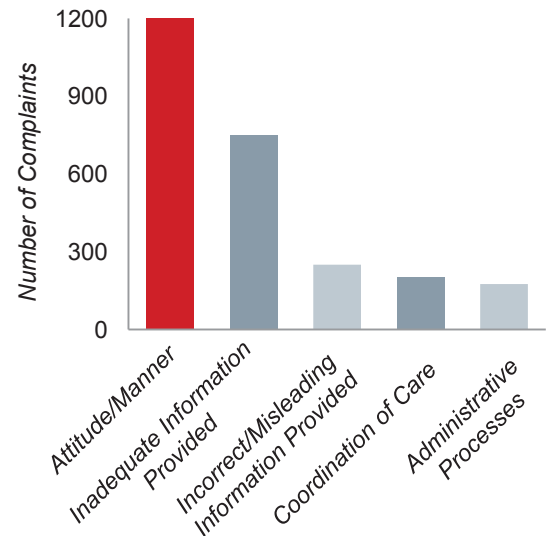
Being treated with compassion and empathy is extremely important to patients, but all too often, attitudes and behaviours of staff fail to meet the standard of care patients expect and deserve. In fact, one of the most significant sources of patient and family complaints is the perceived negative attitude and behaviour of staff members.

Forgetting the “Art” of Caring

Percentage of NHS Complaints to Ombudsman Related to Staff Attitudes, Behaviours and Communication



Topic of Complaints to Australian Health Commissioners

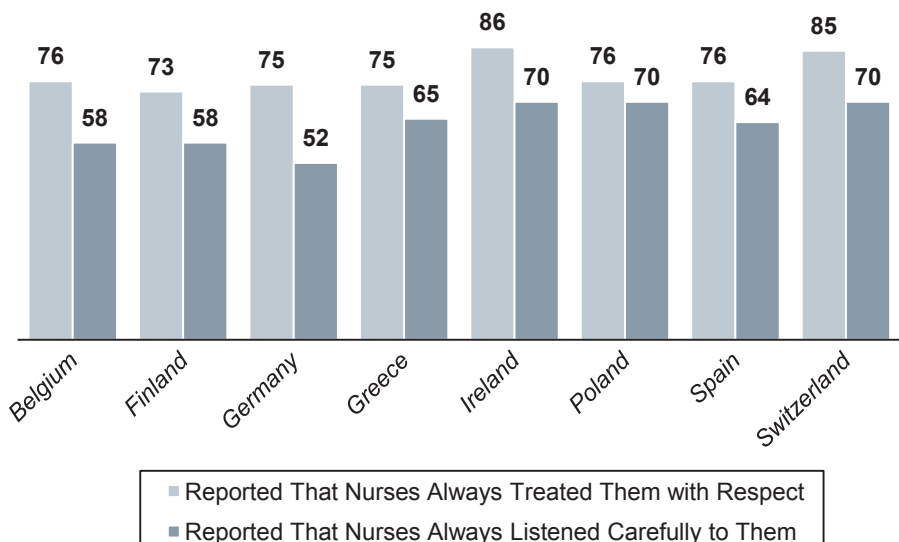


In many of the eight countries surveyed in a study published in the *British Medical Journal* in March 2012, nearly 1 in 4 patients report that nurses do *not* always treat them with respect. Similarly, over one-third of patients report that nurses do not always listen carefully to them.

The non-clinical, caring aspect of a nurse's role is, in many ways, just as important as his or her clinical or technical role. But unfortunately, staff members often neglect some of the most basic elements of this responsibility—such as always treating patients with respect—in their daily practice.

Percentage of Patients Reporting Outcomes on Measures Related to Nurse Compassion

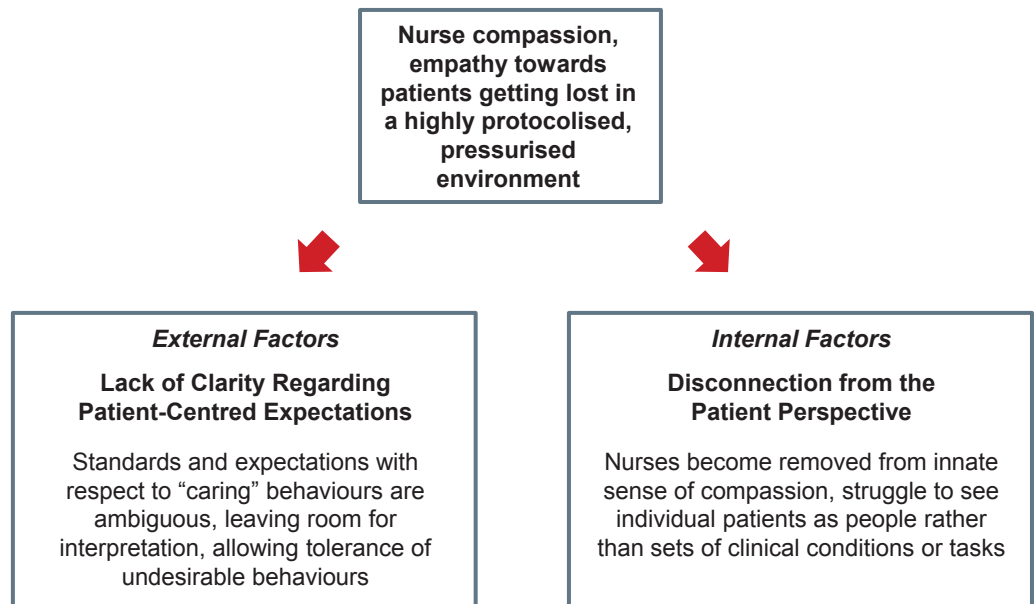
n=11,318



Source: Francis, Robert, *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009*, February 2010; Australian Commission on Safety and Quality in Health Care. *Windows into Safety and Quality in Health Care 2009*. Sydney: ACSQHC, 2009: 42; "Patient safety, satisfaction, and Quality of Hospital Care: Cross Sectional Surveys of Nurses and Patients in 12 Countries in Europe and the United States" *British Medical Journal*, 20 March 2012; Global Centre for Nursing Executives interviews and analysis.

Organisations can leverage two critical opportunities for reinvigorating compassionate caregiving and positively inflecting the attitude and behaviour of staff. First, applying external pressure by setting clear expectations for a high standard of compassionate care. Second, cultivating staff members' innate sense of compassion by providing them with opportunities to connect to the patient perspective.

Reinvigorating Compassionate Caregiving





Reinvigorating Compassionate Caregiving

I

Set Patient-Centred Expectations

#1: Staff-Driven Code of Conduct

II

Connect Nurses to the Patient Perspective

#2: High-Impact Patient Storytelling
#3: Off-Ward Experience Shadowing
#4: Patient Personalisation Posters

Supporting Practice: Candidate Compassion Screening

Practice #1: Staff-Driven Code of Conduct

— Practice in Brief —

Frontline staff develop and commit to a discrete list of specific, actionable behaviours aimed at raising the standard of care on their wards.

Rationale

Leaders typically establish an organisational vision for patient-centred care and communicate this at a high level, but the ambition is rarely made meaningful for frontline staff. As a result, staff often lack a specific and common understanding of what patient-centred care means in their local area and what behaviours they are expected to exhibit in line with this definition.

Implementation Components

Component #1: Prompt Staff Reflection on Their Practice

Provide staff with an opportunity to reflect on how they can individually and collectively promote patient-centred behaviour within their daily practice.

Component #2: Facilitate Local Commitment to Specific, Actionable Behaviours

Encourage staff to commit formally and publicly to their chosen behaviours so they can hold themselves and each other accountable.

Practice Assessment

Relatively low-cost and low-effort practice yielding potentially large and sustainable improvements in compassionate caregiving at ward level.

Global Centre for Nursing Executive Grades

Practice Impact: A

Hospital Effort: A-

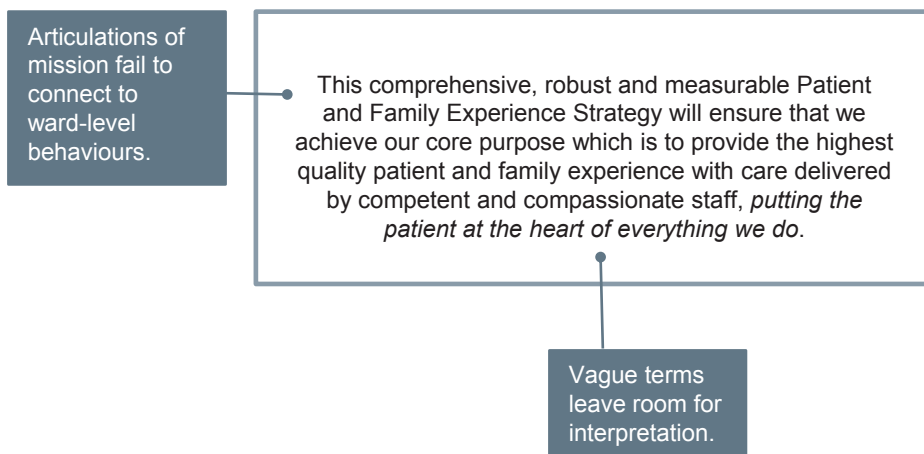
Many organisations assume that they are already setting clear expectations for treating patients in a caring manner.

Patient experience “statements” are often inspirational at a strategic level, but the language actually does little to help nurses understand exactly what is expected of them in their daily work.

Behavioural Expectations Lacking Clarity

Organisation-Wide Ambition Not Made Meaningful for Staff

Sample Patient Experience Strategy Statement

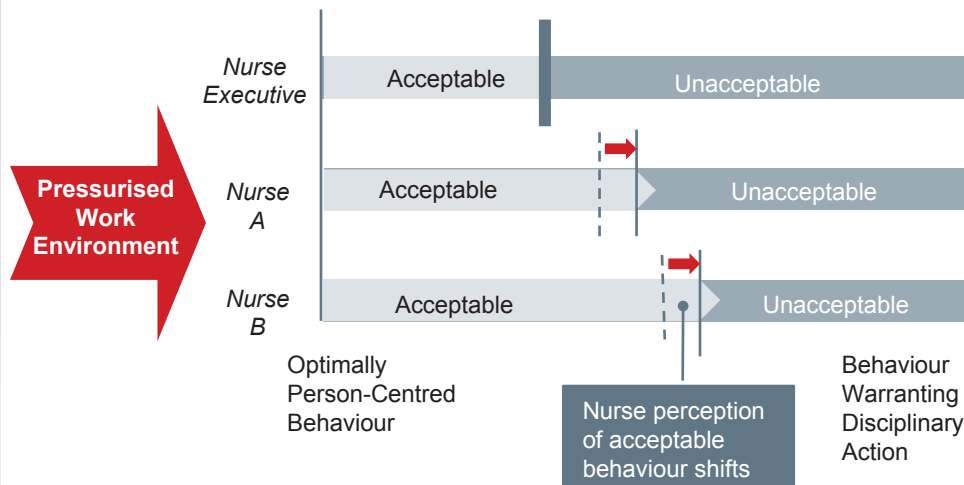


Relying solely on broad, somewhat vague statements allows for a significant amount of room for interpretation. First, the definition of “acceptable” behaviours may differ among staff members. Even more troubling, when conditions on the ward are challenging, definitions of acceptable behaviours are subject to change. Without clear expectations about where the line is drawn, nurses under pressure can subconsciously and collectively redefine what’s acceptable, allowing their own behaviour and the behaviour of their peers to move further away from the level of compassionate care expected by the patient and organisation.

Stretching the Boundaries of Acceptable Behaviour

Pressure, Lack of Clarity Allow Standards to Slowly Slip

Nurses Views of Acceptable versus Unacceptable Behaviour



To establish clearer standards for patient-centred behaviour, leaders at Northumbria Healthcare NHS Foundation Trust in North Tyneside, England facilitate staff-driven development of ward-specific “codes of conduct.”

The first component of this tactic is to provide the opportunity for staff to reflect on their practice as it relates to ensuring a high-quality patient experience on the ward. A facilitator who has gained credibility with staff—in Northumbria’s case, by working shifts alongside frontline nurses as a health care assistant—engages nurses in discussions regarding practice on the ward. This includes reflection on what individual nurses feel is done well on the ward as well as what they feel could be improved.

Following this conversation, the facilitator prompts individual ward nurses to share their opinions about how the patient experience can be improved in their area. These ideas are anonymous but are collected on large charts set up in staff-only areas.

Component #1: Prompt Staff Reflection on Their Practice

Guidelines for Supporting Staff in Setting Standards of Behaviour



Ensure Facilitator Credibility

- Facilitator who has existing, or has gained, credibility on ward
- Objective, positive individual dedicated to understanding staff perspective



Open Dialogue to Reflect on Practice

- Structured questions to promote reflection, ask staff what care looks like at best, worst
- “Safe,” “no-blame” environment for staff to share thoughts



Lead Staff in Articulating Commitment

- Staff agrees upon discrete list of clear behavioural expectations
- Charter signed by all ward staff to solidify commitment

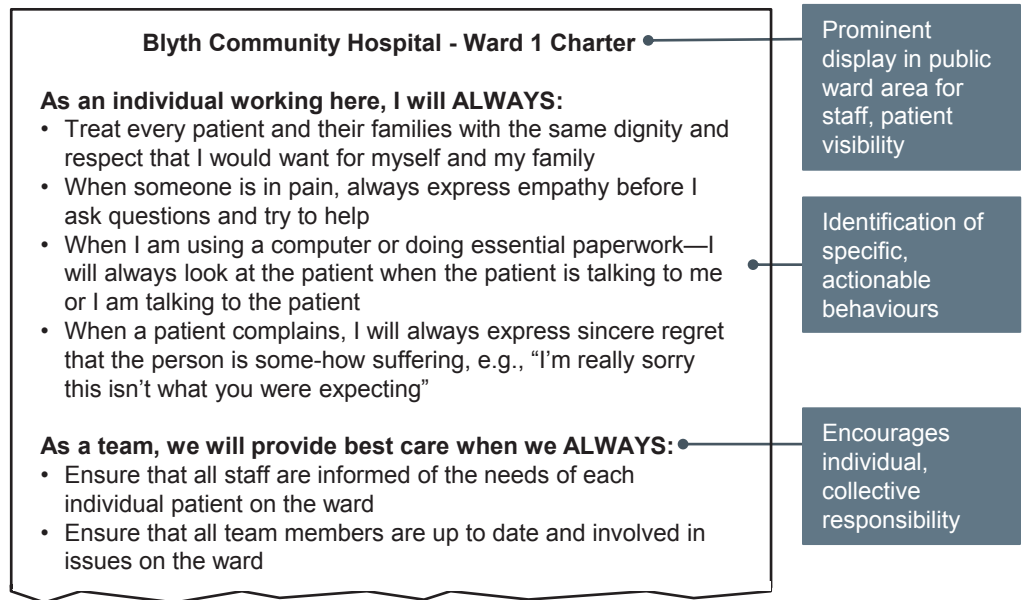


Case in Brief: Northumbria Healthcare NHS Foundation Trust

- 1,375-bed acute trust located in Northumberland and North Tyneside, UK
- Real-time patient experience measurement revealed suboptimal patient experience scores on rehabilitation ward within community hospital in November 2010
- Chief Executive identified high-potential leader to direct intervention to transform patient experience on ward in January 2011
- Team agreed upon actionable list of “always” and “never” events for their ward, committing to patient-centred behaviours April 2011
- Finalist for Patient Experience Network Award in 2011

Once ideas about improving the patient experience on the ward have been compiled, the facilitator leads the group in a discussion aimed at deciding which of the behaviours listed they want to commit to as individuals and as a team. At the end of this session, leaders at Northumbria developed a completed ward charter. This demonstrates the importance of our second component: facilitating staff commitment to specific, actionable behaviours. Through this exercise, staff establish a clear standard of care provision for themselves as individuals and as a team.

Component #2: Facilitate Staff Commitment to Specific, Actionable Behaviours



Results from Northumbria's real-time patient experience surveys have demonstrated significant improvement since 2010. In the "respect and dignity" domain of these surveys, the ward achieved a perfect score in the two measurement periods following the intervention.

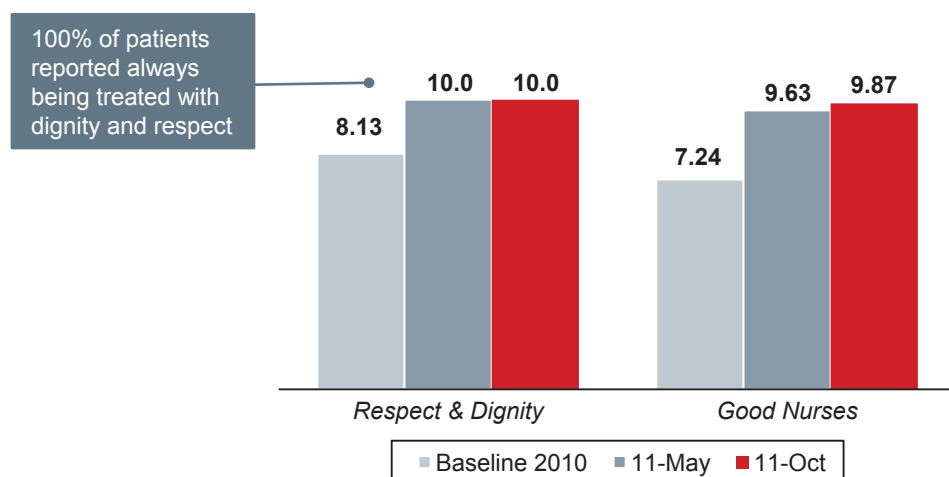
Leaders at Northumbria report that the development of this charter was critical to the culture change that transformed this ward. The display of the charter has enabled staff to send the message, in their words: "This is who we are, this is what we're about, and this is the kind of care we deliver on our ward."

A complete version of Northumbria's "Ward 1 Charter" can be found in the Appendix of this study.

Setting Clear Standards Triggers Culture Change

Patients Reporting Increase in Satisfaction¹

Average Score Out of 10 on Real-Time Patient Experience Surveys Conducted at Northumbria



“

Proud of the Team

"All I wanted was to be proud of the team and the care we provide, and now I really am."

Staff Nurse, Northumbria Healthcare NHS Foundation Trust

Source: Northumbria NHS Foundation Trust, North Tyneside, UK; Global Centre for Nursing Executives interviews and analysis.



Reinvigorating Compassionate Caregiving

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Connect Nurses to the Patient Perspective

#2: High-Impact Patient Storytelling
#3: Off-Ward Experience Shadowing
#4: Patient Personalisation Posters

Supporting Practice: Candidate Compassion Screening

Practice #2: High-Impact Patient Storytelling

— Practice in Brief —

Nurse leaders capture and widely share a large number of patient stories that reflect the breadth and diversity of patient experiences.

Rationale

Sharing patient stories can be an extremely powerful strategy for helping nurses to understand the patient perspective. Typically, if patient stories are collected at all, it is usually done on an ad-hoc basis or only when patients proactively reach out to leaders to describe their experience. As a result, stories obtained often do not reflect the full spectrum of patient experiences. Moreover, collected stories are often shared with staff only sporadically, minimising their potential impact.

Implementation Components

Component #1: Facilitate Patient Story Submission

Provide patients with clear instructions about when (and how) to submit their stories. The goal is to encourage many more patients to share their stories.

Component #2: Hardwire Story Capture

Standardise a method for capturing and preserving patient stories. Stories should be archived in a single location, easily accessible to staff.

Component #3: Ensure Consistent Story Dissemination

Maximise the impact and reach of patient stories by ensuring they are shared with frontline caregivers in a systematic manner.

Component #4: Effectively Leverage Stories to Drive Improvement

Practice offers substantial opportunity to enhance frontline nurse understanding of the entire patient experience; requires significant manager or educator time to develop appropriate shadowing experiences and debrief with frontline nurse.

Practice Assessment

Relatively low-cost and low-effort practice that helps nurses to better understand the patient perspective, yielding potentially large improvements in caregiver empathy and compassion.

Global Centre for Nursing Executive Grades

Practice Impact: A

Hospital Effort: B

The first component of High-Impact Patient Storytelling is ensuring patients are encouraged to share their stories and have clear instructions for how to do so. Leaders at York Hospital in York, Maine, cite a simple, yet comprehensive flier as a highly effective method of encouraging patients to submit their stories, in this case, to a dedicated patient story voicemail hotline, called “Care to Share.”

Component #1: Facilitate Patient Story Submission

York’s “Care to Share” Flier



Makes sincere plea for patient stories—good or bad—captured in patient’s own voice

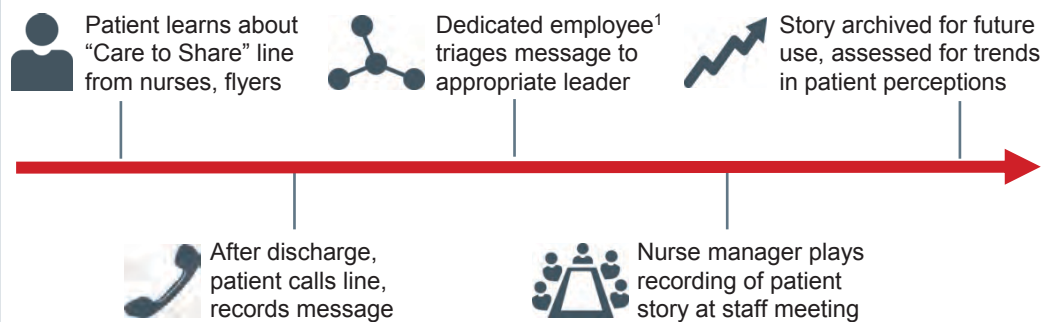
Provides simple description of phone line, how to record story

Explains how stories will be used by hospital, employees

The second component of this practice is embedding a structure and process for patient story capture. The goal is to systematically record and preserve all stories shared by patients. At York Hospital, stories are captured by their “Care to Share” line and automatically saved to a hospital server.

Component #2: Hardwire Story Capture

Process for Capturing and Disseminating Patient Stories at York Hospital



Case in Brief: York Hospital

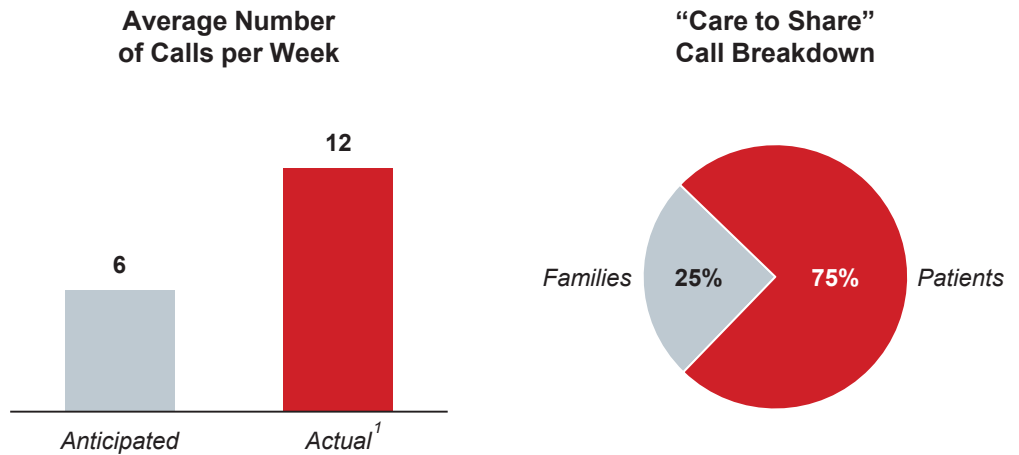
- 79-bed hospital located in York, Maine
- Dedicated “Care to Share” patient story line went live in July 2011
- Patient messages directly recorded onto hospital server, allows unlimited recording time
- Implementation of voicemail system directly on hospital server required 12 to 16 IT hours; regularly listening and triaging patient messages requires one hour per week

A complete version of York’s “Care to Share Flier” and answering machine message scripting can be found in the Appendix of this study.

1) Director of Rehabilitation responsible for “Care to Share” line at York; most employees in patient experience/service roles would be suitable for the position.

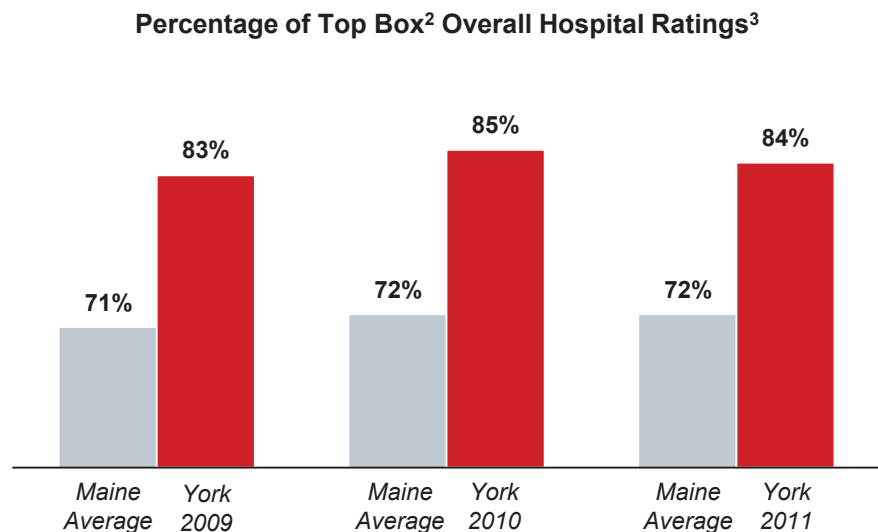
Evidence suggests that when provided with a clear call to action to share their stories, patients and families are willing to do so. Early results from York Hospital have been positive. York Hospital has exceeded internal expectations regarding the number of patient stories it would capture on its “Care to Share” line. In addition to calls from patients, the line has also begun to receive stories from patients’ family members.

Exceeding Utilisation Expectations



Leaders at York believe their focus on sharing patient stories has helped them achieve consistently strong patient satisfaction. York Hospital has consistently outperformed the state average on key patient experience metrics.

Consistently Outperforming in Patient Satisfaction



1) As of September 2011.

2) Percentage of patients choosing “9” or “10” on 10-point scale for “willingness to recommend” the hospital

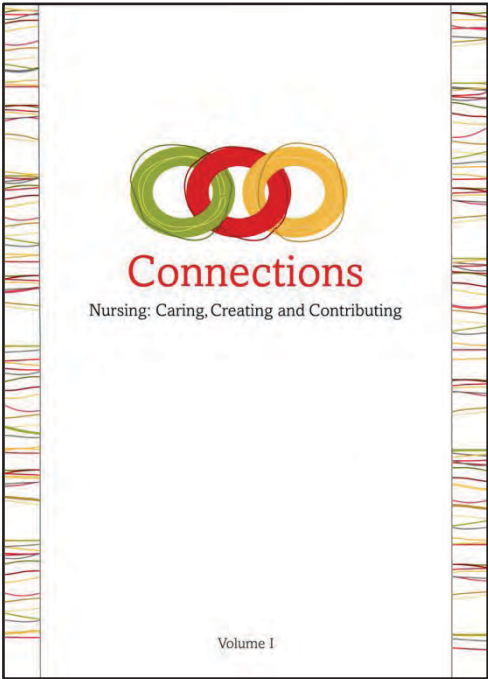
3) Based on HCAHPS (Hospital Consumer Assessment of Health Care Providers and Systems) US national database.

Source: York Hospital, York, ME; Global Centre for Nursing Executives interviews and analysis.

The third component of effectively leveraging patient stories is ensuring consistent story dissemination. There are a number of ways to circulate patient stories, including in print. Nursing and patient experience leaders at Vidant Medical Center in Greenville, North Carolina, ensure stories are consistently relayed to staff through a staff-generated publication entitled *Connections*. To create the publication, staff members relayed patient stories, in their own words, with the aim of helping their colleagues reconnect with the mission of the nursing profession.

Component #3: Ensure Consistent Story Dissemination

“Connections” Publication at Vidant Medical Center



“Connections” Table of Contents

Contents	
Dedication.....	IV
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That Says It All.....	25
My New Best Friend.....	26
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Case in Brief: Vidant Medical Center

- 861-bed academic medical centre located in Greenville, North Carolina; flagship hospital of Vidant Health
- Solicited stories from caregivers demonstrating the power of patient- and family-centred care
- Published *Connections* in June 2011; includes 66 unique caregiver stories
- Publication distributed to all nursing staff; serves as desk reference for caregivers to reconnect with mission of healing in the moment

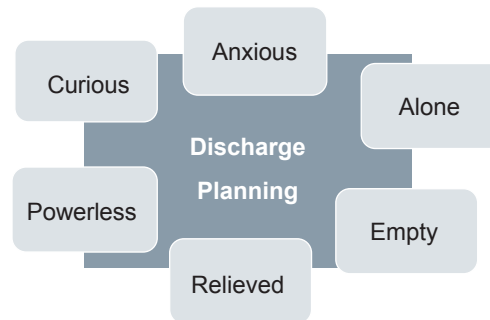
Source: Vidant Medical Center, Greenville, NC; Global Centre for Nursing Executives interviews and analysis.

Capturing and disseminating patient stories is an extremely powerful strategy, but sometimes staff members still struggle to connect these stories to their own actions and change their behaviour accordingly.

To overcome this issue, NHS Lothian Health Board in Edinburgh, Scotland, implemented a patient story collection methodology entitled Emotional Touchpoints. This tactic allows patients' emotional reactions to drive storytelling, focusing in on specific points in their journey and how the patient or family member felt at each of these points.

Component #4: Effectively Leverage Stories to Drive Improvement

Representative Touchpoint



Representative Touchpoint Story

Touchpoint: Discharge Planning

I feel I am going into the unknown. I feel empty and slightly powerless as I don't know what people are going to be helping me with when I go home.

I don't know what's ahead of me. I don't know what life is going to be like. I could not wait to get home last time. I feel a bit guilty that it all might be my fault, why I am here again. I feel a bit confused about everything, lots of little things to sort out. I lay awake in bed at night thinking it all over.

The physios visited me today. I felt relieved when they told me they were going to teach my daughter how to help me with my therapy. It was nice to know that I wouldn't have to do it alone.



Emotions Cannot Be Disputed

If a patient says I felt upset or happy, you can't dispute that because that's how they actually felt. So that makes it a pretty powerful lever for change.

Charge Nurse, NHS Lothian



Case in Brief: NHS Lothian Health Board

- 3,909-bed Health Board in Scotland, serving residents of Edinburgh, Midlothian, East Lothian and West Lothian
- Project inspired by Bate & Robert¹ (2007) experience-based design work, led by charge nurse for elderly medical ward
- Patients, relatives visited during inpatient stay to solicit touchpoint story
- Nurse leaders visit four patients a month, record stories
- Stories shared with staff, prompt discussion about how to change practice moving forward

1) Bate & Robert, *Bringing User Experience to Healthcare Improvement*, 2007.

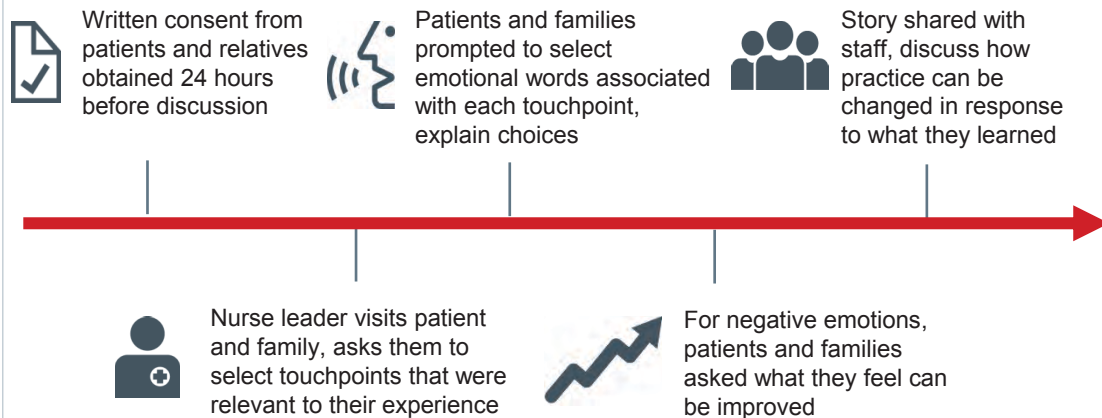
Source: NHS Lothian Health Board, Lothian, UK; Global Centre for Nursing Executives interviews and analysis.

The Emotional Touchpoints process is relatively simple. Patients and family members assign 'feeling words' to specific points in their journey. Feedback is collected and shared with staff to drive discussion on how to use what they've learned to improve practice for future patients.

NHS Lothian's touchpoint "Feeling Word" list can be found in the Appendix of this study.

Story Collection Creates Opportunity for Improvement

Process of Obtaining and Sharing Touchpoint Stories



Hearing these stories and what patients were experiencing during specific points in their care helps staff to see patients as individuals with a variety of emotions and reactions to different elements of care. The Ward where emotional touchpoints was first implemented at Lothian has seen some impressive results. Leaders on this ward have not received a formal complaint in over five years.

For additional guidance on collecting and sharing patient stories, see:

advisory.com/gcne/patientstories



Touchpoints Impacting Staff Behaviour

Staff Delivering Compassionate Care

5

Years since the last formal complaint was reported on Ward 50

“

Prompting Reflection on Daily Practice

“Actions taken forward are based on real and meaningful evidence, and staff feel moved and motivated to have another look at what we do.”

“Using Emotional Touchpoints to Learn About the Experience of Receiving Care”
NHS Lothian Health Board

Practice #3: Off-Ward Experience Shadowing

— Practice in Brief —

To better understand the off-ward experiences of their patients, nurses shadow patients during the most common off-ward procedures.

Rationale

While nurses are very familiar with the patient care provided on their assigned wards or care areas, they have less visibility into the care patients receive while off the ward. As a result, they can find it challenging to prepare patients for off-ward procedures or anticipate their physical and emotional care needs after they return to the ward.

Implementation Components

Component #1: Nurses Shadow Patients Undergoing Most Common Off-Ward Experiences

Nurses observe (or directly experience via simulation) some of the most common treatments patients receive while off the ward.

Component #2: Debrief to Discuss Key Insights

Immediately after the shadowing experience, participants should debrief with a manager or educator to discuss what they observed and how their observations will impact their practice.

Practice Assessment

Relatively low-cost and low-effort practice that helps nurses to better understand the patient perspective, yielding potentially large improvements in caregiver empathy and compassion.

Global Centre for Nursing Executive Grades

Practice Impact: B+

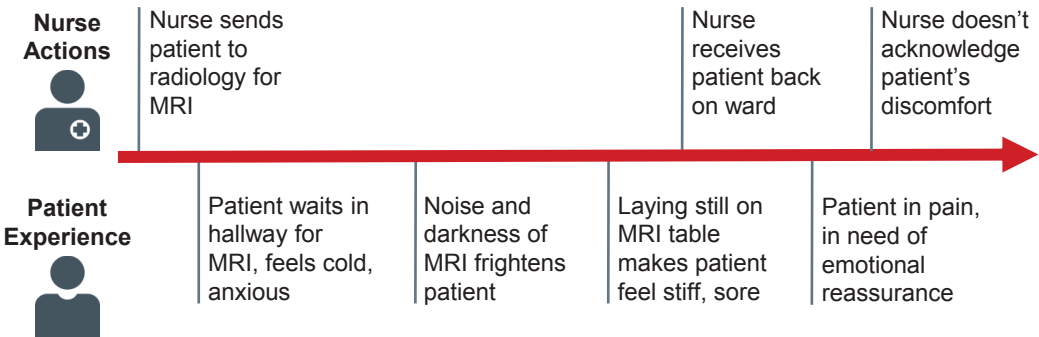
Hospital Effort: B

While frontline staff are very familiar with the care provided on their ward, they are much less familiar with other wards, where significant portions of their patients' care may occur—for example, in the operating theatre or a procedural suite. As a result, nurses may not know what their patients feel, see, and experience when they receive care in another part of the hospital. This knowledge gap is a barrier to both patient experience and patient safety.

The timeline to the right demonstrates this gap. The nurse witnesses only a fraction of the events a patient experiences, and as a result may be unaware of the impact those experiences have had on the patient's physical or emotional well-being.

Limited Caregiver Visibility into Off-Ward Occurrences

Nurse Perception of Patient Care and Overall Patient Experience on Goulet Hospital¹ Oncology Ward



1) Pseudonym.

Source: Global Centre for Nursing Executives interviews and analysis.

Oncology nurse leaders at Bethesda North Hospital in Cincinnati, Ohio, recognised frontline staff did not necessarily know what their patients experienced during off-ward procedures and devised a tactic to overcome this knowledge gap. Since the late 1990s, all new oncology nurses have been required to participate in off-ward shadowing experiences during ward orientation. These experiences allow new nurses to observe or simulate what their patients experience off the ward. The table to the right outlines the shadowing opportunities experienced by Bethesda North's oncology nurses, and provides potential off-ward shadowing experiences for other types of wards.

Component #1: Nurses Shadow Patients Undergoing Most Common Off-Ward Experiences

Five Oncology Shadowing Experiences at Bethesda North

Capsule Description	Key Benefits	Potential Variations
Radiation Tour: Nurse tours radiation oncology department, meets staff, lays on radiation table	Allows nurses to personally experience discomfort of radiation process; opens lines of interdepartmental communication	Tour cath lab, EP lab, nuclear medicine suite
Chemo Administration: Nurse administers chemotherapy in outpatient oncology clinic	Solidifies importance of accurate discharge teaching; reinforces concept that patient experience extends beyond inpatient stay	Observe procedure at primary care, other outpatient clinic
Same-Day Surgery Shift: Nurse spends shift starting IVs and helping with admission paperwork in same-day surgery	Ensures nurses can start, place lines; allows nurses to observe how patients are prepared for surgery, what different procedures entail	Nurse shadows anaesthesiology team
Skin and Wound Rounds: Nurse shadows wound/ostomy/incontinence nurse on rounds	Demonstrates human impact of poor wound care; allows nurses to see long-term impact of marking intended ostomy site	Nurse shadows colleague in ICU
Off-Ward Test Shadowing: Nurse shadows patient during off-ward test or procedure	Informs nurses about what to expect when patients return to ward; ensures caregivers can recognise signs of deterioration	N/A



Case in Brief: Bethesda North Hospital

- 333-bed hospital located in Cincinnati, Ohio
- In 1996, began requiring all new oncology nurses to complete oncology orientation within first 18 months on the ward
- Oncology orientation includes several off-ward shadowing activities to help nurses understand what patients experience physically and emotionally across stay; goal to better enable nurses to anticipate and address patient needs
- Each shadowing session followed by structured debriefing session to discuss the nurse's clinical performance during the exercise, observations, implications for inpatient nursing

In order to ensure that learning is used to drive necessary changes in practice, educators at Bethesda North debrief with the participating nurse after each shadowing experience and discuss two key topics: the clinical skills observed in the off-ward care area, and the physical and emotional experience of the patient. Leaders at Bethesda North cite the structured debriefing session as critical to the success of this tactic, as it provides the opportunity for staff to reflect on what they've learned and how they will change care delivery for future patients as a result.

A complete version of the Off-Ward Shadowing Debriefing Guide can be found in the Appendix of this study.

Component #2: Debrief to Discuss Key Insights

Off-Ward Shadowing Debriefing Guide

Clinical Feedback:

1. How do you think you performed on procedure X? What would you have done differently?
2. Clinically, what did you observe that surprised you? Why?
3. What was the most valuable information you learned about the clinical care/procedures provided outside of the ward?

Experience Debrief:

4. What did you learn about the patient's physical experience of care that surprised you? How will that impact your future practice?
5. What did you learn about the patient's emotional experience of care that surprised you? How will that impact your future practice?
6. Based on the patient's physical and emotional experiences of care that you observed, will you do anything differently to better prepare the patient prior to the procedure? Will you do anything differently to meet the patient's needs after returning to the ward?

Practice #4: Patient Personalisation Posters

Practice in Brief

Patients and families are provided with a blank poster template they can complete and display at their bedside in order to share their desired level of personal information with caregivers.

Rationale

Shorter length of stay, higher patient acuity, and increasing productivity pressures may increase the likelihood that frontline caregivers define patients by their conditions as opposed to viewing them as unique individuals. Patient Personalisation Posters provide caregivers with personal information about their patients, which can help facilitate patient-caregiver connections.

Implementation Components

Component #1: Customise Poster Template

Ward leaders tailor Patient Personalisation Posters to ensure they meet the needs of their unique patient populations.

Component #2: Embed Patient Personalisation Poster into Workflow

Ward leaders modify ward workflow to ensure Patient Personalisation Posters are consistently shared with patients and families and are easily visible to all caregivers entering a patient's room; caregivers use the information on the poster to inform interactions with patients.

Component #3: Engender Staff Buy-In Through Structured Training

Ward leaders achieve staff buy-in for posters by deploying a structured training process in which staff members complete their own posters and view posters completed by their peers.

Component #4: Audit Compliance Through Key Leader Rounding Questions

To ensure staff are using Patient Personalisation Posters to connect with their patients as unique individuals, leaders should audit poster compliance through targeted questions.

Practice Assessment

This practice is minimally resource intensive and a highly effective strategy to help frontline staff learn about their patients and treat them as unique individuals.

Global Centre for Nursing Executive Grades

Practice Impact: B+

Hospital Effort: B+

Shorter length of stay, higher patient acuity, and increasing productivity pressures can make it challenging for caregivers to consistently empathise with, and convey that empathy to, patients. A nurse's perception of a patient is largely defined by his or her clinical presentation. While the clinical presentation is important to providing excellent patient care and satisfaction, providing optimally person-centred care requires caregivers obtain a holistic view of the patient as a person.

One effective way of connecting staff to the patient perspective is enabling frontline staff to get to know their patients by learning about their hobbies, interests and aspirations. Patient Personalisation Posters are a highly effective prompt for fostering these nurse-patient connections in the moment.

Often Focusing on the Patient, Not the Person

Nurse Perception of Patient



- Patient in room 182 admitted two days ago
- Diagnosed with ventilator-associated pneumonia
- Scheduled for diagnostic imaging, blood work
- Acting irritable today; requested additional pain medication twice

Patient Perception of Experience



- Patient has never been admitted to hospital before; anxious about inpatient stay
- Concerned about long-term impact of surgery on ability to work physically demanding job
- Worried about missing daughter's upcoming wedding

“

More Than Meets the Eye

“If you're not taking care of the whole person, you're not taking care of the patient.”

*Chief Nursing Officer
Health System in the Southeast*

The first component of Patient Personalisation Posters is developing a poster template appropriate for a ward's patient population. Frontline staff in the Liver Transplant Surgical ICU at UCLA Medical Center in Los Angeles, California, created a poster template called "Getting to Know You."

While Patient Personalisation Posters can be modified to meet a patient population's unique needs, the Global Centre recommends any poster contain information such as the patient's family, background, hobbies, and preferences.

For additional guidance on Patient Personalisation Posters, see:

advisory.com/gcne/personalisationposters



To hear about this initiative firsthand from leaders at UCLA, visit:

advisory.com/gcne/UCLA



A complete version of UCLA's "Getting to Know You Poster" can be found in the Appendix of this study.

Component #1: Customise Poster Template

"Getting to Know You" Poster at UCLA

Designated fields personalise patient by capturing family, background, hobbies, preferences

Prominent placement near patient bedside serves as conversation starter for caregivers

Poster travels with patient across inpatient stay, providing sense of continuity, comfort

Poster content informs plan of care by highlighting patient's goals after hospitalisation



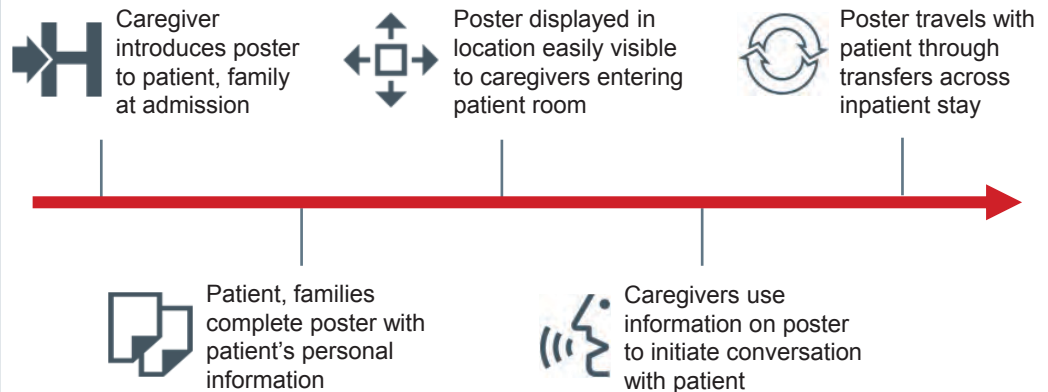
Case in Brief: Ronald Reagan UCLA Medical Center

- 520-bed academic medical centre located in Los Angeles, California
- Frontline nurse introduced "Getting to Know You" posters on ICU in October 2008 as part of Advisory Board Talent Development's "Frontline Impact" program; currently in place on three wards
- Posters distributed to all patients, families at admission; completed posters kept in Plexiglas frames at patient bedside, travel with patient across inpatient stay

The second component of Patient Personalisation Posters is embedding the poster into workflow. Key aspects include: automatically sharing a blank template with patients and families, prominently positioning completed posters, and ensuring caregivers look at posters when entering a room.

Component #2: Embed Patient Personalisation Poster into Workflow

Process for Utilising “Getting to Know You” Posters at UCLA



The third component of Patient Personalisation Posters is engendering staff buy-in through structured training. One Canadian organisation, Ron Medical Center, a pseudonym, used a thorough, three-step process to maximise staff compliance with their “My Story” poster initiative. The goal of the training is for staff members to recognise the value of Patient Personalisation Posters and the breadth of information that can be conveyed through this type of poster. They found this approach to be very successful for setting appropriate context and ensuring staff use the posters consistently in daily practice.

Component #3: Engender Staff Buy-In Through Structured Training

Three-Step Training Process for Patient Posters at Ron Medical Center¹



Video-Prompted Facilitated Discussion

- Ward champions present media clips from popular television shows during one-hour training session to facilitate discussion of appropriate (and inappropriate) ways to connect with patients



Self-Completion of Poster Exercise

- Staff members encouraged to complete own patient posters to share with each other
- Exercise reinforces benefits of sharing personal information with others, reveals common gaps in patient information



Reinforcement Through Bedside Blitzes

- Project leaders conduct five- minute presentations with nurses at bedside to discuss purpose of patient posters, provide logistical guidance
- Opportunity to refresh previously trained nurses, teach untrained nurses about initiative

1) Pseudonym.

The final component of Patient Personalisation Posters is for leaders to audit compliance by using the targeted rounding questions shown here. The goal of these questions is to determine the extent to which frontline staff are using the posters to learn about their patients as unique individuals.

Component #4: Audit Compliance Through Key Leader Rounding Questions



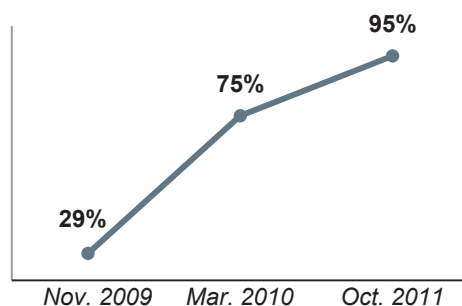
Questions for Executives to Ask Frontline Staff on Rounds to Audit Caregiver Empathy

- ☐ Do you have any patients who love sports?
- ☐ Tell me what one of your patients is most looking forward to upon discharge.
- ☐ Which patient on the ward do you think you have the most in common with? Why?
- ☐ Tell me about the most inspiring patient story you've heard in the past month. How did it impact you?
- ☐ Tell me about the most upsetting patient story you've heard in the past month. Why was it upsetting?
- ☐ What do you think your patients find most frightening about hospitalisation? Why?

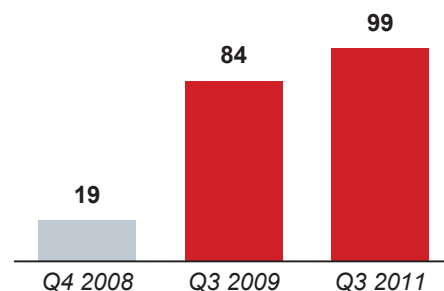
Patient Personalisation Posters can significantly impact patient satisfaction scores. Since UCLA's Liver Transplant Surgical ICU implemented them in November 2009, scores for "patient confidence and trust" in nurses on the pilot ward has risen from the 19th percentile in Q4 of 2008 to the 99th percentile in Q3 of 2011.

Realising Returns from Patient Posters at UCLA

Percentage of Patients with Completed "Getting to Know You" Posters on ICU¹



Percentile Ranking for Patient Confidence and Trust in ICU Nurses



Leaders at UCLA and Ron Medical Center³ cite the implementation guidance shown to the right as crucial to the successful rollout of Patient Personalisation Posters. In particular, there are two tips that are especially important for facilitating success in this initiative. First, ensure posters clearly state all information is optional. Patients and families are filling out the posters themselves, so it should be made clear that they do not need to include any information they are uncomfortable sharing. Second, provide posters to families in the waiting area. This can be a great activity to help reduce anxiety during the all-too-stressful wait period.

Implementation Guidance for Patient Posters



Summary of Key Implementation Tips for Patient Personalisation Posters

- ☐ Secure widespread staff buy-in for initiative by stating benefits of posters upfront; consider having staff complete poster about themselves to demonstrate power of initiative
- ☐ Involve staff in content and design of poster creation; incorporate fields that capture important, yet often overlooked, patient information
- ☐ Provide posters for families to complete as waiting room activity
- ☐ Enhance patient and family comfort with initiative by clearly stating all information is optional
- ☐ Place posters where they can clearly be seen by all caregivers entering patient room, encourage caregivers to use posters as conversation starter with patients and families
- ☐ Encourage ongoing staff compliance by regularly tracking poster completion, informing staff of benefits of posters for patients and families
- ☐ Allow patient, family to take poster with them across inpatient stay and after discharge

¹) As measured by monthly audits conducted by Unit Practice Council.

²) Based on NRC Picker database.

³) Pseudonym



Reinvigorating Compassionate Caregiving

I

Set Patient-Centred Expectations

#1: Staff-Driven Code of Conduct

II

Connect Nurses to the Patient Perspective

#2: High-Impact Patient Storytelling
#3: Off-Ward Experience Shadowing
#4: Patient Personalisation Posters

Supporting Practice: Candidate Compassion Screening

Supporting Practice: Candidate Compassion Screening

— Practice in Brief —

To ensure nurse candidates are evaluated for their empathy and compassion, in addition to their clinical competencies, leaders involved in nurse hiring incorporate mechanisms for assessing patient-centredness into the hiring process.

Rationale

Leaders involved in nurse hiring are often focused on selecting candidates with exceptional skills and extensive clinical experience. They typically fail to screen for empathy and compassion, qualities that are equally important to providing optimal patient care.

Implementation Components

Component #1: Incorporate the Patient Perspective into the Hiring Process

Organisation invites patient and family representation onto routine candidate interviews.

Component #2: Prompt Demonstration of Attitudes and Behaviours

Nurse managers observe group discussions among candidates in order to evaluate their teamwork abilities and their natural tendency to consider and accommodate the patient and family perspective.

Practice Assessment

Strategy offers unique opportunity to evaluate candidates' "softer" qualities and more accurately predict their attitudes and behaviours on the wards.

Global Centre for Nursing Executive Grades

Practice Impact: A

Hospital Effort: B-

The practices so far in this section have focused entirely on reinvigorating compassionate caregiving amongst *existing* staff. The unfortunate reality, however, is that not all staff—either currently in the organisation or those coming into the organisation—are fully equipped to provide compassionate care. There are some individuals who may struggle with this even if the standards have been set and the tools have been provided to connect with the patient experience.

Getting to the Root of the Problem

Some Candidates Not Motivated by Compassionate Care

GREYPRIDE

Alarming levels of care for older people in our hospitals—experienced it yourself?

COMMENTS: *“It is not true that this treatment is due to understaffing or cuts or even training; it’s due to people in the job who don’t care.”*

“

Here for the Wrong Reasons

“We have some staff who I think come into the profession for the wrong reasons. They may think the pay wasn’t too bad and it was pretty secure employment. But that’s not the reason for coming into nursing. Hopefully you come into it because you care about people a bit more than because it’s just a job.”

*Director of Nursing Practice
NHS England Trust*

Leaders may find it difficult to identify these individuals because most often, hiring processes are focused on evaluating clinical experience, academic achievement and leadership potential. These professional skills are critical competencies. Unfortunately, however, the focus on these elements often comes at the expense of equally important patient and family-centred care priorities.

Prioritising Professional Qualifications

... to the Detriment of “Softer” Skills

Sample Hospital Interview Committee Priorities

- Clinical experience
- Likelihood of retention
- Problem-solving skills
- Conflict resolution capabilities
- Leadership potential
- Academic achievement
- Knowledge of professional protocols
- Resourcefulness

“

Focus on Clinical Experience

We tend to be more interested in getting the best of the best: academically prepared nurses, clinically prepared nurses. But that doesn’t always translate into the caring, compassion and patient and family-centred focus that we want nurses to have as well.

*Nursing Recruitment Advisor
Kingston General Hospital, Ontario*

In order to more effectively screen for compassionate care, leaders at Kingston General Hospital began incorporating patient representatives on their interview panels. These representatives have two key roles. First, a patient or family representative is included on the interview panel and is encouraged to ask the candidate questions. Leaders at Kingston report that these questions are often of a very different nature than the kinds of questions that staff ask. Second, the patient interviewer is meaningfully involved in the debrief that follows the candidate interview.

Kingston advises that the effectiveness of this practice depends on staff's commitment to taking the patient's input seriously.

Component #1: Incorporate the Patient Perspective into the Interview Process

Valued Role on Interview Panel



Patient/family interviewer allocated set number of questions to ensure active participation

Active Involvement in Debrief



Patient/family interviewers invited to share their impressions of candidates during hiring decision-making process



A Unique Perspective

"Health care professionals can become so task-focused that we lose sight of the human side, the dignity side and the vulnerability side. And that's in the foremost part of the former patient's mind. That's the type of thing they're looking for. Involving the patients and families in their plan of care. Recognising that hospitalisation is just one short span in their life continuum."

*Nurse Recruitment Advisor
Kingston General Hospital*



Case in Brief: Kingston General Hospital

- 430-bed regional hospital located in Kingston, Ontario
- Facility serves 500,000 residents in rural Canada. Serves as local hospital to Kingston community and as tertiary/referral hospital for complex and specialty inpatient care for the region
- In February 2010, developed a body of patient experience advisors to inform work at a strategic level. Began using these advisors on interview panels in June 2011
- Currently, wards request patient advisor participation in interviews when filling vacancies. Kingston plans to incorporate patient participation in all staff interviews by 2013
- To date, seven advisors have participated in over 30 nurse candidate interviews in the areas of medicine, resource pool, emergency and critical care

Kingston General provides patient interviewers with the tools necessary to make a meaningful contribution to the hiring process. Incorporating patient and family representation into the interview process is a low-resource, effective means of improving an organisation's ability to screen for patient-centredness in nurse candidates.

Kingston General Hospital's "Patient Interviewer Guide," can be found in the Appendix of this study.

Even if leaders can appropriately prioritise the assessment of compassion during the screening process, many organisations find it challenging to accurately predict how a nurse will *behave* when he or she is actually on the wards.

Structuring the Patient Interviewer Role

Representative Patient Interviewer Guide

Question	Ideal Response	Evaluation
What does Patient and Family Centred Care (PFCC) mean to you? How do you integrate PFCC into your practice?	<ul style="list-style-type: none">• Patient Advocacy• Effective Communication• Patient at centre of all we do• Patient/family wishes are respected• Patient/family involved in decisions	Questions directed at understanding nurse values related to patient-centred care
Describe the characteristics a professional nurse should demonstrate.	<ul style="list-style-type: none">• Values• Positive attitude• Organisation/person fit• Professional/courteous• Patience	Scenario aimed at assessing propensity to consider patient and family perspective
Tell us about a time when you had a conflict with a patient/family over the plan of care. How did you resolve the conflict?	<ul style="list-style-type: none">• Ask about patient's point of view• Respect patient's preferences• Respectfully describes different points of view• Recognises the dynamics that factor into different perspectives	

Difficult to Predict Candidate Behaviour

Nurse in Interview



- States commitment to person-centred care when prompted
- Responds articulately, accurately to interviewer questions
- Appears kind and respectful in discussions with interviewers

Nurse on Ward



- Fails to respond to call bells in a timely manner even when not occupied with other patients, tasks
- Makes judgments on his or her patients' lifestyle choices, beliefs
- Is rude to patients and their families on consistent basis



Not Always What They Seem

"People can tell us what we want to hear. And we think, wow, they're great. We then employ them. And some of them, we then soon realise that they're totally different from the people we interviewed. Attitudes towards patients, lack of compassion, and you think: what planet are people from?"

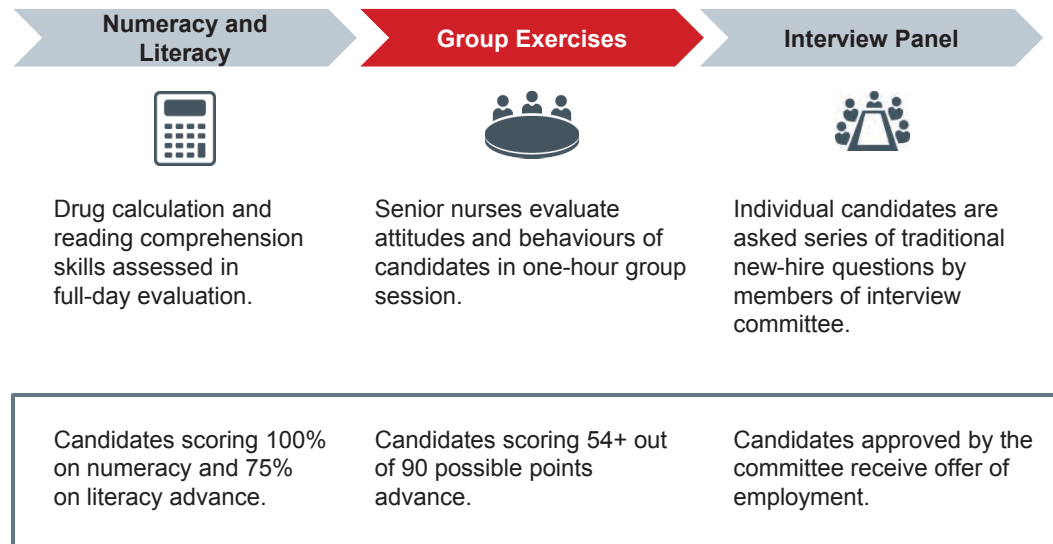
Mental Health Nursing Awareness Project Lead, NHS England Community Mental Health Trust

Leaders at Central and North West London (CNWL) NHS Foundation Trust developed a rigorous process that—when paired with the patient interviewer practice—is having a significant impact on their ability to hire the highest-quality nursing staff. CNWL’s “Assessment Centre” process involves three key steps. A particularly innovative element of this strategy is the second component: group exercises.

To get a better sense for how candidates will communicate and interact with patients, families, and peers, Central and North West London provides small groups of candidates with patient-related case studies to discuss amongst themselves while senior nurses observe. The session lasts for approximately one hour, and the candidates are simply asked to discuss their views on a particular topic. Leaders at Central and North West London suggest that the typical topics chosen are considered slightly controversial. This allows observers to assess how candidates will behave in challenging situations.

Component #2: Prompt Demonstration of Attitudes and Behaviours

Central and North West London Assessment Centre Candidate Screening Process



Case in Brief: Central and North West London NHS Foundation Trust

- 900-bed mental health trust in London, UK
- Nursing leaders recognised need for more rigorous screening process, were devoting significant resources towards performance managing nurses displaying poor attitudes and behaviours
- Assessment Centre process implemented in June 2009
- To date, over 200 nurses have been recruited through the Assessment Centre process

To the right, you can see an example of one such case study. On the far right, you see an excerpt of the criteria that senior nurses are using to evaluate candidates during this interaction. As candidates discuss the issue, senior nurses evaluate their ability to respect one another's views, consider the multiple perspectives represented in the case study, and express their thoughts and opinions appropriately.

Leveraging Group Discussion to Assess Patient-Centredness

Representative Case Study for Group Exercise

Discussion Topics for Band 5 Assessment Centre

Please note that these topics have been developed to assess your ability to engage in a group process, communication skills and values/attitudes and are not meant to describe any view or perspective that the Trust may have on these issues.

- **Carer Involvement**—Given the issue of patient confidentiality, should carers be given information about the patient and their prognosis and progress? What are your views?

Group Discussion Scoring Criteria Excerpt

#5: Respects others' views

Acceptable: Acknowledges other people's views and responds to what they have said when answering. If other people's views are different from theirs they are still able to accept them and challenge them respectfully.

Not acceptable: Dismisses the views of other verbally or non verbally e.g. sneering or tutting at something that is said. Completely ignores what another person has said.

SCORE (1-10): _____

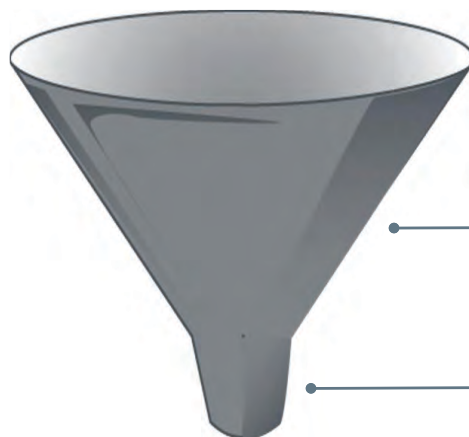
#6: Has considerations for others in the group

This process has given leaders at CNWL a mechanism to be very selective about who they hire. Admittedly, Central and North West London leaders report that when they first began this process, some nursing leaders were frustrated with the delay it caused in filling vacancies. Eventually, noticing the significant improvement in the quality of staff being recruited into the organisation, leaders accepted the new process.

Leaders at this organisation report a reduction in complaints and issues around staff attitude and behaviour, and that the overall standard of patient care has risen.

For full-sized versions of sample discussion topics and group discussion scoring sheet, see the Appendix of this study.

Decreasing Quantity, Increasing Quality



85 candidates apply; undertake numeracy and literacy tests

20 candidates (24% of initial applicant pool) advance to group work

12 candidates (60% of remaining candidates) advance to interview



Quality nurses well worth the wait

"Staff on the wards have told us that they have noticed a big difference in the quality of the nurses coming through from the Assessment Centre. At first, they weren't getting enough staff, but now that we've filled those vacancies, they are delighted. And they wouldn't do it any other way. So it's definitely driving up quality."

Director of Nursing Practice, Central and North West London NHS Foundation Trust



Elevating the Patient Experience: Advancing Towards Person-Centred Care

Reinvigorating Compassionate Caregiving

I

Set Patient-
Centred
Expectations

#1: Staff-Driven
Code of
Conduct

II

Connect Nurses to
the Patient
Perspective

#2: High-Impact Patient
Storytelling
#3: Off-Ward Experience
Shadowing
#4: Patient
Personalisation
Posters

*Supporting Practice:
Candidate Compassion Screening*

Promoting Patient, Family and Consumer Involvement

III

Structure Opportunities
for Participation at the
Bedside

#5: Comprehensive Patient
Orientation
#6: Patient-Centred Daily
Care Plan
#7: Two-Way Communication
Boards
#8: Patient Care Partners
#9: Family-Initiated Rapid
Response Team
#10: Patient and Family Peer
Mentors

IV

Embed Consumers
into Organisational
Planning

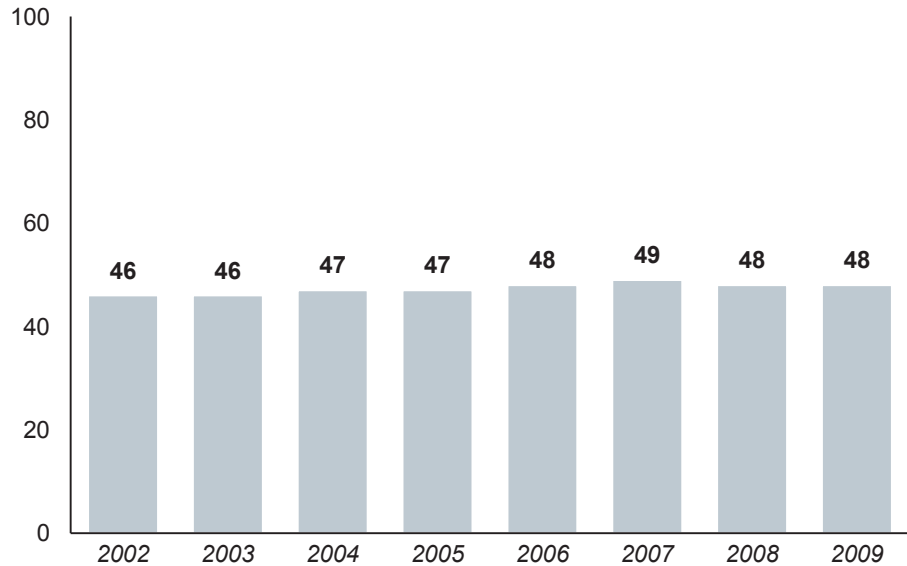
#11: Embedded Patient
and Family Advisors
#12: Patient Education
e-Advisors

As discussed in the preamble, the modern health care environment requires a greater degree of patient and family involvement in care, but health care delivery systems are often struggling to meet this expectation.

Struggling to Facilitate Patient Involvement

Proportion of UK Inpatients Who Wanted More Involvement in Treatment Decisions

n~69,000



Unfortunately, a tradition of paternalistic care delivery often prevents health care organisations from improving in this area. Care providers are accustomed to making decisions *for* patients instead of *with* them. As a result, rather than leveraging a potentially powerful resource to improve quality of care and the patient experience, clinicians often marginalise patients and their families. This risks that patients will have no choice but to continue to take a passive role in their treatment—or worse—be discouraged from seeking any care at all.

Paternalistic Culture Impedes Patient Participation



“Clinician Knows Best” Approach Prevails

“I think this paternalistic, nurse-driven attitude towards care is not out of meanness. It’s because doctors and nurses think they know what’s best for the patient. They want to do good, and they want to do their best for the patient, but I think sometimes they go about it the wrong way instead of having an equal partnership with the patient. They’re often TELLING the patient what to do. And I don’t think that’s the best approach in today’s world.”

*Clinical Nurse Specialist
European Public Hospital*



An Untapped Opportunity

“In times when human resources may be at a shortage and everybody’s stretched to their max, we can really utilise patients and families to move the care plan along. It’s just knowing how to involve them that’s important.”

*Nurse Recruitment Advisor
Canadian Acute Care Hospital*



Patients Feel Powerless

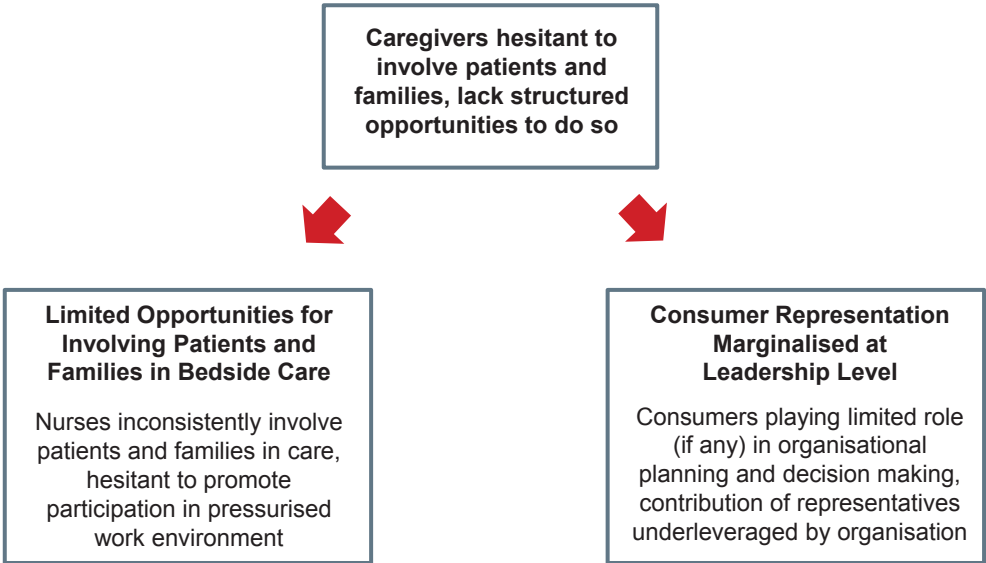
“The relationship has been very distant since my doctors do not care what I say to them; they listen to me but they do not take that into account. I have continuously felt very powerless and not in control about the situation. Hence I have become much more passive and I currently try to avoid going to the doctor’s office.”

*45-year old male patient with chronic disease
European Acute Care Hospital*

Source: Coulter, A. Collins, A. “Making Shared Decision-Making a Reality: Nothing About Me Without Me” *The King’s Fund* 2011; “Eurobarometer Qualitative Study: Patient Involvement Aggregate Report” *European Commission, Directorate-General for Health and Consumers* May 2012; Global Centre for Nursing Executives interviews and analysis.

To facilitate true partnership in patient care, leaders must take steps to actively promote patient, family and consumer involvement in daily operations, at all levels of the organisation. First, it is important to ensure that patients and families are encouraged to participate throughout the care episode, remaining informed and involved across the course of the patient journey. Second, hospital leadership must also demonstrate a commitment to the patient-centred ambition by inviting consumer participation at the highest echelons of the organisation.

Promoting Patient, Family and Consumer Involvement





Promoting Patient, Family and Consumer Involvement

III

Structure Opportunities for Participation at the Bedside

- #5: Comprehensive Patient Orientation
- #6: Patient-Centred Daily Care Plan
- #7: Two-Way Communication Boards
- #8: Patient Care Partners
- #9: Family-Initiated Rapid Response Team
- #10: Patient and Family Peer Mentors

IV

Embed Consumers into Organisational Planning

- #11: Embedded Patient and Family Advisors
- #12: Patient Education e-Advisors

Practice #5: Comprehensive Patient Orientation

— Practice in Brief —

Clinical leaders develop a comprehensive orientation video designed specifically to provide information patients and their families want and need to know prior to hospitalisation.

Rationale

In the case of planned hospitalisations, information is typically provided to patients and families according to what caregivers feel is important, rather than what patients or families themselves most want to know. Providing more comprehensive upfront education, targeted specifically at answering common patient and family questions, can alleviate patient anxiety and prepare them to play a more active role in their treatment.

Implementation Components

Component #1: Solicit Input from Key Stakeholders to Identify Essential Information

Consult staff, former patients and their families to identify most critical information to share in order to ease patient anxiety and equip patients and families with essential knowledge for making informed decisions.

Component #2: Provide Opportunity to Tailor Education to Individual Patient Needs

Establish mechanism to allow for education that is flexible to patient needs based on specific diagnosis and clinical pathway.

Practice Assessment

This strategy is a highly effective, though resource intensive, means of improving upfront patient education in order to activate patients and families in care. Feasibility is limited to more predictable clinical pathways.

Global Centre for Nursing Executive Grades

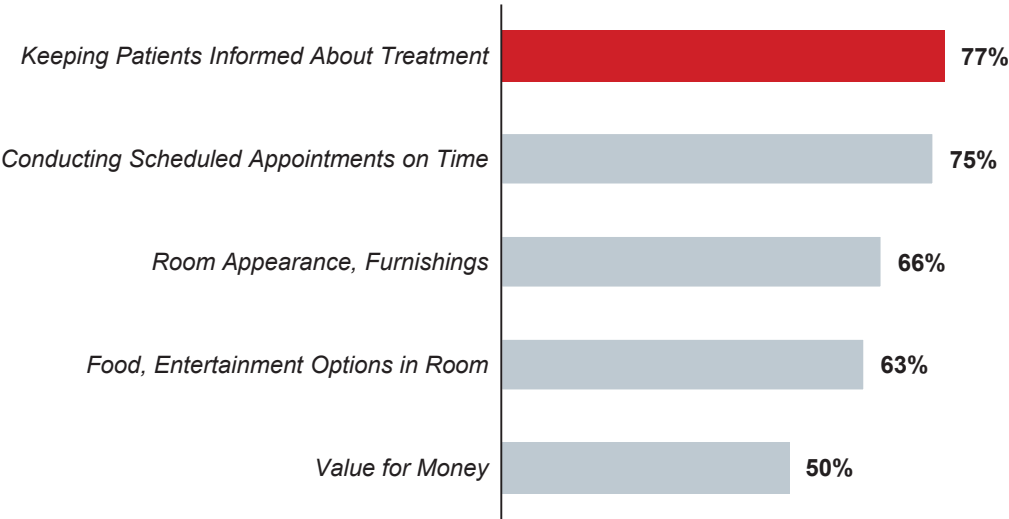
Practice Impact: A-

Hospital Effort: B-

Remaining informed about treatment across the episode of care is incredibly important to both patients and their families. Given the choice, a large percentage of patients would go so far as to switch hospitals in order to be kept more informed about their treatment.

Patients Putting a Premium on Education

Percentage of Patients¹ Reporting a Willingness to Change Hospitals According to Hospital Performance in Select Areas



1) Commercially insured inpatients.

Source: Grote K, Newman J, Sutaria S, "A Better Hospital Experience," *The McKinsey Quarterly*, November 2007; Global Centre for Nursing Executives interviews and analysis.

Leaders must prepare patients and families for involvement from the very beginning of the patient journey—in some cases, before they are admitted to hospital. To ease patient anxiety and equip patients and families to actively participate in care related to the diagnosis of colorectal cancer, clinicians at Prince Charles Hospital in Wales developed a comprehensive patient orientation video.

Caregivers at Prince Charles recruited a task force of patients and families who had prior experience with colorectal cancer to advise them on the creation of this video.

Leaders wanted to ensure they were including the information that patients and their families felt was most important. In order to accomplish this goal, this group of patients and staff met routinely for several months to develop and edit the video script.

Component #1: Solicit Input from Key Stakeholders to Identify Essential Information

Key Components of Prince Charles Hospital's Approach



Solicit Input from Advisory Group of Former Patients

- Leverage advisory group's experience to develop content, understand what they wish they had known
- Review scripting to translate jargon, eliminate anxiety-producing words, phrases



Provide Comprehensive Overview of the Patient Journey

- Step-by-step walk-through of treatment across the continuum
- Customisable to patient's individual experiences and needs
- Provides realistic portrayal of ward environment, procedures



Visually Introduce Patients to Ward Environment and Staff

- Minimise anxiety caused by unfamiliarity with staff members, ward environment
- Orient patient to surroundings, what to expect



Case in Brief: Cwm Taf Health Board

- Approximately 450-bed health board serving approximately 325,000 people principally covering the Merthyr Tydfil and Rhondda Cynon Taff Local Authority areas
- Orientation video project developed to enhance information given to colorectal surgery patients at Prince Charles Hospital; project plan developed September 2008 and funded through grant from Johnson & Johnson
- Multidisciplinary project group of staff, patients provided advice on content, scripting; patients recruited primarily from Colorectal and Stoma Care Support Group
- Film completed January 2009, distributed April 2009
- Film runs approximately 40 minutes; two hours of footage incorporated onto DVD with optional scenes
- Overall winner for Patient Experience Network Award 2011

To view an overview video clip of Cwm Taf's orientation DVD, visit:

advisory.com/gcne/CwmTaf

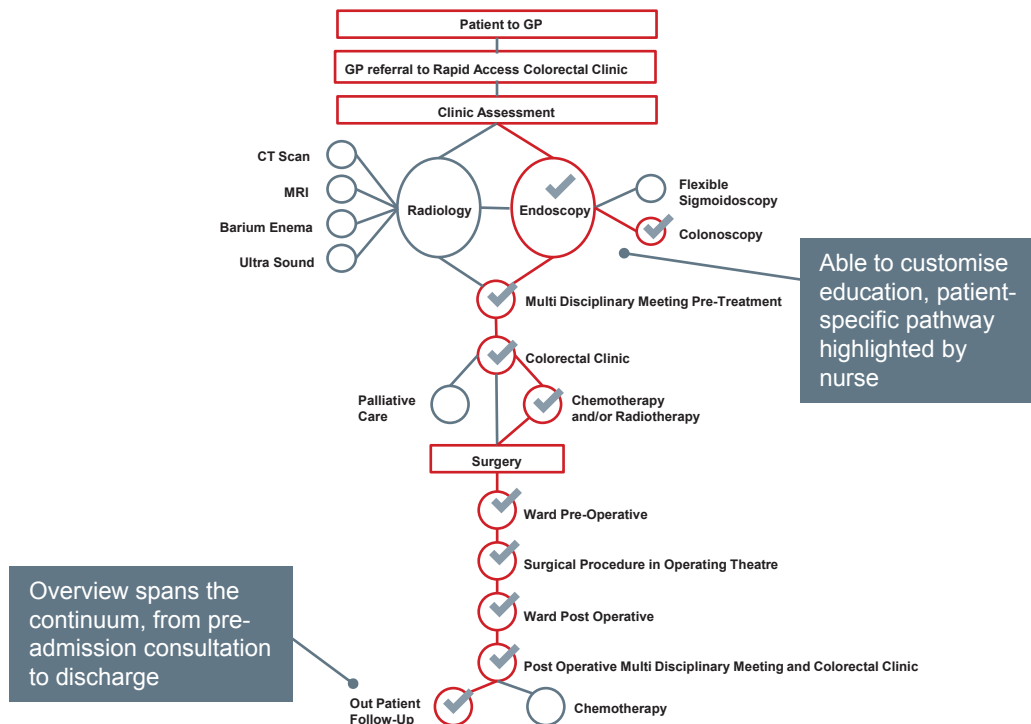


Patients are given the DVD during a routine consultation, in which a nurse walks through the DVD insert. The specialist nurse indicates the steps that will be most relevant to that individual patient's journey. This exercise serves two important purposes. First, it provides a structure for a conversation about the patient journey. Second, since the scene selection feature of the DVD allows viewers to seek additional information on specific steps in the journey, it provides an opportunity for care providers to identify segments of the DVD that the patient and his or her family may be interested in viewing in greater detail.

Providing robust, tailored and comprehensive orientation benefits patients and families by easing their anxiety and activating them in the care process. Ultimately, the distribution of the DVD benefits staff as well. When patients and families are better informed, care providers can optimise their consultations and make the most effective use of limited time. Leaders at Prince Charles Hospital are careful to note that the DVD is not a substitute for clinician-patient interaction and education. Rather, it is intended to complement and enhance the quality of that interaction.

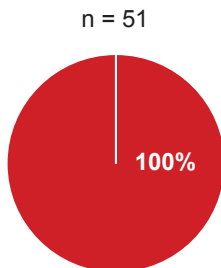
Component #2: Provide Opportunity to Tailor Education to Individual Patient Needs

Cwm Taf Patient Information DVD Insert



Patient-Centred Orientation Achieves Multiple Aims

Patients Reporting Satisfaction with the DVD



- Patient can easily share information about treatment, prognosis with family members
- Prepares relatives to support patient through journey, reduce anxiety

“

Optimising Consultation

“It helps us to focus the patient, and obviously when they do come back to see us, we’re finding that their questions are much more directed, and they are optimising the information that they receive in their second consultation.”

Senior Colorectal Nurse Specialist, Prince Charles Hospital

Practice #6: Patient-Centred Daily Care Plan

— Practice in Brief —

Caregivers provide patients with an automatically generated daily care plan written in patient-friendly terms and then review the care plan with them. The aim of the practice is to help patients understand their plan of care, equipping them to ask informed questions and provide input into treatment decisions.

Rationale

Patients and families are often not informed of the specific elements of the patient's care plan—and even when they are, the information is often conveyed in clinical terms that patients and families cannot readily understand. By providing patients and family members with a written care plan that uses easy-to-understand layman's terms and reviewing the plan with them, nurses can equip patients and families to play a more active role in their care.

Implementation Components

Component #1: Translate Clinical Jargon into Plain Language

As part of the process of automatically generating the care plan, translate clinical terms into language patients and families can readily understand.

Component #2: Provide Daily Care Plan to Patient

Provide each patient with an automatically generated, printed care plan auto-populated by the electronic medical record (EMR).

Component #3: Review Care Plan with Patient and Family

Frontline staff discuss the care plan daily with each patient to confirm the patient understands the key elements of care for the day, and surface any discrepancies between the document and the patient's or family's perception of the care plan.

Practice Assessment

This practice has the potential to dramatically improve patients' understanding of their own clinical goals and their role in advancing those goals. It requires an electronic documentation system and an up-front investment in automating the report. However, once initial investments are in place, the practice requires minimal ongoing resources.

Global Centre for Nursing Executive Grades

Practice Impact: A

Hospital Effort: B-

The first key component of the Patient-Centred Daily Care Plan is to convert potentially confusing medical terms into language patients and families can easily understand. At Abington Memorial Hospital in Abington, Pennsylvania, inputs from the EMR are automatically translated into patient-friendly terms for their Daily CARE Plan.

Component #1: Translate Clinical Jargon into Plain Language

Sample Translations Included on Patient-Centred Daily Care Plan

Clinical Terminology	Patient-Friendly Translation
O2 Therapy Cannula 2.0 LPM	A way to deliver needed oxygen to help you breathe better
Oximetry (Resp) Routine	A way to check the percentage of oxygen in your blood
Comprehensive Metabolic Pnl	A blood test that measures your blood sugar level, electrolyte and fluid balance, kidney function and liver function
CBC/Platelets	A complete blood count (CBC) provides important information about the kinds and numbers of cells in the blood, especially red blood cells, white blood cells, and platelets
CK w/Reflexive MB	A blood test that measures the amount of muscle enzyme in your blood



Case in Brief: Abington Memorial Hospital

- 627-bed, Magnet-recognised hospital located in Abington, Pennsylvania, winner of the 2008 Magnet Prize and 2011 Magnet Prize Honor
- IT department automated translation of clinical terminology used in the plan of care to layman's terms; goal to create copy of plan of care that could be easily understood by patients
- Paper-based Kardex automated in 2005
- Nursing Informatics Director, nursing staff, and EMR vendor worked to automate pulling, printing of reports for nurses
- Nurse walks patient through translated CARE Plan daily, highlights most important information; patient keeps highlighted CARE plan for reference
- Daily CARE Plan recipient of 2008 Magnet Award

The second component is to provide patients with a written summary of their daily plan of care. Frontline staff at Abington Memorial accomplish this by automating a printed daily report which is entirely populated from existing EMR inputs. It outlines central elements of care, including prescribed medications, laboratory and radiology tests, nutrition, and consults.

A complete version of Abington Memorial's "Daily CARE Plan" can be found in the Appendix of this study.

Component #2: Provide Daily Care Plan to Patient

Abington Memorial's Daily Care Plan¹



Your personal guide for Communication, Access to Information, Resources, & Education

SMITH, ANGEL **ADMIT DATE: 11/09/11**

Health Issues: Admitting Dx Chest Pain

Health Issues: Secondary Dx Cough

Allergies: Penicillin

Code Orders: No Code/DNR Per Patient

Medications

Acetaminophen Tablet 1000mg (every 6 hours) (as needed)

Heparin (10,000 Units/mL) Injection 5000 Unit(s) (every 12 hours)

Aspirin Tablet 325 mg (once a day)

Digoxin Tablet 125 mcg (once a day)

Respiratory Care

O2 Therapy Cannula 2.0 LPM (continuous)- A way to deliver needed oxygen to help you breathe better.

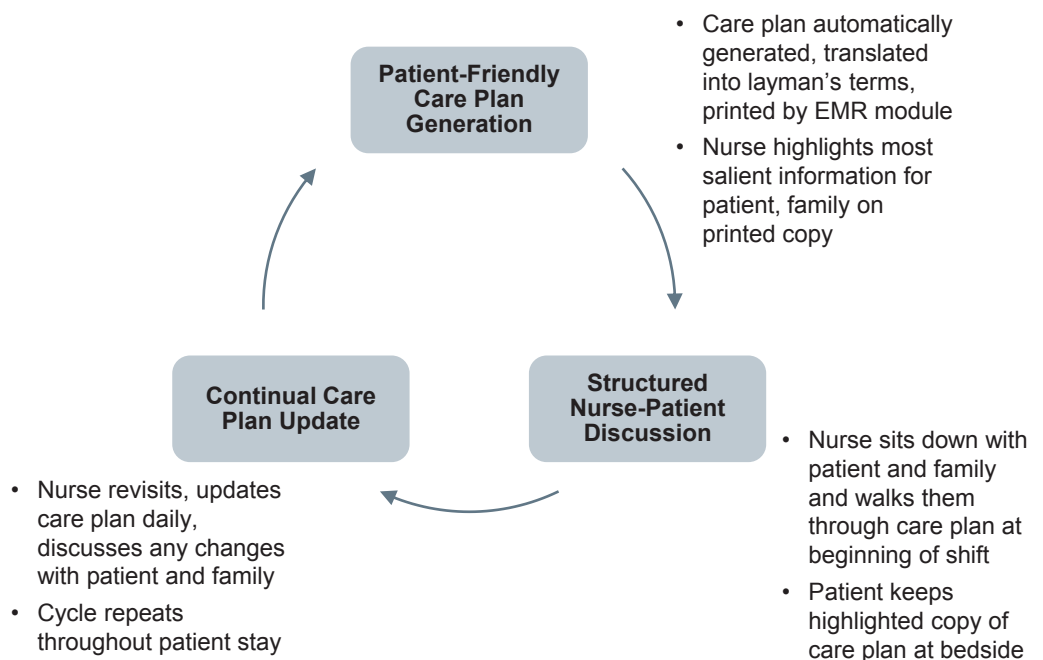
Oximetry (Resp) Routine (one time)- A test to check the percentage of oxygen in your blood

Nutrition

Diet – Common Cardiac Diet Lunch

The third component is to review the care plan each day with the patient and their family members. This not only reinforces patient and family understanding of the care plan, but provides patients and families with an opportunity to voice any discrepancies between the written care plan and their understanding of the care that should be provided.

Component #3: Review Care Plan with Patient and Family



1) Select excerpts.

Leaders seeking a less resource-intensive alternative to the Patient-Centred Daily Care Plan but still wishing to increase patient understanding of key elements of care should consider the option shown to the right. Leaders at The Children's Mercy Hospital in Kansas City, Missouri, developed the Family-Friendly Medication List, which provides patients and families with a list of medications and associated information in plain language. Like Abington Memorial Hospital's Daily Care Plan, the Family-Friendly Medication List is automatically generated from existing clinical data.

Ensuring Patient Comprehension of Medications

The Children's Mercy Hospital's Family-Friendly Medication List

Run Date: 10/18/11 15:42

Family Friendly Medication List

Page: 1 of 2

Patient/Parent/Guardian Copy

Patient: Jane Smith

Date of Birth: 7/6/1998

Medical Record # 2569423

Height: 4'11"

Weight: 98 lbs

Adverse Reactions: No Known Adverse Reactions


Medication	Dose	Route	How Often	Scheduled Times*	Comments
VALGANciclovir (VALGANciclovir)	100 mg	Oral	2 times a day		
**ceftriaxone (Rocephin)	1,170 mg	Intravenous	every 24 hours		

All of patient's medications listed prominently on single, easy-to-read chart

Route and frequency of administration of medications written in layman's terms to ensure patient and family comprehension

Designated field for patients, families to record questions for physician or comments about medications

A complete version of The Children Mercy Hospital's "Family-Friendly Medication List" can be found in the Appendix of this study.



Case in Brief: The Children's Mercy Hospital

- 319-bed, Magnet-recognised paediatric academic medical centre located in Kansas City, Missouri
- Family-Friendly Medication List implemented in March 2010; automatically generated from the EMR, printed and provided to patients and families daily
- Lists all patient's medications, method of delivery, and frequency of administration in layman's terms
- Nurses use Family-Friendly Medication List for teaching patients and families about their medications throughout the hospital stay

Source: The Children's Mercy Hospital, Kansas City, MO; Global Centre for Nursing Executives interviews and analysis.

In addition to the three components described on the preceding pages, leaders at Abington Memorial and Mercy Children's Hospital offer the guidance shown here for successfully implementing Patient-Centred Daily Care Plans.

Key Daily Care Plan Implementation Guidance

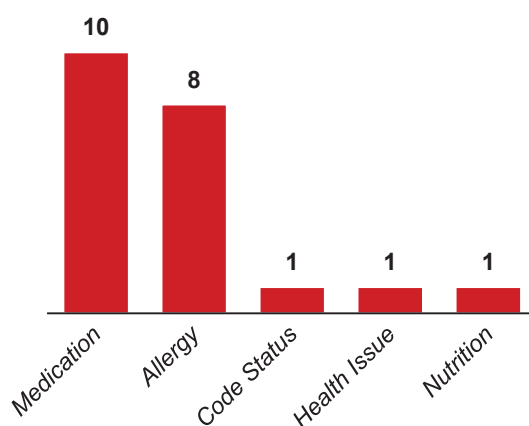
Guidance for Introducing and Best Leveraging Patient-Centred Daily Care Plans	
✓	Involve frontline staff in implementation by soliciting feedback on components of patient-centred care plan; leverage frontline staff knowledge of patient informational needs to craft most useful translations of clinical information
✓	Seek feedback on language and format from patient, family advisors to maximise utility of patient-centered care plan or MAR ¹
✓	Ensure effectively translated clinical information used as a complement to, not a substitute for, in-person education
✓	Assess effectiveness of patient-centred care plans or MARs during and after rollout via discharge phone calls; revise if necessary

Abington's Daily Care Plan advances multiple goals, including patient safety. Across 2009, leaders at Abington Memorial identified more than 250 near misses, many of which were identified by patients following review of the Patient-Centred Daily Care Plan.

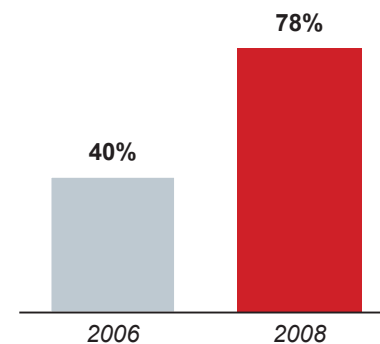
Advancing Complementary Goals

Near Misses Identified in 2009

n=254



Percentage of Patients Whose Nurses Reviewed the Daily CARE Plan with Them



1) Medication Administration Record.

Source: Abington Memorial Hospital, Abington, PA; Children's Mercy Hospital, Kansas City, MO; Global Centre for Nursing Executives interviews and analysis.

Practice #7: Two-Way Communication Board

— Practice in Brief —

Communication Boards are placed in patient rooms and updated daily to convey key information to patients and family members about the plan of care.

Communication Boards Erasable whiteboards kept at the patient's bedside. Designed to be a visual means of communicating information among patients and multidisciplinary caregivers. These boards typically include information related to plan of care for the day and discharge planning.

Rationale

In the absence of Communication Boards, caregivers communicate essential information to patients verbally as it becomes available, or in response to patient and family member inquiries. Many hospitals have adopted Two-Way Communication Boards as a tool to keep patients abreast of their care plans. However, all too often, caregiver compliance remains low and Communication Boards are underutilised. Nurse leaders can improve caregiver use of Communication Boards by systematically soliciting staff and patient input on Communication Board design and workflow.

Implementation Components

Component #1: Gather Frontline Staff Feedback on Proposed Communication Board Elements

Solicit the input of frontline staff members to ensure Communication Boards will meet caregiver communication needs and frontline staff are invested in the success of Communication Boards.

Component #2: Gather Former Patient Feedback on Proposed Communication Board Elements

Solicit the input of former patients on proposed Communication Board elements and where in patient rooms the boards should be placed.

Component #3: Audit Communication Board Completion Through Structured Method

Once Communication Boards have been deployed, institute a standardised auditing method to ensure frontline staff members are consistently using Communication Boards.

Practice Assessment

This practice provides an effective and straightforward method of communicating essential information to patients and families. It is recommended for all organisations.

Global Centre for Nursing Executive Grades

Practice Impact: B+

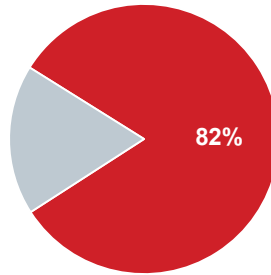
Hospital Effort: B

Though Communication Boards are seen in hospitals around the world, they are frequently underutilised. One reason so many institutions struggle to successfully implement Communication Boards is widespread confusion regarding which caregiver is responsible for completing them. In most cases, frontline nurses are best positioned to be responsible for updating Communication Boards daily, with the goal of conveying key information about the plan of care to patients and families.

A Nurse-Driven Tool for Patient Communication

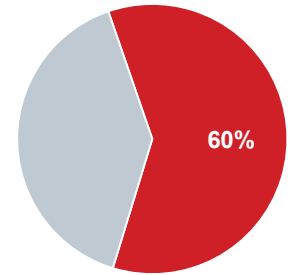
Percentage of House Staff Who Think Nurses Should Be Responsible for Filling Out Communication Board

n=118



Percentage of Nurses Who Think They Should Be Responsible for Filling Out Communication Board

n=104



Study in Brief: "Patient Communication Boards as a Communication Tool in the Hospital Setting: A Survey of Practices and Recommendations"

- One-month survey of staff at University of California, San Francisco: Participants asked to report frequency of use, usefulness, attitudes toward Communication Boards; respondents included 104 nurses, 118 internal medicine house staff, 321 hospitalists
- Majority of respondents reported nurses should be responsible for putting information on Communication Boards, including over 80% of organisation staff and 60% of nurses

A simple audit can identify potential opportunities for improvement at organisations that have deployed Communication Boards.

The following pages contain focused guidance on improving performance on Communication Board elements addressed in questions six, seven, and eight.

Assessing Your Communication Board Strategy

Two-Way Communication Board Red Flag Audit

Answer the questions below to assess your institution's current two-way communication board efforts. Multiple "no" responses suggests your institution should consider revising its two-way Communication Board format and contents.

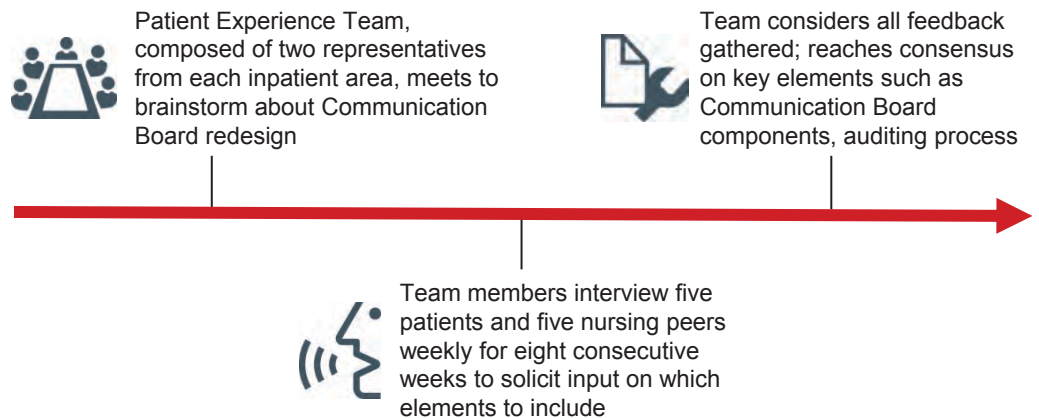
Does your institution:

	Yes	No
1. Ensure staff can easily access the board in patient rooms without disturbing patients?	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide an ample number of Communication Board pens near the board?	<input type="checkbox"/>	<input type="checkbox"/>
3. Include between six and ten elements on the Communication Board?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ensure a two-way exchange of information (e.g., fields for caregiver-to-patient communication and fields for patient-to-caregiver communication)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Enable wards with unique patient populations, (such as mother-baby or ED), to customise the Communication Boards to best meet the needs of patient and staff in these care areas?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have a sound process in place for soliciting and integrating staff input into Communication Board design?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have a sound process in place for soliciting and integrating former or current patient input into Communication Board design?	<input type="checkbox"/>	<input type="checkbox"/>
8. Enforce a consistent auditing strategy to ensure Communication Board compliance?	<input type="checkbox"/>	<input type="checkbox"/>

The first component of successfully adopting Communication Boards is soliciting staff input on Communication Board design. The goal is to ensure Communication Boards meet caregivers' needs and that frontline caregivers are invested in Communication Board success. Leaders at Medical Center Arlington in Arlington, Texas, used a three-step process to solicit caregiver input.

Component #1: Gather Frontline Staff Feedback on Proposed Communication Board Elements

A Three-Step Process for Gathering Communication Board Feedback at Medical Center Arlington



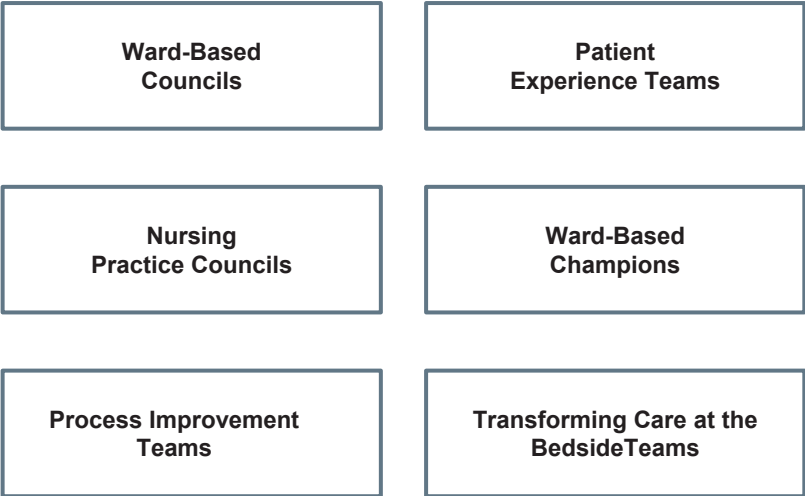
Case in Brief: Medical Center Arlington

- 236-bed hospital, located in Arlington, Texas
- In Q4 of 2010, launched patient experience teams dedicated to improving communication; teams initially met weekly, now meet monthly
- Positive Patient Experience team led development of standardised inpatient ward Communication Boards; ED Communication Boards modified to reflect different needs of patient population
- Organisation-wide Communication Board compliance close to 90% in 2011

To gather frontline input on Communication Board design, nursing leaders can use existing structures and communication channels.

Leveraging Existing Channels for Frontline Input

Potential Structures for Eliciting Frontline Staff Feedback on Communication Boards



The Global Centre for Nursing Executives recommends using the questions shown to the right to elicit detailed feedback from frontline staff on Communication Board design and workflow. These questions are drawn from questions used by nurse leaders at Women and Infants Hospital of Rhode Island.

Facilitation Guide to Prompt Meaningful Staff Input

Guide for Gathering Frontline Staff Feedback on Communication Board Elements

- Which elements would our patients find most helpful on our Communication Boards?
- From a bedside nurse perspective, which elements would be most helpful to include on the Communication Board?
- Who will be responsible for filling out the information on Communication Boards? When?
- Where will we place Communication Boards to ensure all staff can easily access them?
- Should all Communication Boards look the same, or will some wards want to customise them?
- What is the fairest and most effective way to ensure that Communication Boards are always completed?



Case in Brief: Women and Infants Hospital of Rhode Island

- 197-bed hospital, located in Providence, Rhode Island
- Redesigned Communication Board template in 2011; allowed nurses to participate in redesign by offering input on which elements to include from sample Communication Boards
- Proposed Communication Board design also vetted through Family Advisory Council to ensure patient friendliness
- Boards largely standardised across hospital, although customised for mother-baby wards

The second component of successfully deploying Communication Boards is gathering *patient* feedback on Communication Board content to ensure the boards proactively provide patients with desired information. The Global Centre for Nursing Executives recommends using the questions to the right to elicit meaningful feedback from current and former patients.

Component #2: Gather Former Patient Feedback on Proposed Communication Board Elements

Guide for Gathering Patient Feedback on Communication Board Elements

- As a patient, what information would it be most important for staff to write on the Communication Board?
- As a patient, what kind of information did you not know that you would have liked to know? Would a Communication Board be a good place to provide future patients with this information?
- Would you find a designated field where patients and families could write questions or comments helpful?
- What is the best place to display Communication Boards to ensure all patients can see them?
- How often do you think Communication Board information should be updated?

When soliciting patient and staff input on Communication Board design, the Global Centre for Nursing Executives recommends sharing the picklist of potential elements shown to the right. The goal is to inform patient and staff recommendations and ensure all potential elements are considered.

Facilitating Discussion with the Global Centre's Picklist

Potential Communication Board Elements



- | | |
|-----------------------------|---|
| ✓ Goal for the day | ✓ Charge nurse name and number |
| ✓ RN name and number | ✓ Patient preferences |
| ✓ Physician name and number | ✓ Most important thing care team can do for patient |
| ✓ Rapid response team line | ✓ PCA name and number |
| ✓ Procedures for the day | ✓ Case manager name |
| ✓ Patient/family questions | ✓ Dietary aid name and number |
| ✓ Spokesperson's name | ✓ Time of last pain medication |
| ✓ Estimated discharge date | |
| ✓ Pain scale | |

After gathering frontline staff and former patient feedback, nurse leaders should finalise the Communication Board design and deploy Communication Boards in all inpatient wards.

Leaders at Sentara Bayside Hospital in Virginia Beach, Virginia, ultimately decided on the board shown here after seeking extensive stakeholder input.

The Global Centre's "Communication Board Library" can be found in the Appendix of this study.














For additional guidance on implementing Communication Boards, see:

advisory.com/gcne/communicationboard



Posting Patient- and Caregiver-Friendly Communication Boards

Sentara Bayside's Communication Board

 You are in Room #:	 The Phone # is:	 SENTARA. We improve health everyday
 Your Care Team for this shift is:	 Today's Date:  Your Physician(s):	
 Our goal for today:	 What you have scheduled for today:	
 Your Special Precautions: <input type="checkbox"/> Fall Risk <input type="checkbox"/> Other <input type="checkbox"/> Isolation <input type="checkbox"/> NPO-nothing by mouth		
Family Initiated Rapid Response Safety Team FIRST: Dial 5-5555 If You're Concerned, So Are We		
 Spokesperson:	 Your Questions and/or comments:	
 Opportunity for Excellence 1. 2. 3.		
 Your care is our highest priority. If you would not rate your care as excellent, please speak with the Charge Nurse of this unit. The following are also available:		



Case in Brief: Sentara Bayside Hospital

- 158-bed hospital, located in Virginia Beach, Virginia
- Communication Boards developed in August 2009 by All Committed to Excellence Team, rolled out organisation-wide October 2009; similar board also implemented at Sentara Leigh Hospital in Norfolk, Virginia
- During Communication Board development process patient volunteers in hospital beds offered feedback on communication board placement and size; based on feedback collected, team decided boards should be 24x36 inches

The final component of successfully implementing Communication Boards is auditing caregiver compliance. The keys to a successful auditing process are consistency and caregiver buy-in. To that end, the Global Centre for Nursing Executives recommends allowing frontline staff a voice in selecting the auditing process. All four methods shown to the right can be effective in promoting compliance; allowing staff input improves buy-in without impacting the value of auditing.

Component #3: Audit Communication Board Completion Through Structured Method

Select Auditing Tactics

Auditing Method	Benefits	Institution
Weekly Compliance Report Review: Nurses mark initials on piece of paper in each room at change of shift indicating that board has been updated; compliance report sent to nurse managers weekly for distribution	<ul style="list-style-type: none"> • Gives sense of ownership • Relies on honor system 	Sentara Bayside Hospital 158-bed hospital in Virginia Beach, VA
Bedside Report Peer Audit: Communication Boards updated at bedside shift report; off-going and oncoming nurses hold each other accountable for compliance	<ul style="list-style-type: none"> • Incorporated into pre-existing workflow for frontline staff • Promotes peer accountability 	Goulet Hospital¹
Random Weekly Spot-Check: Positive Patient Experience Team ² members each audit 10 rooms weekly	Frontline held accountable by combination of peers and clinical directors signaling both top-down and grassroots support	Medical Center Arlington 236-bed hospital in Arlington, TX
Regular Manager Audits: Managers audit compliance during daily rounding	<ul style="list-style-type: none"> • Incorporated into pre-existing manager workflow • Emphasises importance of compliance to bedside staff, patients and families, and hospital leadership 	Vidant Health 1,400+ bed health system headquartered in Greenville, NC

1) Composite.

2) Composed of one or two representatives from each inpatient unit.

Source: Sentara Bayside Hospital, Virginia Beach, VA; Medical Center Arlington, Arlington, TX; Vidant Health, Greenville, NC; Global Centre for Nursing Executives interviews and analysis.

Practice #8: Patient Care Partners

— Practice in Brief —

A patient's family member or friend volunteers to formally serve as part of the care team and perform patient care responsibilities mutually agreed upon by the volunteer, patient and formal care team.

Rationale

Patients' friends and family members are often present throughout a patient's inpatient stay. However, they are rarely integrated into the care team or provided with clearly defined patient care tasks. As a result, hospital staff underutilise a potential resource, and family members and friends miss out on an opportunity to help the patient recover. The practice also serves as an opportunity for family members to learn—in a controlled environment and under the supervision of qualified staff—how to help manage the patient's condition, which is increasingly important in the era of chronic disease.

Implementation Components

Component #1: Screen Potential Patient Care Partners

Assess whether a patient's friends or family members have sufficient time, energy, focus, and motivation to serve as an effective Care Partner.

Component #2: Assign Care Partner Key Responsibilities

Frontline staff collaborate with the Care Partner to clearly define what responsibilities he or she will assume.

Component #3: Orient Care Partners to the Role

Provide Care Partners with a thorough orientation to the ward layout, key hospital resources, and defined patient care tasks.

Practice Assessment

This is a highly effective method of empowering patients' friends and family members in their care. It has the potential to off-load select responsibilities from frontline staff and re-assign them to Patient Care Partners. However, evaluating and orienting potential Patient Care Partners can require a significant time investment.

Global Centre for Nursing Executive Grades

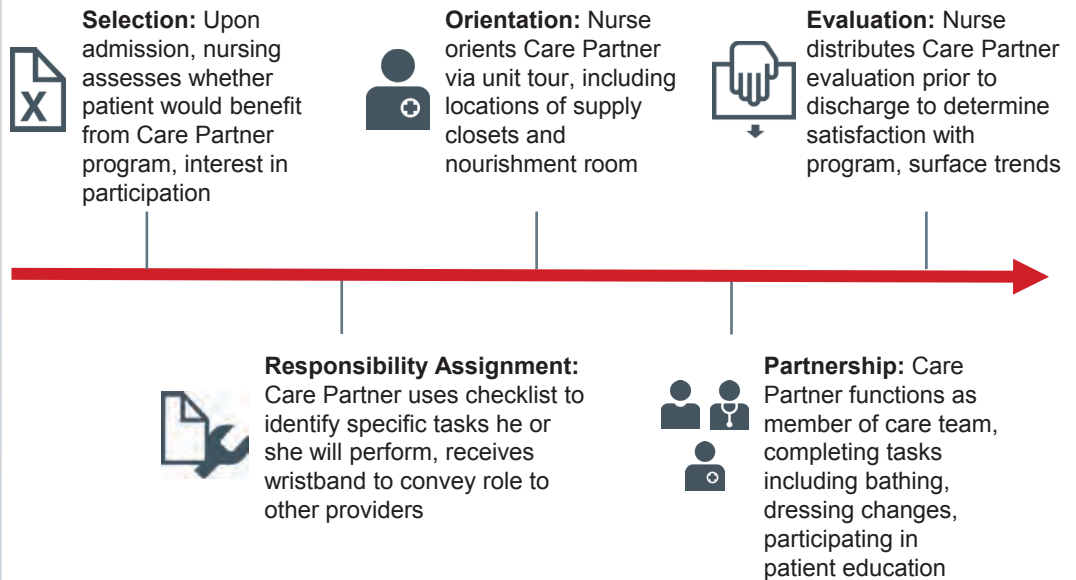
Practice Impact: B+

Hospital Effort: B

To more actively involve friends and family members in patient care, leaders at Sharp Memorial Hospital in San Diego, California, implemented the Patient Care Partner program. An overview of the program is shown to the right. The first three components are essential to the success of the Care Partner program and are described in detail on the following pages.

Formalising Family Member or Friend Role as a Care Partner

Key Steps of the Care Partner Process at Sharp Memorial



Case in Brief: Sharp Memorial Hospital

- 675-bed hospital located in San Diego, California; part of Sharp HealthCare
- Care Partner program initiated in August 2009; piloted for six months on a med/surg ward, now implemented throughout the organisation
- Upon admission, nurse assesses whether patient would benefit from Care Partner program, candidates provided with brochure describing program; currently levels of participation range from 5% to 30%
- Bedside nurse orients Care Partner to ward via tour including location of linen room, ice machine, nourishment room, snack cart, exits, resource person
- Program participants select how involved they want to be in loved one's care by completing a checklist of optional tasks
- Conducted study entitled "Exploring the Lived Experience of the Care Partner Participating in the Care Partner Program"; data revealed that the more care partners participated, the more acknowledgement they received, and the more empowered they felt

The first component is screening potential Patient Care Partners to assess their compatibility and interest in the role. Leaders at Sharp Memorial believe friends or family members of patients that meet the criteria listed to the right make the most effective Care Partners.

Component #1: Screen Potential Patient Care Partners



Checklist of Desired Care Partner Attributes

- ☐ Patient's anticipated length of stay is greater than one day
- ☐ Care Partner demonstrates positive dynamic with patient
- ☐ Care Partner and patient express mutual desire for Care Partner to adopt official support role
- ☐ Care Partner is available regularly to assist and support patient
- ☐ Care Partner does not have significant medical complications that impede meaningful participation in his or her role
- ☐ Care Partner demonstrates emotional resiliency

The second component is for a patient’s assigned caregivers to collaborate with the Care Partner to mutually agree upon the patient care responsibilities the Care Partner will perform. At Sharp, a member of the care team presents a list of potential activities to the Care Partner. The Care Partner may choose as many or as few tasks from the list as desired.

Component #2: Assign Care Partner Key Responsibilities

Care Partner Involvement Checklist

☐ Be the spokesperson for family/friends about patient’s progress

☐ Sit with patient and offer advice

☐ Assist with meals, menu selection, feed patient

☐ Provide juice and snacks

☐ Obtain gown and other linens

☐ Be available for educational opportunities to learn about illness, treatment

☐ Educate guests, staff on hand hygiene upon entering, leaving room

☐ Help with baths and personal care

☐ Record intake and output

☐ Learn simple treatments, wound care for home care

☐ Be available for educational opportunities to learn about illness, treatment

☐ Help patient to bathroom

☐ Be available during the nights

☐ Walk with patient in the hall

The final component is orienting Care Partners to their role. Frontline staff conducting the orientation equip Care Partners with the information needed to safely and effectively support the patient without placing an additional burden on frontline caregivers.

Component #3: Orient Care Partners to the Role

Key Elements of Care Partner Orientation Process at Sharp Memorial

Ward Tour

Once designated, Care Partner given tour of ward by nursing personnel

Introduction to Resources

Care Partner directed to Family Resource Center where educational materials, videos, books are available

Provision of Benefits

Care Partner introduced to cafeteria discount and free parking available with their wristband

Safety Education

Care Partner views hand hygiene video to ensure proper hand hygiene maintained across patient stay

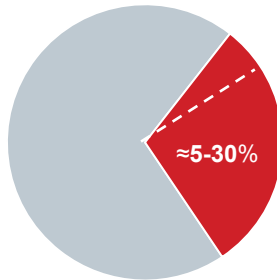
A collection of Sharp Memorial’s Care Partner Tools can be found in the Appendix of this study.

Source: Sharp Memorial Hospital, San Diego, CA; Global Centre for Nursing Executives interviews and analysis.

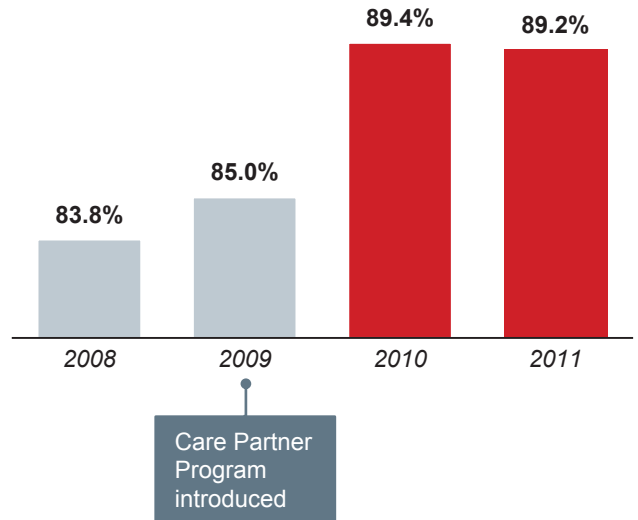
Leaders at Sharp consider the Care Partner program a key pillar of their patient experience strategy, which has yielded strong patient satisfaction scores year after year.

Patient Satisfaction Rises with Formalised Family Involvement

Percentage of Patients With Family or Friends Opting Into Care Partner Program¹



Percentage of Top Box Overall Hospital Ratings²



In addition to implementing the components described on the preceding pages, leaders at Sharp offer additional recommendations to those institutions seeking to establish a Patient Care Partner program.

Key Care Partner Implementation Guidance

Additional Considerations

- ☐ Designate ward-based champions for the Care Partner program to train frontline staff during huddles, provide coaching as needed
- ☐ Develop system to clearly identify trained Care Partners; options include bracelets, door signage, field on whiteboard
- ☐ Equip frontline staff with resources, such as a brochure to explain the program, checklist of tasks the Care Partner will perform, and ward tour itinerary

To hear about this initiative firsthand from leaders at Sharp Memorial, visit:

advisory.com/gcne/Sharp



1) Represents range of participation by unit.
2) According to Press Ganey database.

Practice #9: Family-Initiated Rapid Response Team

Practice in Brief

Family members are empowered to request urgent assistance from caregivers not directly involved in a patient's case to address an unmet concern about a patient's condition.

Rapid Response Teams (also known as Medical Emergency Teams or METs) for the purposes of this practice refers to the group of “on-call” clinicians with critical care expertise that is responsible for evaluating patients who develop signs and symptoms of clinical deterioration. The aim of these teams is to anticipate and prevent avoidable patient decline.

Rationale

Family members are often most knowledgeable about a patient's typical behaviour and health and may be able to detect subtle changes in patient status that are less visible to the care team. In many cases, however, the patient's family still lacks both the authority and opportunity to act on their observations, limiting their ability to play a truly influential role in safeguarding the safety of their loved one while in the inpatient setting. Enabling families to directly access a new caregiver unfamiliar with the patient's case ensures clinicians hear and address concerns expressed about unmet patient needs.

Implementation Components

Component #1: Educate Staff and Family About Family-Initiated RRT

Ensure staff and families are knowledgeable about the Family-Initiated Rapid Response Team (RRT), including when and how families can activate the RRT.

Component #2: Establish In-the-Moment Prompts for Families

Provide families with in-the-moment prompts to ensure they can immediately access the RRT when needed.

Component #3: Hardwire Follow-Up with Patient, Family

Ensure a trained individual follows up with families who call the RRT to confirm that all patient needs have been met.

Practice Assessment

This practice is foundational to elevating patient safety and the patient experience. It is recommended for all hospitals with established Rapid Response Teams.

Global Centre for Nursing Executive Grades

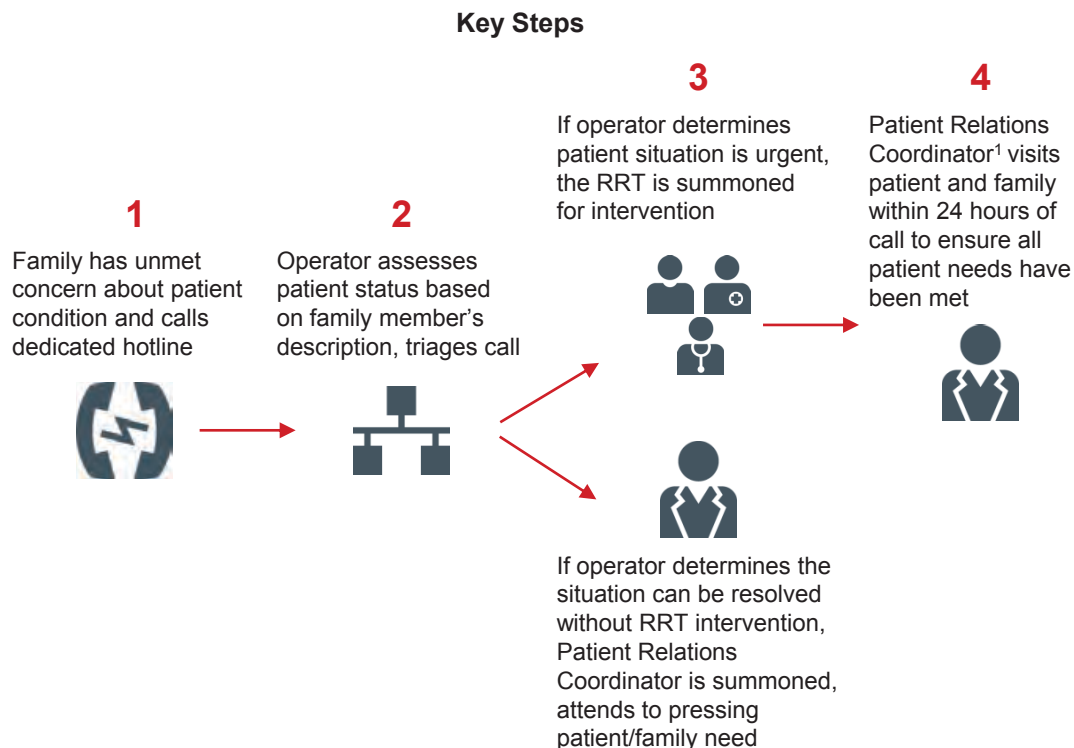
Practice Impact: A

Hospital Effort: B+

UPMC Shadyside was the first institution to implement a Family-Initiated Rapid Response Team, also known as Condition H. The practice has since spread to many institutions, including across the UPMC system.

UPMC has developed an effective process of activating Condition H. However, leaders at institutions with strong Condition H programs acknowledge designing the process is the lesser challenge. A greater challenge is ensuring it is used appropriately by patients and family members. Achieving appropriate utilisation of the Family-Initiated RRT hinges on three critical components.

Family-Initiated Rapid Response at UPMC



Case in Brief: UPMC Health System

- 20-bed health system based in Western Pennsylvania
- Condition H introduced at Children's Hospital of Pittsburgh in September 2005, followed by UPMC Presbyterian; policy extended system-wide in 2008
- Key implementation steps included conducting interviews with patients to understand most pressing concerns, staff in-service and patient education sessions, communications to medical and hospital staff, simulation of mock Condition H
- Patients, families oriented to Condition H via program brochure, signs in patient rooms, stickers on telephones with hotline number, signage in public areas of the hospital
- 94% of patients report needs were met following family-initiated rapid response from October 2010 to October 2011

1) A staff member tasked with addressing patient and family complaints

Source: UPMC, Pittsburgh, PA; Global Centre for Nursing Executives interviews and analysis.

The first component of Family-Initiated Rapid Response Team is providing hospital staff with extensive up-front education about the Family-Initiated RRT.

UPMC Shadyside uses a Condition H Information Sheet to explain the process to admissions team members. The goal is to ensure hospital staff members do not react defensively to Family-Initiated RRT calls.

A complete version of UPMC's "Condition H Information Sheet for Admissions Team" can be found in the Appendix of this study.

It is equally important to educate families about Family-Initiated RRT to ensure family members are well-informed about the RRT resource and process. Frontline staff at UPMC use carefully crafted scripting to explain the process to families on their wards.

A complete version of UPMC's "Sample Scripting for Educating Families About Condition H" can be found in the Appendix of this study.

Component #1: Educate Staff and Family About Family-Initiated RRT

Condition H Information Sheet for Admissions Team

What is it?

It is a "Condition Help" that patients/families can initiate in the case of:

- There is an emergency and you cannot get the attention of hospital staff
- You see a change in the patient's condition and the health care team is not recognising the concern
- You have spoken to the hospital staff and you continue to have serious concerns about the patient's care
- There is a breakdown in how care is given, or uncertainty over what needs to be done

Who Responds?

Physician, Floor Nurse, ANC (Nursing Supervisor), and Patient Relations Coordinator (when in house)

Why at UPMC Shadyside?

At UPMC Shadyside Hospital we are building the hospital of the future with the help of patients and families we care for. We believe in teamwork and ask that families/patients be a part of the team when visiting loved ones.

Sample Scripting for Educating Families About Condition H

"I want to share information with you on the newest addition to our hospital's Rapid Response Teams. (May need to explain to them what a Rapid Response Team is and share that we have teams that come to patients' rescue when hospital personnel call condition A or C in clinical crisis situations). "The new addition to the Rapid Response Teams is called a "Condition Help" that patients/families/visitors can initiate in the case of."

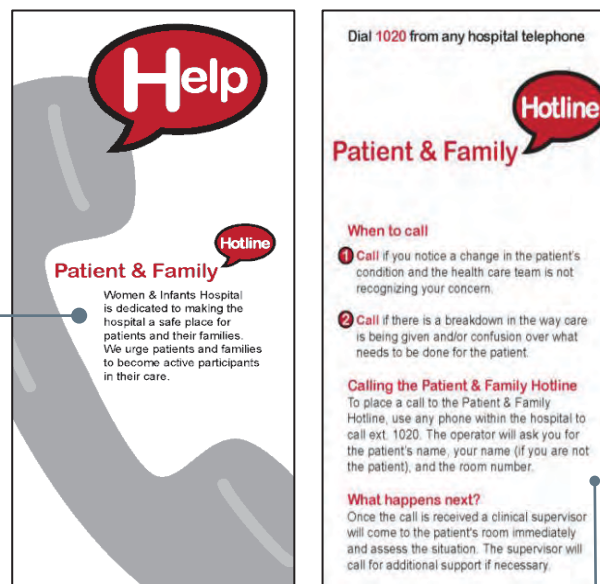
"A change you (the patient/visitor) notice in your loved one's condition when you have tried to express it to the health care team and felt you weren't listened to. Condition H can also be called if there is a breakdown in how care is being given and confusion over what needs to be done or if patients/families have conflicts with what is happening. Condition H can also be called when an emergency occurs when you (patient or visitor) is/are unable to locate hospital personnel. A condition H can be called for those situations that you would call 911 for when at home. "Please try to locate hospital staff first, but if your attempts are unsuccessful, a condition H may be called."

The second component of the practice is establishing in-the-moment prompts for families to call the Family-Initiated Rapid Response Team when needed. While an up-front understanding of the Family-Initiated RRT is essential, without these prompts, families may struggle to remember how to access this resource. Effective in-the-moment resources include brochures, posters, tent cards displayed on tables next to patients' beds, and reminders on Communication Boards.

Component #2: Establish In-the-Moment Prompts for Families

Women and Infants Hospital of Rhode Island Condition H Brochure

Inviting language encourages patients and families to activate the care team



Explains to families when and how to call, and what to expect following the call

A full-sized version of Women and Infants Hospital's "Condition H Brochure" can be found in the Appendix of this study.



Case in Brief: Women and Infants Hospital of Rhode Island

- 197-bed hospital located in Providence, Rhode Island
- Condition H implemented in 2009
- Received between five and ten calls since 2009; majority of calls pertain to breakdowns in communication

The final step in this practice is hardwiring follow-up with the patient and family. A dedicated individual should follow up within a short time frame with all families who call the RRT to ensure their concerns have been addressed. Staff at UPMC Shadyside use a follow up form to structure a discussion with patients and families after a Family-Initiated RRT activation.

A full-sized version of UPMC Shadyside's "Condition H Follow-Up Form" can be found in the Appendix of this study.

Component #3: Hardwire Follow-Up with Patient, Family

UPMC Shadyside's Condition H Follow-Up Form

6. Name of Caller: _____

7. Relationship to Patient :

☐ Patient ☐ Family ☐ Friend

☐ Staff ☐ Clergy ☐ Other

8. Nature of Call:

☐ 1. Medical Management ☐ 7. Delay in Care

☐ 2. Diet Related ☐ 8. Dissatisfaction with Staff

☐ 3. Psychosocial Issues ☐ 9. False Call/Cancelled

☐ 4. Discharge Planning Related ☐ 10. Communication Breakdown

☐ 5. Clarification of Orders ☐ 11. Allergy Related

☐ 6. Pain Control/Medication Related ☐ 12. Other: _____

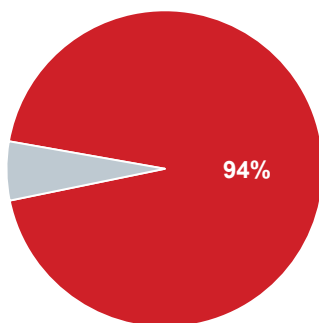
9. Briefly describe the happenings that occurred prior to initiation of Condition H: _____

Recent results suggest Family-Initiated RRTs are supporting UPMC's patient safety and satisfaction efforts. Between October 2010 and 2011, 94% of patients reported their needs were met following a Condition H call.

Seeing Returns on Family Activation of the Care Team

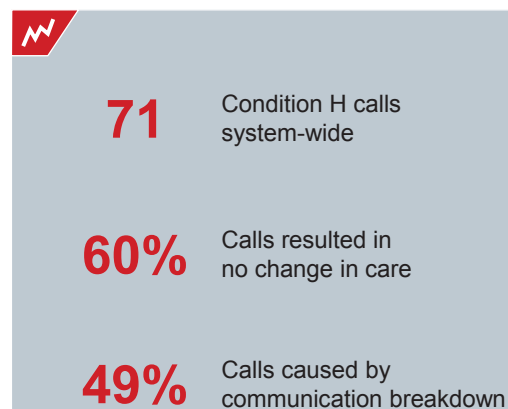
Percentage of Patients Reporting Their Needs Were Met Following a Condition H Call

n=71



UPMC Condition H Utilisation

October 2010 to October 2011



Practice #10: Patient and Family Peer Mentors

— Practice in Brief —

Current patients are matched with mentors who are former patients (or family members of former patients) who have had a similar inpatient experience; mentors provide emotional support and guidance to patients and/or families throughout the care episode.

Rationale

Caregivers often do not have direct experience of what it is like to be hospitalised for a specific condition or event. In contrast, patient and family mentors who have been in similar situations can both truly empathise with the patient and offer detailed, practical guidance on long-term self-care. In addition, volunteers often have more time available to spend providing this type of support than caregivers.

Implementation Components

Component #1: Identify Individuals Well Suited for the Program

Develop a process for identifying and attracting mentors and mentees who are well suited for partnership. Selected mentors should have strong interpersonal skills and the ability to support others without becoming overburdened.

Component #2: Facilitate Thoughtful Mentor-Mentee Pairing

Pair mentors and mentees based on shared experience.

Component #3: Prepare the Organisation for Successful Partnership

Ensure that mentors and staff have a comprehensive understanding of the role of the mentor and how this role integrates into the broader care team. Allow staff to surface questions or concerns up front.

Component #4: Provide Mentors with Ongoing Support

Offer support to the mentor after all mentor-mentee interactions to ensure mentors practice good self-care.

Practice Assessment

This practice is resource intensive and is not appropriate for all patients; however, it is highly impactful for patients with long-term hospitalisations, conditions with a prolonged course of treatment, or trauma patients.

Global Centre for Nursing Executive Grades

Practice Impact: A-

Hospital Effort: B+

The first component of this practice is identifying individuals who would be a good fit for the program—both current patients who would benefit from the partnership as well as previous patients who would serve as effective mentors.

Clinicians at Northumbria NHS Foundation Trust developed a peer support program for stroke patients in response to poor rates of re-engagement with the community among this patient population. Northumbria recruited stroke support volunteers to help patients and their families connect to community resources immediately post-discharge. Northumbria publicised the program to stroke patients through the use of a flier and through word-of-mouth from caregivers.

A full-sized version of Northumbria's Stroke Peer Support Program flier can be found in the Appendix of this study.

Component #1: Identify Individuals Well-Suited for the Program

Northumbria Stroke Peer Support Program Patient Recruitment Leaflet

Support offered for both patients and carers

Volunteers uniquely qualified to provide emotional comfort

Providing a bridge to the community resources

Stroke Support Volunteer

Are you a patient or carer?

Would you like to talk to us - we are either a patient or carer living with stroke?

We understand and can listen to any worries you may have because of stroke.

We can direct you to information and Support following stroke.

Let the staff know that you would like to see us!



Utilising Credible Educators

"This was just another opportunity to reinforce that information provision. And to do that with real credibility with someone who's actually had direct experience with stroke. And we just thought that message may well hit home harder with that."

Director of Patient Experience, Northumbria Healthcare NHS Trust

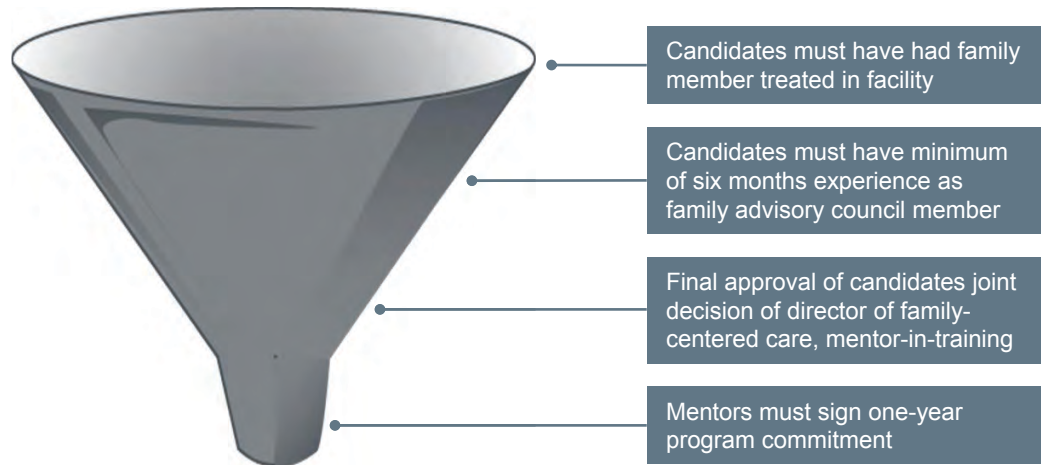


Case in Brief: Northumbria Healthcare NHS Foundation Trust

- 1,375-bed acute trust providing health care services within Northumberland and North Tyneside, UK
- Patient journey survey exercise indicated 80% of former stroke patients were failing to re-engage in community. Local community services were expanded in response, 2005
- Carer involved in long-term community services saw need for early orientation to community care, suggested developing a peer mentorship program, implemented November 2009
- Volunteers visit stroke patients shortly after diagnosis; typically visit patient in hospital one to two times across inpatient stay
- Winner of Patient Experience Network Award for "Communicating Effectively with Patients & Families" in 2010
- 23 volunteers have had over 1,000 contacts with patients on three stroke wards to date; Northumbria hopes to start using volunteers to conduct home visits in the coming months, currently working on expanding this practice to its elderly care wards

In addition to targeting patients who may benefit from the program, it is also necessary to identify and rigorously screen potential mentors. Mentors must possess the appropriate interpersonal skills, knowledge, and self-care to succeed in the role and ensure overall program success. Joe DiMaggio Children's Hospital in Hollywood, Florida, used four selection filters to evaluate which candidates were an appropriate fit for their Family Mentor program.

Mentor Screening Process at Joe DiMaggio Children's



Case in Brief: Joe DiMaggio Children's Hospital

- 204-bed children's hospital located in Hollywood, Florida
- Implemented family mentor program in 2008; goal to enhance emotional support for patient families
- Ten members of family advisory council currently serve as family mentors; approximately two pairings made between mentors and families each month
- Patient families can be nominated for program by family advocates, child life specialists, social workers, physicians or nurses
- Mentors meet with selected mentees at bedside, clinic, office, or ambulatory settings; may also provide telephone support from home
- Patient satisfaction scores consistently in top one or two percentile of Press Ganey national database

The second component for developing a successful mentoring program is facilitating thoughtful mentor-mentee pairing. Matching mentors to patients and families on the basis of a shared experience ensures both parties derive maximum value from the relationship. Three key elements—family identification, mentor-mentee matching, and one-on-one meetings—set the groundwork for meaningful pairings.

A complete version of Joe DiMaggio’s “Family Mentor Dos and Don’ts” can be found in the Appendix of this study.

Once mentors and mentees are selected and paired, organisations must take the necessary steps to prepare all parties for their new partnership. To be successful with a program of this nature, staff must understand the distinct value provided by the mentors. It is also important for staff to be clear on how the mentor’s role fits in with the roles played by others on the care team.

Component #2: Facilitate Thoughtful Mentor-Mentee Pairing

Key Components of Mentor-Mentee Pairing at Joe DiMaggio Children’s

Family Identification



Patient families selected for mentorship program based on desire to connect with families who have traveled a similar path, caregiver recommendation

Mentor-Mentee Matching



Mentors paired with identified families based on patient diagnosis, long-term course of treatment, family characteristics/demographics, and patient prognosis

One-on-One Meetings



Mentors meet one-on-one with family mentees for 30 to 60 minutes each visit; visit frequency depends on patient diagnosis, family needs

Component #3: Prepare the Organisation for Successful Partnership

Evaluation of Volunteers



- Interested parties screened by psychologist, ensuring patients and carers are psychologically, emotionally prepared to participate

Multidisciplinary Volunteer Training



- 30-hour multidisciplinary training session provided
- Volunteers oriented to variety of stroke symptoms, community resources

Staff Orientation



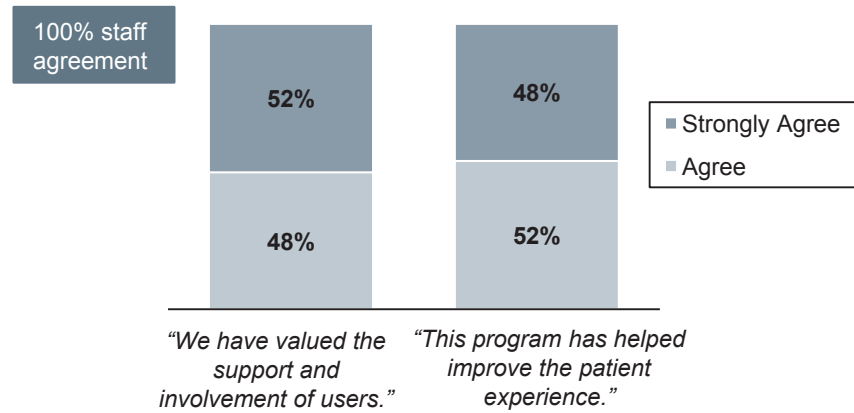
- Staff training session held to address effective introduction of volunteers onto care team
- Orientation gains staff buy-in and surfaces questions, concerns

Source: Northumbria NHS Healthcare Foundation Trust, North Tyneside, UK; Joe DiMaggio Children’s Hospital, Hollywood, Florida, US; Global Centre for Nursing Executives interviews and analysis.

When staff are well prepared for mentor involvement, however, they can benefit significantly from mentor participation. Staff are often very appreciative of the additional emotional and educational support these mentors provide to patients and their families.

Staff Seeing the Benefits of Mentor Involvement

Staff Response to Stroke Peer Support Program¹



Feeling Supported by Volunteers

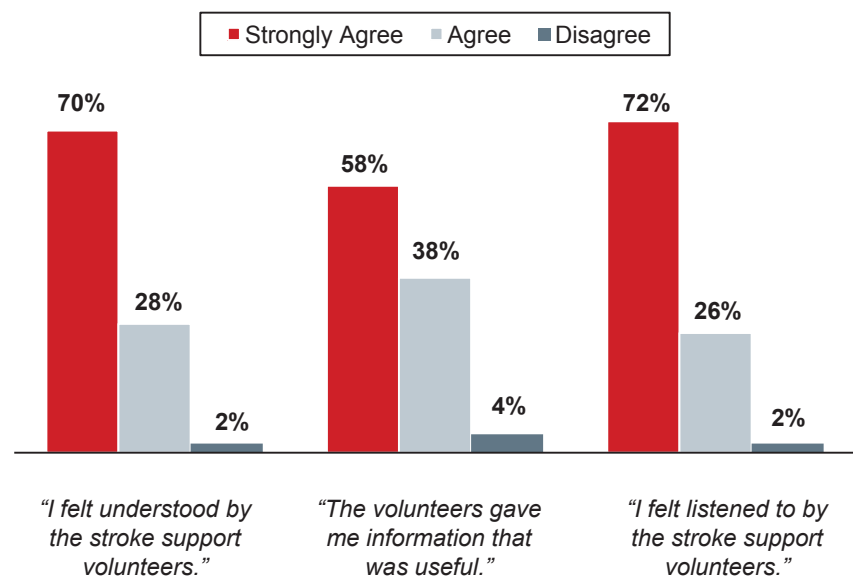
"They seem to think, 'oh, fantastic, this is just all the extra help we need.' It's when staff see it that way that it becomes really rich."

Director of Patient Experience, Northumbria Healthcare NHS Trust

Most importantly, patients and their carers are also recognising the benefits of mentor involvement. Leveraging the experience and expertise of mentors helps patients and their families to feel less anxious, more informed and better prepared to re-engage in the community post-discharge.

Feeling Informed and Supported Across Journey

Percentage of Patients and Carers Reporting Positive Results¹



1) Responses from Northumbria's Stroke Peer Support program effectiveness survey.

Source: Northumbria NHS Healthcare Foundation Trust, North Tyneside, UK; Global Centre for Nursing Executives interviews and analysis.

Peer mentoring can be particularly valuable in situations where the clinical event is sudden and life-altering, as the adjustment can be a significant to shock to patients and their families. As a result, they are often in need of support above and beyond what clinical staff are able to provide.

Recognising the benefit of peer support in following trauma, Vanderbilt University Medical Center in Nashville, Tennessee, has established a peer support program on the trauma ward. This program provides patients and families recovering from a traumatic injury with an opportunity to connect with a mentor who was formerly a trauma patient (or family member of a trauma patient).

Extending Peer Mentorship to Adult Trauma Patients

Two Forums for Peer Visitor Meetings at Vanderbilt

Trauma Ward Rotation



Peer visitors round on trauma unit weekly; meet with individual patients, families for 20 to 30 minutes each

One-on-One Follow-Up



Interested patients, families may schedule 60- to 90-minute follow-up sessions with peer visitor



Case in Brief: Vanderbilt University Medical Center

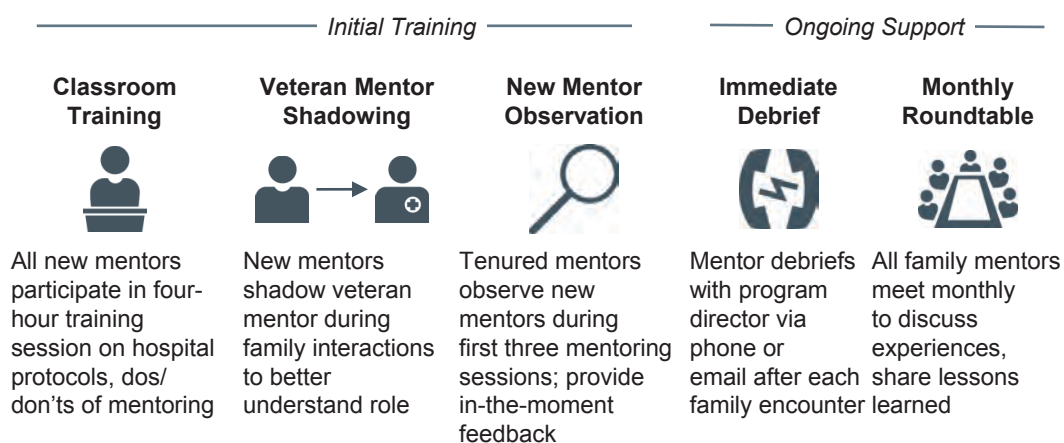
- 916-bed academic medical centre located in Nashville, Tennessee
- Implemented “Peer Visitor” program in trauma ward in 2009; has 18 active peer visitors
- Peer visitors round on families of patients in ICU; visit both patients and families once patients are transferred to step-down ward
- Mentors provide emotional support to patients, families by supplying educational materials about injury, sharing personal stories, offering insight into post-discharge care
- Mentors recruited through the Trauma Survivors Network at Vanderbilt

The final component for ensuring the success of a peer mentoring program is to provide mentors with ongoing support.

Regardless of the population served—whether it be stroke patients, trauma patients or the families of paediatric cancer patients—the peer mentor role is emotionally intense and can be draining for volunteers. It is thus essential to the success of the program that leaders ensure mentors are practicing good self-care as they fulfill the responsibilities of their role. Joe DiMaggio Children's Hospital is committed to providing up-front and ongoing group support for their mentors. Establishing and maintaining this network of mentors also enables volunteers to consistently share best practices and learn valuable lessons from each other's experiences.

Component #4: Provide Mentors with Ongoing Support

Mentor Resources at Joe DiMaggio Children's



A number of practices in this section have touched on the importance of providing thorough and comprehensible information to patients and families as a means of preparing them for active participation in care across the continuum. The additional best practices shown to the right also help to activate patients and families by providing them with the information they need to make informed decisions and practice self-care, both during the hospital stay and post-discharge. These best practices can be accessed via the web addresses below.

For additional information on these best practices, see:

advisory.com/gcne/KeyLearner



advisory.com/gcne/TeachBack



advisory.com/gcne/JBR



Revisiting Best Practices for Keeping Patients and Families Informed Throughout the Care Process

Global Centre for Nursing Executives Best Practices for Patient Education

Best Practice	Capsule Description
Key Learner Identification	Care team asks three simple questions to determine patient’s primary at-home caregiver, key learner recorded on whiteboard to ensure he or she is present when education is presented
Three-Day Integrated Teach-Back	Comprehensive, condition-specific education delivered throughout stay; patients asked to teach back key elements across three days, each day focuses on a specific aspect of successful post-discharge care: knowledge, attitude and behaviour
Joint Bedside Report	Oncoming and off-going nurse perform change-of-shift report at patient bedside, providing an opportunity for peer-to-peer nurse feedback and ensuring patient and family questions are answered

Source: Global Centre for Nursing Executives interviews and analysis.



Promoting Patient, Family and Consumer Involvement

III

Structure Opportunities for Participation at the Bedside

- #5: Comprehensive Patient Orientation
- #6: Patient-Centred Daily Care Plan
- #7: Two-Way Communication Boards
- #8: Patient Care Partners
- #9: Family-Initiated Rapid Response Team
- #10: Patient and Family Peer Mentors

IV

Embed Consumers into Organisational Planning

- #11: Embedded Patient and Family Advisors
- #12: Patient Education e-Advisors

Practice #11: Embedded Patient and Family Advisors

— Practice in Brief —

Community members, including former patients and family members, join a Consumer Advisory Council, also known as a Patient and Family Advisory Council (PFAC), to provide the patient perspective on the care experience and identify opportunities for improvement; advisors may also join active hospital committees and task forces to ensure the patient perspective is embedded into hospital strategy and decision making.

Rationale

Community members, particularly former patients and family members, have a unique perspective that hospital staff are unable to offer. Bringing former patients and family members together to share their perspective as patient advisors is an effective way to surface improvement opportunities, engage the public in improving the health service and ensure that the patient and family perspective is regularly integrated into organisational decision making.

Implementation Components

Component #1: Screen Potential Patient and Family Advisors

Assess whether potential advisors have necessary skills, time, motivation, and interest in becoming an advisor.

Component #2: Train Volunteers to Be Effective Advocates

Train advisors on their new role, including: how to be an effective advisor and how to serve on hospital-based teams or councils.

Component #3: Integrate Advisors into Hospital Structures and Operations

Embed patient and family advisors into active decision-making bodies (including committees, task forces, and process improvement teams). The goal is to incorporate the patient perspective into ongoing hospital decisions.

Component #4: Entrust Advisors with Meaningful Responsibility

Provide advisors with the opportunity to impact key strategic priorities, defining their role in quality improvement efforts and clinical governance.

Practice Assessment

This practice requires a moderate level of investment—most notably, a hospital employee will need to serve as an advisory council facilitator (often a part-time role); hospitals should only establish a council if an individual is available to serve in this capacity. When led by a facilitator, a patient and family advisory council can help leaders develop strong partnerships with consumers and ensure that decisions being made always take the patient and family perspective into account.

Global Centre for Nursing Executive Grades

Practice Impact: A-

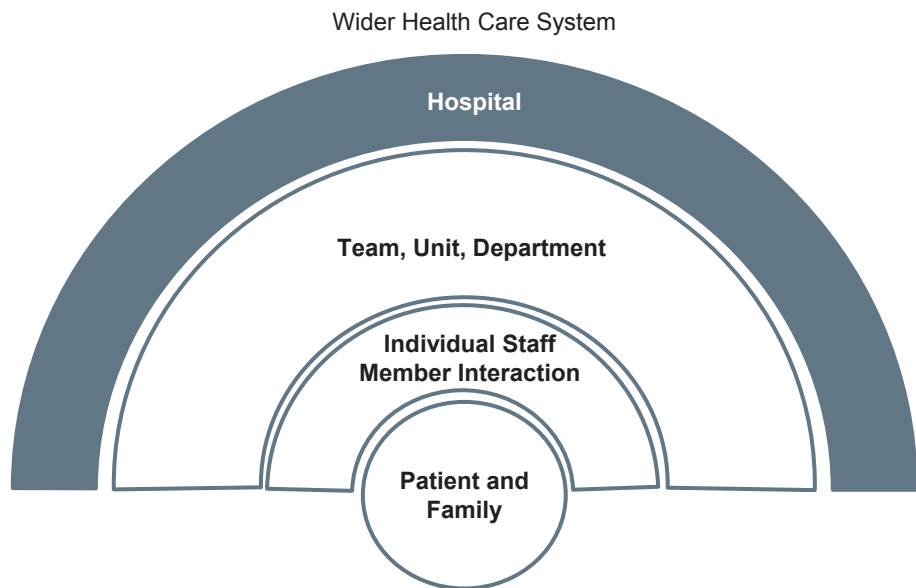
Hospital Effort: B+

An individual's experience with the health care service is impacted at a number of levels. Thus far, this publication has primarily discussed interventions for improving the patient experience at the ward level and through individual staff member interactions. And as discussed in the essay portion of this publication, the wider health care system is exerting considerable pressure to improve in this area and is adjusting incentives and operations to make patient-centred care a priority.

An often under-leveraged opportunity to improve patient experiences of care, however, exists at the hospital governance level. To ensure the consistent provision of patient-focused care, executives must reinforce this priority at all levels of the institution. One of the most effective strategies for doing so is systematically embedding patient and family representation into organisational planning.

Requiring Commitment at Every Level of Health Care

Relationships That Affect Patient's Experience of Hospital



Study in Brief: *Exploring How to Improve Patient Experiences in Hospital at Both National and Local Levels*

- Authored by Jocelyn Cornwell, PhD, Director of The Point of Care program, The King's Fund, United Kingdom
- Discussion paper published in *Nursing Times* analysing the types of patient experience interventions most likely to yield positive results
- Reviews lessons learned from available research on existing interventions designed to improve patients' experiences
- Utilises research to inform development of a framework for understanding factors that shape patient experiences with health care; aims to assist leaders in directing action and resource allocation towards most impactful activities

Source: "Exploring How to Improve Patients' Experience in Hospital at Both National and Local Levels," *Nursing Times*, 7 July 2009; Global Centre for Nursing Executives interviews and analysis.

A number of countries around the world, such as Scotland, England and Australia, are required by law to include consumers in organisational planning in the health sector. Yet even with longstanding mechanisms for incorporating patient and family representation in decision-making, many providers struggle to extend participation beyond minimum *compliance* with this concept to true *partnership*. Realising this ambition requires a degree of transparency to which most hospital leaders are unaccustomed, and maximising the effectiveness of these bodies can prove challenging.

Difficult to Optimise Consumer Participation

Progress Towards Optimal Consumer Engagement

*Minimum Compliance
with Mandate*

*Operating in True Partnership
with Consumers*



Variability in Performance

Stakeholders are increasingly expecting to see more consumer participation with consumer representatives having input into the way problems are discussed and solved. And there's a continuum...there are some organisations that have only just started that journey, and there are others who have been doing it for 20 years.

Executive Director of Nursing and Midwifery, Australian Public Hospital

Recognising the growing importance of patient-centred care, a number of organisations around the world are refocusing their efforts to optimise the use of their patient, family, and consumer advisory groups.

The first component necessary for ensuring advisor contributions are made meaningful is recruiting and screening the right people into these positions. Future advisors must have the sufficient time, motivation, and skills to enact positive change. University of Washington Medical Center uses a rigorous screening process to evaluate potential advisors. To determine if advisors are a good fit for the council, the coordinator ensures candidates have constructive ideas for improving the hospital's patient experience and are willing and able to devote sufficient time to be active participants.

University of Washington Medical Center's recruitment flier, outreach letter, and application forms can be found in the Appendix of this study.

For additional guidance on establishing a Patient and Family Advisory Council, visit:

advisory.com/gcne/PFAC



Component #1: Screen Potential Patient and Family Advisors

University of Washington Medical Center's Ward-Based Patient Advisory Council Recruitment and Selection Process



Staff member, such as bedside nurse, nominates patient/ family member for ward-based council membership



If interested in council membership, nominee completes, submits application; coordinator meets with nominee, refers nominee to best-fit council



Council facilitator sends nominee letter, email outlining program, extending invitation to apply



Two co-leaders of recommended Patient Advisory Council interview applicant over telephone to assess fit and explain time commitment



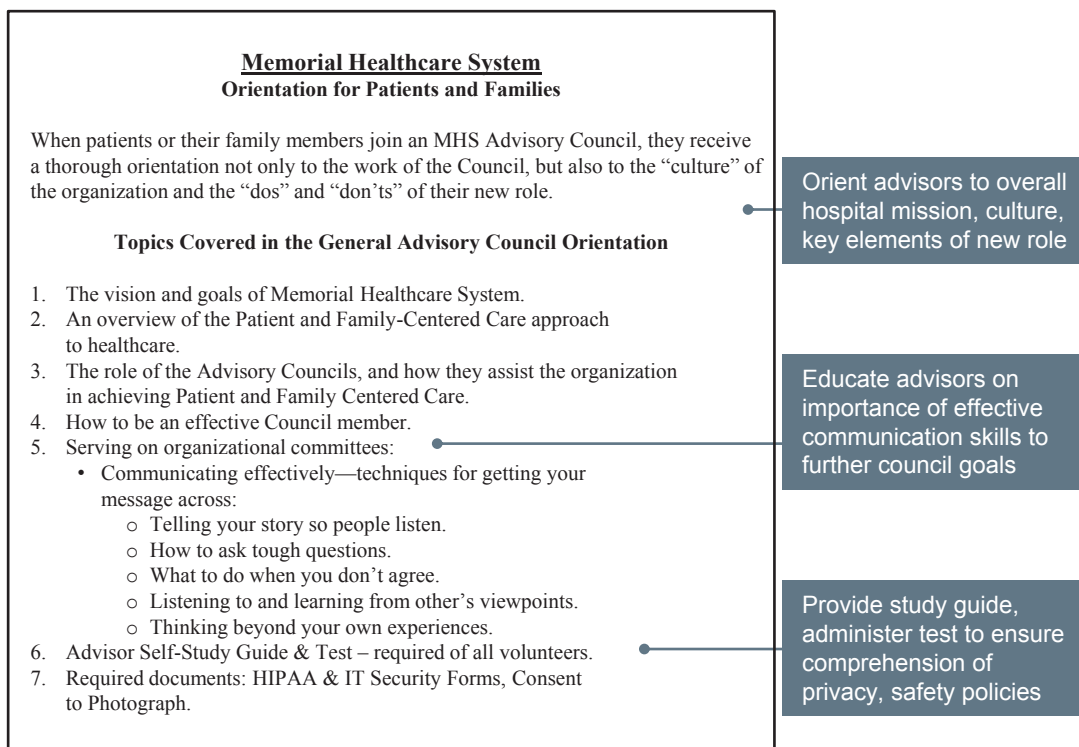
Case in Brief: University of Washington Medical Center

- 450-bed academic medical centre located in Seattle, Washington
- Implemented Patient and Family Advisory Council on three wards in 2003; have subsequently expanded to seven wards
- Patients, families may be nominated to serve on ward-based council by staff members, self-select based on recruiting fliers posted around hospital
- Advisors are asked to make one-year commitment and are expected to attend seven of nine annual meetings
- Hospital-wide patient and family steering committee helps to elevate efforts of ward-based councils; patients, families interested in steering committee participation attend information session with three to four other applicants, share hospital experiences; Patient and Family Advisory Council coordinator evaluates candidates on communication, interpersonal skills

The second component is to train selected advisors to be effective council members and advocates. To ensure advisors at Memorial Regional Hospital in Hollywood, Florida, fully understand the expectations of the role and are able to inflect change in hospital processes, the PFAC facilitator orients new advisors through the agenda shown to the right.

Component #2: Train Volunteers to Be Effective Advocates

Memorial Regional's Advisory Council Orientation Outline



A full-sized version of Memorial Regional’s “Advisory Council Orientation Outline” can be found in the Appendix of this study.



Case in Brief: Memorial Regional Hospital

- 684-bed hospital located in Hollywood, Florida; part of Memorial Healthcare System
- Organisation-wide Patient and Family Advisory Council implemented in 2005; has 30 active members in addition to six nurse managers who regularly attend
- Each hospital committee includes seats for one to two patient advisors, including: performance committee, quality care committee, discharge planning task force, falls team, smoke-free campus task force, bereavement committee
- HCAHPS top-box score for September 2011 was 92%

The third component is integrating advisors into active hospital decision-making bodies (committees, task forces, etc.) to ensure the patient perspective is embedded into ongoing hospital projects. The goal is to ensure that decisions being made at the highest levels of the organisation do not compromise the patient and family experience but rather enhance it.

Component #3: Integrate Advisors into Hospital Structures and Operations

Small Sample of Short-and Long-Term Committees Currently Utilising Patient Experience Advisors

- Accessibility Steering Committee
- Elder Friendly Steering Committee
- Interprofessional Education Committee
- Patient Safety and Quality
- Accreditation Committee
- Defining a Culture of Safety and Safe Reporting
- Hand Hygiene Working Group
- Visitation Policy Group
- Venous Thromboembolism Prophylaxis Group



Recognising the Value of Patient Input

“At least three times a week, somebody’s phoning me saying, we have an educational piece we want to put before the council; we’re starting a new committee and we want an advisor on it. The organisation is really beginning to see that this is the way things are done and they’re a great resource to have on these committees.”

*Patient and Family-Centred Care Lead
Kingston General Hospital*



Impressive Commitment by Patient Experience Advisors

49

Total Patient Experience Advisors active in organisation

325

Hours worked by patient experience advisors, June 2012

264

Current opportunities for Advisor involvement



Case in Brief: Kingston General Hospital

- 430-bed regional hospital located in Kingston, Ontario
- Facility serves 500,000 residents in rural Canada. Local hospital to Kingston community, tertiary/referral hospital for complex and specialty inpatient care for the region
- Leaders sought to incorporate patient experience advisors into organisational decision making, solicited guidance from Medical College of Georgia, US
- In February 2010, leaders developed a body of patient experience advisors to inform decision making at strategic level as part of broader Patient and Family-Centred care initiative
- Patient Experience advisory council began with three advisors, grew to 12 from 2010 to date

The fourth component is entrusting advisors with meaningful responsibility. Defining an advisor's responsibility encourages their continued engagement with the advisory group and allows the organisation to see maximum value from the advisors' contribution.

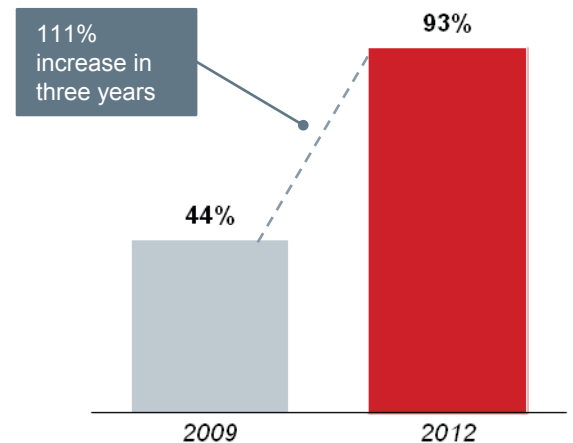
In an effort to engage consumers in patient safety initiatives, the Patient and Family Advisory Council at Kingston General Hospital designed and posted hand hygiene posters around the hospital. Depending on poster placement, these were updated regularly with corporate and ward-level compliance data. Due, in part, to the patient experience advisors' work, Kingston has seen significant gains in hand hygiene compliance since the creation and distribution of these posters.

A full-sized version of Kingston General Hospital's hand hygiene poster can be found in the Appendix of this study.

Component #4: Entrust Advisors with Meaningful Responsibility



Hand Hygiene Compliance¹



1) Based on results of weekly hand hygiene audits at Kingston General Hospital

Melbourne Health in Victoria, Australia, is another organisation experiencing significant benefits from engaging their consumer advisors in clinical governance efforts. Melbourne Health is committed to routinely including a Community Advisory Committee member onto their Root Cause Analyses. Leaders report that consumer involvement in this activity encourages the group to push the limits of their thinking and consider a perspective that is all too often poorly represented in these discussions.

Involving Consumers in Clinical Governance at Melbourne Health

Melbourne Health's Evaluation of Consumer Participation in Root Cause Analyses



A Valuable Contribution

"I see my role as being really important because we're *outside* the organisation but *understand* the organisation. We don't see from the organisation perspective but see from the common sense, community perspective. You question judgment, you question processes, and when other people around the table think 'that's just how it is,' for us, no, that's not just 'how it is.'"

Community Advisory Committee Member
Melbourne Health

Results and Findings—Staff¹ Interviews

Respondents were asked to best describe what consumers bring to RCA discussions. The following comments were provided:

- To bring in a consumer/patient perspective
- To bring a more holistic view of the case
- To bring a different point of view than that of staff
- To put themselves in the patient's shoes so it doesn't happen again
- To bring their own experience of health services to the discussion
- To look at things a bit more broadly and reassure that we are not missing anything

A full-sized version of Melbourne Health's staff evaluation sheet can be found in the Appendix of this study.



Case in Brief: Melbourne Health

- 1,400-bed health service organisation located in Melbourne, Victoria
- Provides comprehensive acute, subacute, and community-based health care programs to one-third of metropolitan Melbourne's population, general and specialist services to regional and rural Victorians and statewide services
- Established Consumer Advisory Committee in 2001 in response to changes to the Health Services Act of 1988
- CAC currently consists of nine committee members, tenure ranging from three years to five years, meet monthly as a whole committee
- Consumer participation in root cause analyses began July 2005; in 2008–2009, staff requests for consumer involvement were received for 100% of RCAs conducted during the year
- Community Advisory Committee highly commended for Minister for Health's award for delivering local and responsive governance, 2011

¹) Facilitators of RCA, Quality Consultants, generally with a nursing background (non-medical), working groups with a consumer representative.

Practice #12: Patient Education e-Advisors

— Practice in Brief —

For consumers who may not be an ideal fit for an advisory council position, organisations engage former patients or family members to review early drafts of patient-focused educational materials and provide feedback on their clarity and comprehensiveness.

Rationale

Patient education materials are typically written by clinicians. As a result, they can be filled with clinical jargon that patients and families struggle to understand. To make patient education material more accessible to patients, former patients (and family members) should review early drafts of clinical materials and provide feedback on the clarity and “user-friendliness” of the materials.

Implementation Components

Component #1: Solicit Feedback on Clarity of Educational Materials from Former Patients and Family Members

Leaders overseeing patient education systematically collect the feedback of patients and families on drafts of patient education materials to ensure materials are clear and user friendly.

Practice Assessment

This practice requires few additional resources and is highly effective in ensuring patient education materials are clearly comprehensible to their intended audience.

Global Centre for Nursing Executive Grades

Practice Impact: B

Hospital Effort: A-

To ensure patient education materials can be clearly understood by the intended audience, some institutions are soliciting the input of current and former patients. These patients provide actionable feedback on the clarity and usability of draft materials.

At University of Washington Medical Center in Seattle, a group of former patients known as Materials Review Advisors fulfills this role. The Materials Review Advisors use a templated form to provide highly structured feedback on draft patient education materials. The form also has space at the bottom for additional comments. All Advisor feedback is incorporated into a summary report that goes to the author of the patient education document.

A complete version of UWMC's "Patient Advisor Editing Guidelines" can be found in the Appendix of this study.

Component #1: Solicit Feedback on Clarity of Educational Materials from Former Patients and Family Members

UWMC's Patient Advisor Editing Guidelines

University of Washington Medical Center
Patient and Family Education Services

Patient Education Material – Advisor Feedback

Please take a few minutes to read and review this new patient education handout:

Title: _____ Subject: _____

I am a (check one): ☐ Patient ☐ Family member of a patient ☐ Other (describe): _____

Please read this new education handout and then rate it using this scale. Check the box in the column that best describes your opinion: *Poor, Okay or Great*. Check *Does Not Apply* if the item does not apply to the handout.

	Does Not Apply	Poor	Okay	Great
1. The title describes the content of the handout.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The introductory paragraph tells about the content of the handout.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The information is clearly presented and well organized.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The material is easy to read.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The diagrams, drawings, tables or checklists are easy to understand.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Medical terms are explained.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Overall, what did you think of this handout?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Checklist draws attention to specific elements of educational materials that require patient and family feedback

Editing guidelines focus heavily on readability, organisation, and clarity of educational materials



Case in Brief: University of Washington Medical Center

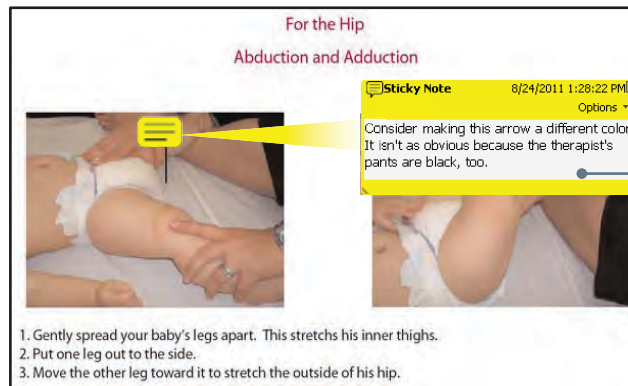
- 450-bed, Magnet-recognised academic medical centre located in Seattle, Washington
- Materials Review Advisors selected from broader pool of applicants to the Patient and Family Advisory Council; Council applicants are directed to Materials Review Advisor program if current Council openings are not a good fit or too time consuming
- Existing members of the Council may also participate as Materials Review Advisors if they so choose; membership in the two programs is not mutually exclusive
- To help Materials Review Advisors provide specific and actionable feedback on materials they review, they receive guidance in the form of a checklist with editing guidelines written by a University of Washington health editor; they also attend a training session before they begin reviewing materials

A second method of soliciting patient feedback is to ask for open-ended feedback on draft educational materials.

At Riley Hospital for Children at IU Health, family volunteers known as e-Advisors provide comments on the materials through the sticky note feature in Adobe Acrobat.

Surfacing Pitfalls Only a Patient Would See

e-Advisor Feedback Recorded on “Sticky Notes” at Riley Hospital for Children at IU Health



Advisors provide free-form feedback on electronic drafts of educational materials using Adobe Acrobat's “sticky note” feature; share comments with hospital family-centred care coordinator by email

! If e-Advisor lacks computer access, he or she may receive printed copies of materials, provide feedback on paper



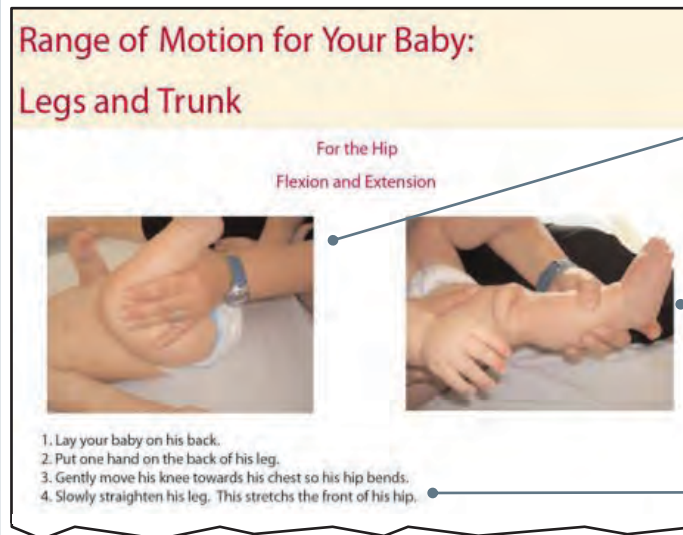
Case in Brief: Riley Hospital for Children at IU Health

- 455-bed, Magnet-recognised paediatric hospital located in Indianapolis, Indiana; part of Indiana University Health
- e-Advisor program initiated in 2009 to enhance clarity of educational materials; program currently has approximately 40 active e-Advisors
- e-Advisors review an average of 10 educational documents per month

Even without a structured form to prompt feedback, patients can provide concrete guidance and suggestions.

Incorporate Advisor Comments into Education Materials

e-Advisor Feedback on Range of Motion Exercise Guide



Change in response to e-Advisor Suggestion: Number each photo and the step to which it corresponds.

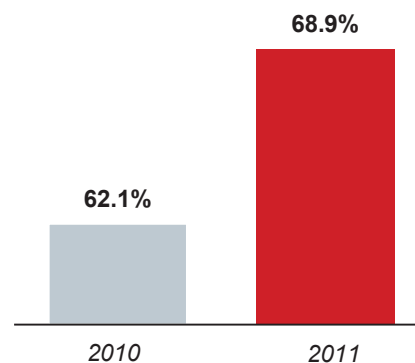
Change in response to e-Advisor Suggestion: Create another step here instructing caregivers to do the exercise on the other side. Most of the demonstrations shown are on the left side of the body.

Change in response to e-Advisor Suggestion: Clarify how many times this exercise should be done.

Improving the quality of patient educational materials can elevate overall patient satisfaction. Nursing leaders at Riley Hospital for Children at IU Health attribute the increase in patient satisfaction scores from 2010 to 2011 in part to the introduction of the e-Advisor program.

e-Advisors Contributing to Overall Patient Satisfaction

Overall Inpatient Satisfaction Scores¹ at Riley Hospital for Children at IU Health



A complete version of Riley Hospital for Children at IU Health's e-advisor feedback on educational materials can be found in the Appendix of this study.

1) Percentage of parents rating their overall experience as "excellent" on NRC Picker survey.

Source: Riley Hospital for Children at IU Health, Indianapolis, IN; Global Centre for Nursing Executives interviews and analysis.

Overall implementation guidance for embedding consumers in organisational planning appears to the right. Leaders at successful organisations around the world have cited these tips as some of the most important factors in helping them to achieve true strategic partnership with consumers.

Implementation Guidance for Embedding Consumers in Organisational Planning

- ✓ Allow consumer participants to drive agenda, begin meetings by soliciting advisor ideas, questions
- ✓ Patient and Family Advisory Council facilitator should ensure advisors are focused on projects in which they can make meaningful change
- ✓ Encourage consumer participation in projects that enhance ward-level visibility; allow staff to see and understand consumer advisor impact
- ✓ Assign advisors hospital staff “buddy” in standing committees to orient advisor to committee processes, advocate for patient perspective in the meetings
- ✓ Dedicate PFAC facilitator time to consistently solicit feedback on project work, encourage ongoing progress
- ✓ Assign advisors to committees, projects based on professional, hospital experience, interest
- ✓ Hardwire process for advisors who sit on standing committees to report back, debrief with larger PFAC
- ✓ For consumers who may not be an ideal fit for an advisory council or hospital committee, engage them in reviewing education materials as e-Advisors



Supplemental Practices

Supplemental Practices

The Global Centre for Nursing Executives was overwhelmed with the number of promising strategies uncovered throughout the course of our research. We have listed below brief descriptions of some additional best practices that may be of interest to specific organisations depending on their patient-centred care strategy and performance.

The full, comprehensive versions of these supplemental practices can be found on our website, www.advisory.com/gcne, by typing in the title of this publication and selecting Supplemental Practices on the right rail.

#13: Staff-Driven Hourly Rounding

Practice in Brief

Frontline nurses and support personnel round on patients at hourly intervals to ensure safety and address real-time patient needs. Guidance on implementation, facilitating staff compliance and a literature log are available.

Rationale

Evidence demonstrates that nurses performing intentional rounds on patients on an hourly basis contributes to improved quality, safety, and patient experience outcomes. Many hospitals have adopted hourly rounding for these purposes, but compliance with the practice often remains low, in part due to lack of caregiver buy-in. Nurse leaders can improve hourly rounding compliance by systematically soliciting staff input on hourly rounding process flow, enfranchising staff and investing them in its success.

#14: Waiting Room Care Cards

Practice in Brief

Frontline staff provide waiting families with a one-page card that clearly lists the duration of common procedures and provides instructions regarding which staff members can accurately answer questions about the status of their family member.

Rationale

Patients' families often received mixed messages about how long procedures will last, causing confusion and a great deal of anxiety. Providing clear and realistic guidelines about the length of common procedures can alleviate this anxiety and often contributes to improved patient and family satisfaction.

#15: Proactive Patient Preference Screening

Practice in Brief

Caregivers proactively solicit patient preferences about their care environment and use the information to anticipate and address patient needs.

Rationale

Pre-emptively soliciting patient preferences allows caregivers to get to know their patients as individuals and ultimately provide care that is customised to their specific wants and needs.

Supplemental Practices (cont.)

#16: Structured Volunteer Rounding

Practice in Brief

Non-clinical volunteers round on patients to uncover and address real-time patient needs.

Rationale

Using a volunteer to address non-clinical patient needs can help to alleviate the burden on nurses while ensuring that patient needs are met in a timely manner. Patients are also potentially more likely to raise less critical concerns with a neutral party, as opposed to interrupting busy nursing staff.

#17: Patient Experience Blueprinting

Practice in Brief

To gain insight into the patient's perspective on a selected care process and identify improvement opportunities, volunteers shadow patients and observe their experience. Hospital leaders then translate observations into improvement by deploying targeted teams to act on identified opportunities.

Rationale

Shadowing patients during their hospital journey enables caregivers to identify problems that patients themselves may encounter. Diagnosing these institution-specific barriers to a high quality patient experience then equips leaders to capture and implement ideas for improvement.



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Benefits of Patient-Centred Care Library

Global Centre for Nursing Executives Note on Use: The citations below refer to articles that provide evidence of the operational, economic, quality and workforce benefits of providing patient-centred care. This list is not exhaustive but meant to be a sampling of studies to demonstrate these benefits.

Bertakis K and Azari R, "Determinants and Outcomes of Patient-Centered Care." *Patient Education and Counseling*, 2011.

Bertakis K, "Patient-Centered Care Is Associated with Decreased Health Care Utilization." *Journal of the American Board of Family Medicine*, 2011.

Boulding W, et al., "Relationship Between Patient Satisfaction with Inpatient Care and Hospital Readmission Within 30 Days." *The American Journal of Managed Care*, 17:(1) 99-101, 2011.

DiGola A, et al. "Patient and Family-Centred Collaborative Care: An Orthopaedic Model." *Clinical Orthopaedics and Related Research*, 463:13-19, 2007.

The Joint Commission "Health Care at the Crossroads: Guiding Principles for the Development of the Hospital of the Future." 2008.

Meterko M, et. al. "Mortality Among Patients with Acute Myocardial Infarction: the Influences of Patient-Centered Care and Evidence-Based Medicine." *Health Services Research*, 2010.

Stone X, "A Retrospective Evaluation of the Planetree Patient-Centered Model of Care Program's Impact on Inpatient Quality Outcomes." PhD dissertation, Hahn School of Nursing and Health Science, University of San Diego, 2007.

Northumbria's Ward 1 Charter

Blyth Community Hospital – Ward 1 Charter

April 2011

Our Aim:

This charter sets out the minimum standards we expect from ourselves as individuals and as team, to deliver high quality driven, compassionate service to our patients and their families.

As an individual working here, I will ALWAYS:

- Treat every patient and their families with the same dignity and respect that I would want for myself and my family.
- Value and appreciate the efforts of all members of the team.
- Greet patients and families with a smile and a warm hello.
- Introduce myself to the patient and family, explain my role & welcome them to ward 1.
- When someone is in pain, always express empathy before I ask questions and try to help.
- When I am using a computer or doing essential paperwork – I will always look at the patient when the patient is talking to me or I am are talking to the patient.
- When I respond to a call button, I will always allow the patient to feel that they are my priority at that time and that I take their concern / query seriously.
- When a patient complains, I will always express sincere regret that the person is some-how suffering e.g., *"I'm really sorry this isn't what you were expecting"*
- When appropriate, I will always think for myself, using my own initiative and not always rely on others to provide the solution.
- Speak up when I observe positive or negative behaviours / language that will affect the reputation of our team.

As a team, we will provide best care when we ALWAYS:

- Provide a consistent level of quality care to all of our patients.
- Provide the level of care our patients and their families expect from us.
- Ensure that all staff are informed of the needs of each individual patient on the ward.
- Maintain levels of good work and a positive team spirit.
- Motivate each other to provide the best patient care we can.
- Look honestly at areas for improvement.
- Celebrate success, big or small

Northumbria's Ward 1 Charter (cont.)

- Ensure that all team members are up to date and involved in issues on the ward.
- Care for ourselves and support each other to provide the care we would like to.

As a team, we will provide best care when we ALWAYS:

- Provide a consistent level of quality care to all of our patients.
- Provide the level of care our patients and their families expect from us.
- Ensure that all staff are informed of the needs of each individual patient on the ward.
- Maintain levels of good work and a positive team spirit.
- Motivate each other to provide the best patient care we can.
- Look honestly at areas for improvement.
- Celebrate success, big or small.
- Ensure that all team members are up to date and involved in issues on the ward.
- Care for ourselves and support each other to provide the care we would like to.

As an individual, I will provide best care when I ALWAYS:

- Treat patients with the same dignity and respect that I would give to my loved ones.
- Value and appreciate the efforts of all members of the team.
- Be caring and understanding to both patients and other members of the team.

Behaviours that we expect to NEVER observe on ward 1:

- *Failing to speak up*: Tolerating or justifying poor patient care.
- *Passing on our anxiety to patients*: Patients/ families being told “we are too short staffed to.....”
- *Dignity and respect being compromised in any situation*: The language we use when we provide personal care, the way we feed, the way we interact with patients and their families.
- *Failing to respond with care*: Allowing our patients to feel their concerns are trivial or inconvenient.
- *Not protecting our patients*: Any actions that cause our patients to feel unsafe or uncared for.
- *Communication that patronises*: However well intentioned, using language such as “pet, love, darling....” or words that make adults feel scolded like children.
- *Colleagues who fail to take joint responsibility*: Assume jobs are done without checking.
- *Not protecting our staff*: Using language or displaying behaviour that causes a colleague to feel unappreciated or disrespected.

York Hospital's "Care to Share" Flier

Share your story with us!



York Hospital wants to hear your story... in your words! We invite you to call our "Care to Share" telephone line at any time to share your patient story experience. Good or bad, complaint or compliment, we invite you to tell us in your own voice about your experience at any York Hospital service or community site.

Our ultimate goal is to provide exceptional experiences for patients and their families. It's important for us to know how we are doing! Your message will be listened to by the hospital's Leadership team and staff from the area in which you received services.

How does it work? It's simple. Dial the toll-free, 24-hour phone line at 1-866-851-7479 and leave your message when prompted. This service is as anonymous as you would like it to be. If you wish to leave your name, you may do so, but it is not required. Your message will be recorded and saved in our Administration office for internal use.

So, next time you have an experience at a York Hospital facility - be it as a patient, visitor, or family member, give us a call to share your experience with us! We'd love to hear from you!



15 Hospital Drive, York, Maine 03909 | 207-363-4321 | yorkhospital.com

York Hospital's "Care to Share" Phone Message Script

Global Centre for Nursing Executives Note on Use: This is the exact message patients and family members hear when they call York Hospital's Care to Share line, prior to leaving a message.

Welcome to York Hospital's "Care to Share" phone line, where you can record a message about your experience at York Hospital. Be it good or bad, complaint or compliment, we want to hear from you. The information you provide in this message will be shared with staff and administration so we may learn from your experience. Your call is anonymous, or if you prefer, you may leave your name and contact information at the end of your message to receive a follow-up call. Thanks for choosing York Hospital for your health care needs. We appreciate you taking the time to share your thoughts. Please begin your message after you hear the beep.

NHS Lothian's Emotional Touchpoint Feeling Words List

NEGATIVE WORDS

LOST	HELPLESS
AWFUL	HOT AND BOTHERED
RESENTFUL	SURPRISED
CONCERNED	BITTER
BORED	FRUSTRATED
IRRITATED	DISTRESSED
ANNOYED	OUT OF SORTS
POWERLESS	LOW
WORRIED	LET DOWN
NUMB	DISCOURAGED
CONFUSED	OUT OF CONTROL
SAD	VULNERABLE
EXHAUSTED	ALONE
SCARED	MISUNDERSTOOD
ALL OVER THE PLACE	ANXIOUS
ANGRY	DISSATISFIED
UNSUPPORTED	TIRED
HORRIBLE	DISORGANISED
AWKWARD	A BIT STUPID
EMBARRASSED	UNSURE
GUILTY	FROUGHT
JUDGED	UNSAFE
LABELED	VULNERABLE
TENSE	

NHS Lothian's Emotional Touchpoint Feeling Words List (cont.)

POSITIVE WORDS

LOOKED AFTER	PRIVILEGED
SUPPORTED	BRAVE
TOUCHED	REASSURED
WELCOMED	RELIEVED
DELIGHTED	DETERMINED
HAPPY	CURIOUS
PLEASED	EAGER
RELIEVED	INTERESTED
VALUED	NEEDED
HOPEFUL	CALM
SAFE	PEACEFUL
REFRESHED	TRUSTED
APPRECIATIVE	HIGH
AT EASE	GLAD
HEARD	THANKFUL
CARED FOR	ENCOURAGED
RESPECTED	COMPETENT
KNOWLEDGEABLE	CAPABLE
UP BEAT	COMPASSIONATE
ENTHUSIASTIC	INCLUDED
AT EASE	ACCEPTED
COMFORTABLE	SATISFIED
FORTUNATE	PROUD
APPRECIATED	ACKNOWLEDGED
GRATEFUL	SUPPORTED

Off-Ward Shadowing Debriefing Guide

Global Centre for Nursing Executives Note on Use: This is the debriefing guide recommended for managers to use during their debrief with staff members immediately following an off-ward experience shadowing session.

Clinical Feedback:

1. How do you think you performed on procedure X? What would you have done differently?
2. Clinically, what did you observe that surprised you? Why?
3. What was the most valuable information you learned about the clinical care/procedures provided outside of the ward?

Experience Debrief:

4. What did you learn about the patient's physical experience of care that surprised you? How will that impact your future practice?
5. What did you learn about the patient's emotional experience of care that surprised you? How will that impact your future practice?
6. Based on the patient's physical and emotional experiences of care that you observed, will you do anything differently to better prepare the patient prior to the procedure? Will you do anything differently to meet the patient's needs after returning to the ward?

UCLA's "Getting to Know You" Poster

Getting to know:

(Patient name here)

- I prefer to be called: _____
- I grew up in: _____

- My former occupation was: _____

- At home I live with: _____

- My interests include: _____

- On t.v., I like to watch: _____
- My goals after hospitalization are: _____

8ICU UPC 2009-2010
Note: You are welcome to take this sheet with you upon leaving the room, but please leave the plastic frame with us.

Kingston General Hospital Patient Interviewer Guide

	Question	Ideal Response	Candidate Response	Evaluation
1.	Education & Experience Tell us about your clinical experience and education. Which placements did you like most and why? What are your specific areas of interest and how do you see working at KGH fitting into your career plans? What inspires you to do your best? What motivates you?	<ul style="list-style-type: none"> Plans for career building Desire to be part of KGH for long term career planning 		
2.	Tell us how you chose a career in nursing. What aspects of nursing attracted you to the profession?	<ul style="list-style-type: none"> Candidate answers enthusiastically Describes nursing's importance in society or how nursing impacts people's lives "Meaningful work" Verbal/non-verbal cues in sync Caring, compassionate 		
3.	Critical Thinking/Clinical Problem 	Appropriate use of: <ul style="list-style-type: none"> Problem-solving skills Interpersonal skills Communication skills Collaboration Conflict resolution skills Physical assessment skills 		
4.	Interprofessional Teams Nurses provide care as part of interprofessional teams. Tell us what an interprofessional team means to you and describe what the role of the nurse should be. What does Patient & Family-Centred Care mean to you? How do you integrate PFCC into your practice?	<ul style="list-style-type: none"> Knowledge of interprofessional members and patient/family-centred care Patient advocacy Effective communication Facilitator of care plan Coordination of services <ul style="list-style-type: none"> Patient at center of all we do Patient/family wishes are respected Pt/family involved in decisions 		

Kingston General Hospital Patient Interviewer Guide (cont.)

	Question	Ideal Response	Candidate Response	Evaluation
5.	Professionalism Describe the characteristics a professional nurse should demonstrate.	<ul style="list-style-type: none"> • Values • Positive attitude • Organisation/person fit • Knowledgeable • Respectful • Patient advocacy • Professional/courteous • Objectivity • Patience 		
6.	Conflict Resolution Scenario 	<ul style="list-style-type: none"> • Ask about patient's point of view • Respect patient's preferences • Respectfully describes different points of view • Recognises dynamics that factor into different perspectives 		
7.	Ethics and Critical Thinking An elderly patient is admitted in the night. She has indicated to you that she does not want to be resuscitated. You have the impression that she understands the implications of her decision. What do you do? What resources could you use or access to help you with this issue?	<ul style="list-style-type: none"> • Contact the doctor to come speak with patient and write appropriate order • Contact charge nurse or educator for guidance • Access preprinted orders for Advanced Directives 		
8.	Identifying areas for professional development What are your greatest strengths that will make you a valuable member of the KGH patient care team? What will be your greatest challenge in this position?	<ul style="list-style-type: none"> • Caring • Empathy • Learning • Team player • New grad and just learning • Skills and knowledge • Fitting into the culture • Policies and procedures 		

Kingston General Hospital Patient Interviewer Guide (cont.)

	Question	Ideal Response	Candidate Response	Evaluation
9.	<p>Continuous Learning Scenario</p> <p>You arrive on shift and you are asked to float to a different ward than the one you usually work on. The ward you are reassigned to has a different patient population than what you usually care for and many of the diagnoses are unknown to you.</p> <p>What do you think your learning needs would be?</p> <p>How would you find information to care for your patients during your shift?</p>	<ul style="list-style-type: none"> • Resources current policies and procedures manuals, preprinted orders and collaborative care plans • Uses current research and evidence-based practice • Accesses resource staff of educators and charge nurses 		
10.	<p>CNO Professional Standards</p> <p>Throughout a nurse's career, he or she will be evaluated upon their ability to meet the CNO professional standards.</p> <p>Pick one of the standards and describe how a professional nurse would demonstrate they were meeting this standard.</p> <p>Examples of these standards include: accountability, continuing competence, ethics, knowledge, knowledge application, leadership, therapeutic nurse-client relationships and professional relationships.</p>	<p><i>Refer to standard indicators themselves if scoring.</i></p>		

Kingston General Hospital Patient Interviewer Guide (cont.)

Question		Ideal Response	Candidate Response	Evaluation
11.	Please describe what Leadership means to you. Do you believe that clinical nurses are leaders? Why or why not?	<ul style="list-style-type: none"> • Accountability • Reliability • Effective communication • Leaders of patient care • Role model • Trust 		
12.	Do you have any restrictions that would preclude you from doing the essential duties of this job?			N/A
13.	Have you ever been convicted of a criminal offence for which you have not received a pardon?			N/A
14.	<p>If you were a successful candidate, when would you be available to start?</p> <p>Are you available to work any shift?</p> <p>Are you aware of when the shifts officially start and finish?</p> <p>Do you wish to work full-time, part-time or does it matter?</p>			
15.	How did you hear about the nursing opportunities at KGH?			
16.	Do you have any further questions for us?			

Central and North West London Group Discussion Scoring Sheet

Band 5 Assessment Centre Group Discussion Scoring Sheet											
Candidate Name:	Score	10	9	8	7	6	5	4	3	2	1
		Acceptable					Not Acceptable				
1. Eye Contact		Is appropriate- e.g. Looks at the person who is talking, glances around group and looks at the person they are talking to as well as looking around the group when talking themselves.					Is inappropriate- e.g. staring for periods at one person, not looking at people in the group at all, or looking all over the place when talking.				
2. Is able to express themselves		Can make themselves understood, puts sentences together and can follow a thought or argument through to its conclusion.					Do not structure sentences or comments in a logical fashion, leaps from one point to the next, speech is incomprehensible at times.				
3. Understands the rules of conversation		Is able to take their turn at talking, listens to what other people are saying and allows them time to finish what they are saying. Is able to follow the threads of a discussion and respond appropriately.					Cuts across other people in the group before they have finished, frequently are interrupting other people. Has aside conversation with neighbours. Unable to follow the threads of the discussion. Responds with comments that are unrelated to previous has said.				
4. Respects other people's views		Acknowledges other people's views and responds to what they have said when answering. If other people's views are different from theirs they are still able to accept them and challenge them respectfully.					Dismisses the views of other verbally or non verbally e.g. sneering or tutting at something that is said. Completely ignores what another person has said.				
5. Body Language		Posture is open, arms open, sitting upright, looking at person talking, sitting still and concentrating on the discussion.					Sitting in a threatening manner, leaning a long way forward or leaning into someone else's space, sitting with arms tightly crossed, fidgeting, looking around or eyes shut, not listening to what is being said.				
6. Has consideration for others in the group		Displays manners.					Is rude to other group members, shouts or laughs at comments				
7. Demonstrates an understanding of the topic being discussed		Is able to follow the discussion and interact with others in a knowledgeable way, contributing statements that are correct and relevant to the discussion.					Is not able to participate in the discussion. Comments do not make sense or are incorrect.				
8. Demonstrates an understanding of Mental health issues/has empathy		Has an appreciation for evidence based theories about mental health problems, considers the impact mental illness would have					Demonstrates a judgemental approach to mental health problems, has little understanding of possible causes or impact				

Central and North West London Group Discussion Topic A

Discussion Topics for Band 5 Assessment Centre

Please note that these topics have been developed to assess your ability to engage in a group process, communication skills and values/attitudes and are not meant to describe any view or perspective that the Trust may have on these issues.

- **Carer Involvement** – Given the issue of patient confidentiality, should carers be given information about the patient and their prognosis and progress? What are your views?

Discussion Topics for Band 5 Assessment Centre

Please note that these topics have been developed to assess your ability to engage in a group process, communication skills and values/attitudes and are not meant to describe any view or perspective that the Trust may have on these issues.

- **Advance Directives** – What are the issues and how do these influence treatment?

Central and North West London Group Discussion Topic C

Discussion Topics for Band 5 Assessment Centre

Please note that these topics have been developed to assess your ability to engage in a group process, communication skills and values/attitudes and are not meant to describe any view or perspective that the Trust may have on these issues.

- **Euthanasia** – “People have a right to die as they wish.” What are your views?

Abington Memorial Hospital's "Daily CARE Plan"



Abington Memorial Hospital

Daily "CARE" Plan

Your Personal guide for Communication, Access to Information, Resources & Education

SMITH, ANGEL

Admit Date:

Health Issues: Admitting Dx Chest Pain

Health Issues: Secondary Dx Cough

Allergies: penicillin

Durable Power of Attorney: **Does Patient have DPOA? Yes, on chart

Durable Power of Attorney: **Does Patient Have Living Will? Yes, patient to bring living will/DPOA.

Code Status

Code Orders No Code/DNR Per Patient

Medications

Acetaminophen Tablet 1000 mg (every 6 hours) (as needed)

Maalox Plus Extra Strength Suspension 30 mL (at bedtime) (as needed)

Docusate Sodium Capsule 100 mg (twice a day)

Heparin (10,000 Units/mL) Injection 5000 unit(s) (every 12 hours)

Digoxin Tablet 125 mcg (once a day)

Amiodarone Tablet 200 mg (once a day)

Furosemide Tablet 20 mg (once a day)

Aspirin Tablet 325 mg (once a day)

Nitroglycerin SL Tab 0.4 mg (every 5 minutes) (as needed)

Hydrochlorothiazide Tablet 12.5 mg (once a day)

Isosorbide Dinitrate Tablet 10 mg (twice a day)

Respiratory Care

O2 Therapy Cannula 2.0 LPM (continuous) A way to deliver needed oxygen to help you breathe better.

Oximetry (Resp) Routine (one time) A test to check the percent of oxygen in your blood.

Nutrition

Diet - Common Cardiac Diet Lunch

Laboratory

CK w/Reflexive MB 1100 Lab Rounds A blood test that measures the amount of muscle enzyme in your blood.

Cardiac Troponin 1100 Lab Rounds A blood test that measures the amount of cardiac protein in your blood.

Comprehensive Metabolic Pnl AM Lab Rnds A blood test that measures your blood sugar level, electrolyte and fluid balance, kidney function and liver function.

CBC/Platelets (CBC ONLY) AM Lab Rnds A complete blood count (CBC) provides important information about the kinds and numbers of cells in the blood, especially red blood cells, white blood cells and platelets.

Protime AM Lab Rnds A blood test that measures how long it takes blood to clot.

Digoxin Level AM Lab Rnds A blood test to measure the amount of the medication Digoxin in your blood.

Lipid Profile AM Lab Rnds A blood test that measures blood levels of total cholesterol, LDL cholesterol, HDL cholesterol and triglycerides.

Lipase AM Lab Rnds A blood test to measure the amount of this enzyme in your blood.

Radiology

22-Sep-2006 10:05

Abington Memorial Hospital's "Daily CARE Plan" (cont.)



Abington Memorial Hospital

SMITH, ANGEL

Continued

Radiology

Radiation passes through a patient's body and is recorded on film, video or computer producing anatomical images.

Chest - 2 Views (PA-LAT) Routine

NM Stress Test Routine

Cardiology

EKG (Routine/12 Lead) Routine (on admission) A non-invasive test that records the electrical activity of the heart by using ultrasound.

Cardiolite Exercise Stress Test Routine (one time) A stress test that is similar to the standard treadmill test, but provides the doctor with more information.

Consults

Primary Resident Coverage RES IM-D7 #7607(B069) Routine

Consult Smoking Cessation Comm Hlth

Case Mngmt Consult (Misc.)

Physician Consult Group AMS-CARDIOLOGY(0648)

Rehab Medicine

PT Cardiac Precautions

PT Evaluation Routine (one time)

PLEASE NOTE THAT YOUR PHYSICIAN MAY HAVE ORDERED ADDITIONAL TESTS OR MEDICATIONS WHICH MAY NOT BE INCLUDED IN YOUR "CARE" PLAN

22-Sep-2006 10:05

Children's Mercy Hospital's Family MAR

Run Date: 10/18/11 15:42

Family Friendly Medication List

Patient/Parent/Guardian Copy

Page: 1 of 2

Patient:

Height:

Date of Birth:

Weight:
































Medical Record #

Adverse Reactions: No Known Adverse Reactions

Medication	Dose	Route	How Often	Scheduled Times*	Comments
VALGANCiclovir (VALGANCiclovir)	100 mg	Oral	2 times a day		
**ceftriaxone (Rocephin)	1,170 mg	Intravenous	every 24 hours		
hydroXYzine (Atarax)	10 mg	Oral	once a day (in the evening)		
montelukast (Singulair)	4 mg	Oral	every day		
zinc gluconate (zinc gluconate)	15 mg	Oral	every day		
acetaminophen (acetaminophen)	160 mg	Oral	every 4 hours as needed for Fever or Mild Pain		
lidocaine topical (LMX 4)	1 application	Topical	Unscheduled as needed for Needle Sticks		
D5W - 1/2 NS with KCl 20 mEq/Liter 1000 mL (D5W 1/2NS w/ 20 mEq/L KCl 1000 mL)	1,000 mL	Intravenous	Infusion		















Communication Board Library

Medical Center Arlington's Communication Board

Medical Center Arlington																			
<p> Day: _____ Date: _____</p> <p> Preferred Name: _____</p> <p> Room #: _____  Phone #: 817-467-7486 Ext: _____</p> <p> Doctor: _____</p> <p> Nurse: _____ Ext. _____</p> <p> PCA: _____ Ext. _____</p> <p> Supervisor: _____ Ext. _____</p> <p> Anticipated Discharge Date: _____</p>	<p> What Is The Most Important Thing We Can Do For You Today?</p> <p> Other Important Numbers:</p> <p> Emergency Contact:</p>																		
<p>Pain Control is our GOAL</p> <table border="0"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>0</td><td>2</td><td>4</td><td>6</td><td>8</td><td>10</td></tr><tr><td>NO HURT</td><td>HURTS LITTLE BIT</td><td>HURTS LITTLE MORE</td><td>HURTS EVEN MORE</td><td>HURTS WHOLE LOT</td><td>HURTS WORST</td></tr></table> <p>Time of Last Pain Medication </p> <p><i>Thank you for choosing Medical Center Arlington!</i></p>								0	2	4	6	8	10	NO HURT	HURTS LITTLE BIT	HURTS LITTLE MORE	HURTS EVEN MORE	HURTS WHOLE LOT	HURTS WORST
																			
0	2	4	6	8	10														
NO HURT	HURTS LITTLE BIT	HURTS LITTLE MORE	HURTS EVEN MORE	HURTS WHOLE LOT	HURTS WORST														

Communication Board Library (cont.)
















Women and Infants Hospital of Rhode Island's Communication Board

Women & Infants		Today's Date
	My Room: 4103 My Phone: 401-274-1122 Ext. 2453 Meals / Dietary: Ext. 1528	
Attending: 	Nurse: 	
Med Team: 	Visiting Hours: 	
Plan of Care:		
Questions: 		
Additional Notes: 		
Pain Management		
 0 No hurt	 2 Hurts Little Bit	 4 Hurts Little More
 6 Hurts Even More	 8 Hurts Whole Lot	 10 Hurts Worst
		Pain Goal is: 
We want your stay to be very good. Please contact the Nurse Manager with any questions or concerns at Ext. 1096		

Source: Women and Infants Hospital of Rhode Island, Providence, RI.

Communication Board Library (cont.)

UHS's Communication Board

 <p>_____ TODAY'S DATE</p> <p>S M T W TH F S</p>		<p>YOUR HEALTH CARE TEAM</p>  <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>																									
 <p>_____ ROOM #</p>																											
 <p>_____ ROOM PHONE #</p>																											
 <p>_____ UNIT PHONE #</p>																											
<p>PATIENT AND FAMILY QUESTIONS</p> 		<p>SPECIAL INSTRUCTIONS</p> 																									
<p>GOALS AND PROGRESS</p> 																											
<p>PAIN CONTROL IS OUR GOAL. TELL US HOW YOU FEEL.</p> <p>Nuestra meta es mantener su dolor bajo control. Díganos cómo se siente.</p>																											
<table border="0"> <tr> <td colspan="2">NO PAIN Sin dolor</td> <td colspan="2">DISTRESSING PAIN Dolor angustiante</td> <td colspan="2">EXCRUCIATING PAIN Dolor insoportable</td> </tr> <tr> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>0 NO HURT No duele</td> <td>1 HURTS LITTLE BIT Duele un poquito</td> <td>2 HURTS LITTLE MORE Duele un poco más</td> <td>3 HURTS EVEN MORE Duele aún más</td> <td>4 HURTS WHOLE LOT Duele mucho más</td> <td>5 HURTS WORST Duele muchísimo</td> </tr> </table>				NO PAIN Sin dolor		DISTRESSING PAIN Dolor angustiante		EXCRUCIATING PAIN Dolor insoportable		0	1	2	3	4	5							0 NO HURT No duele	1 HURTS LITTLE BIT Duele un poquito	2 HURTS LITTLE MORE Duele un poco más	3 HURTS EVEN MORE Duele aún más	4 HURTS WHOLE LOT Duele mucho más	5 HURTS WORST Duele muchísimo
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 <p>Emergency Response Team 847-2223</p> <p>For Medical Emergencies</p> <p>If you notice serious medical changes, please discuss with your nurse first. If you are still concerned, call the Emergency Response Team.</p>		<p>PATIENT AND FAMILY INFORMATION</p>  <p>CONTACT NAMES AND PHONE NUMBERS</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>																									

Sharp Memorial Hospital's Care Partner Evaluation



Care Partner Program Evaluation

Please take a moment and let us know how we did with our "Care Partner Program".

Dear Patient: Please complete this section by checking the appropriate box.

<i>Patient Feedback</i>	<i>Never</i>	<i>Sometimes</i>	<i>Usually</i>	<i>Most of the time</i>	<i>Always</i>
1. The Care Partner Program decreased my anxiety while a patient.					
2. The Care Partner Program increased my satisfaction with my hospital care.					
3. My individual needs and concerns were addressed.					
4. I was able to participate in my care.					
5. I received information regarding my condition and plan of care.					
6. The Care Partner packet was helpful.					
7. Did you or family visit in the Family Room?					
8. Would you consider being a Care Partner again if the need arose?					

Additional Comments:



Welcome To The Care Partner Program

Sharp Memorial Hospital's Care Partner Orientation Packet (cont.)



Care Partner Guidelines

The patient selects and decides how the Care Partner will help with his/her care and treatment.

The Care Partner is given a tour of the unit and introduced to the staff.

The Care Partner is trained by staff to do the identified patient care and treatment activities.

The Care Partner is not a replacement for nursing care. We view the Care Partner as a member of the health care team that can enhance the patient's healing experience.

The nurse is responsible for the coordination, evaluation and documentation of the patient's care.

The Care Partner is considered a guest with regard to our hospital policies and liabilities.

The Care Partner armband recognizes the Care Partner as a special member of the patient's team. Please wear your armband when you are participating as a Care Partner.

A key factor for the success of the patient and Care Partner's experience is open communication between the health care team and the Care Partner. Please tell us when you arrive, leave the patient's room and what information/education you would like to receive related to the patient's care.

The Care Partner acts as the communication link between the patient's family and friends.

Please wash your hands when you arrive, before and after any treatment involved in patient care, as instructed by nurse and when you leave.

After spending the day or night with the patient, upon leaving, think of what you want the patient's nurse to know and convey it to him/her.

Sharp Memorial Hospital's Care Partner Orientation Packet (cont.)



CARE PARTNER INFORMATION

Patient Name _____

Care Partner Name _____

Relationship to Patient _____

Phone Number(s) _____

Address _____

Days and times available _____

We view the Care Partner as a member of the health care team that can enhance the patient's healing experience. Due to the level of care, your physician has requested for your loved one to have available the following treatment activities for Care Partners:

Care Partner Checklist:

- ☐ Be the spokesperson for the family and friends about the patient's progress.
- ☐ Sit with the patient and offer support.
- ☐ Assist with meals, menu selection, or feed the patient.
- ☐ Provide juices and snacks.
- ☐ Obtain gown and other linens as needed.
- ☐ Help patient to the bathroom.
- ☐ Walk with patient in the hall.
- ☐ Be available during the nights.
- ☐ Help with baths and personal care.
- ☐ Record intake and output.
- ☐ Learn simple treatments, and wound care for home care.
- ☐ Be available for educational opportunities to learn about illness and treatment.
- ☐ Communicates physical and mental changes to health care team
- ☐ Educate guests and staff of hand hygiene upon entering and leaving room.

Care Partner tour of the unit including exits and resource person give by

Name _____ Date _____

Care Partner Signature _____ Date _____

Patient Signature _____ Date _____

Sharp Memorial Hospital's Care Partner Orientation Packet (cont.)



Introduction

The Patient-Family Centered model of health care promotes personalized, respectful and compassionate care in a healing and nurturing environment.

The Care Partner Program at Sharp Memorial Hospital supports this model in offering patients the opportunity to involve family, friends and loved ones in their care during the hospitalization.

The goal is to minimize the change patients experience when hospitalized from what they are used to in their own homes.

The presence of a familiar person can decrease the anxiety that can affect the healing process. The Care Partner can ease this fear by being involved in every aspect of the patient's care.

The Care Partner can help the health care team know who the patient is. Each person who enters the hospital presents with their own individual characteristics. These characteristics may not be specific to the disease or injury, but to the patient's personal, emotional, spiritual, physical and psychosocial needs.

The goal of Sharp Memorial Hospital's health care team is to meet the individual's need for familiar, supportive care that goes beyond the technological advances health care provides today.

Each patient chooses their Care Partner. The Care Partner and patient decide the level of care they are most comfortable providing, and the Care Partner must understand the needs and wishes of the patient. The staff may provide input to the patient regarding the selection of a Care Partner, and the staff may determine the appropriateness of a Care Partner and the level of their involvement.

Care Partner Guidelines

1. The admitting nurse will introduce the Care Partner Program to appropriate patients on admission. These are patients who have available families and/or friends and who have an interest in this role. If an agency nurse admits the patient, then the responsibility of orientation will fall on a staff nurse the next shift, or the lead RN.
2. The patient selects a Care Partner, family, friend, or significant other to be involved in their care.
3. The Care Partner will fill out the information sheet. The Care Partner will select the level of care and participation, and both patient and Care Partner will sign the confidentiality statement.
4. The patient will give the Care Partner a "Care Partner Wristband", to identify their special role in the patient's care. The Care Partner will wear this wristband when they are engaged in their role as the Care Partner. The Care Partner will also receive a Care Partner folder with a welcome letter from the CNO, a program brochure, and other pertinent information.

Sharp Memorial Hospital's Care Partner Orientation Packet (cont.)

Care Partner Orientation

1. The Care Partner is given a tour of the unit either by the admitting nurse or other designated person. This tour will include the location of the linen room, ice machine, nourishment room, snack cart, exits and resource person.
2. The Family Resource Centers will have information regarding educational materials available and videos and books available for the patient's enjoyment.
3. Meals may be taken in the Cafeteria or brought up to eat with the patient if appropriate. Care Partners will receive a discount in the Cafeteria by showing their wristband.
4. The Care Partner will also watch the "Hand Hygiene" Video

Care Partner Activities

Care Partners actually "Partner" with the nurse and CNA in caring for the patient. The Care Partner activities can be as supportive as helping with the menu selection to learning about treatments and procedures.

The Role of the Care Partner

- The identified family liaison
- "Partner" with the health care team
- Sits with the patient
- Hand holds
- Reads
- Takes calls
- Helps patient select meals
- Assists with patient's spiritual care needs
- Care Partner has knowledge of the patient's Advance Directive
- Communicates patient's wishes
- Supervises patient to the commode
- Assists in personal care
- Has access to ice and water, linens and other frequently needed items
- Patient feedings
- Therapy assistance (physical, occupational, etc.)
- Wound care and dressing changes
- Colostomy care
- Incontinence care
- Tube feedings
- Assists in assessing patient's mental status if appropriate
- Assists in assessing patient's pain management
- Diabetic Education participation
- Assists in understanding patient's medications and leaving the hospital medications

Note: All Care Partners participate in "Leaving the hospital" planning.

Sharp Memorial Hospital's Care Partner Orientation Packet (cont.)

Accountability

Sharp Memorial Hospital will maintain accountability to extend the program and its benefits to patients and families. Ongoing programmatic evaluations of integration to practice include daily rounds by Concierge Services to gather total numbers of Care Partners in each unit, tracking replenishment of supplies provided to Care Partners, and name of Care Partner in the patient's electronic medical record.

Evaluation of the Care Partner Program

A description of the research study to evaluate the Care Partner Program is below.

A qualitative study was conducted, with the analysis currently underway, using a phenomenological approach. Phenomenology is used to study the experience and the meaning of the experience of the people in the study (Polit & Beck, Mateo & Kirchhoff, 2009). The objective of this research project is to describe as accurately as possible the phenomenon of the care partner experience and to understand the perspectives of the people involved in the Care Partner Program.

A convenience sample of families' member who participated in the Care Partner program were invited to join. Non English speaking patients were excluded from the study. Subject recruitment took place through flyers posted on the units. Once contacted, the research nurse explained the nature and the purpose of the study. All participants were asked if they have any questions before having them sign the consent form. The participants were given the option to be interviewed in a closed private office at the hospital or in their home at a convenient time for them. If participants chose to be interviewed in their home; arrangements were made to conduct the interview within one week of patient discharge. The interview took approximately one hour. Interviews were stopped when data saturation was met. All participants were interviewed from the same interview schedule. Interviews were arranged at a date, time, and place convenient to the participant.

Interviews were digitally recorded and professionally transcribed. Analysis of this qualitative research occurs in three phases. During the first phase, each tape-recorded interview was heard in its entirety to capture the fundamental significance of the conversation by the primary investigator. Key phrases will be noted. The transcript will then be coded using the selected approach, identifying essential phrases. Phrases from the previous step will be incorporated into the codes. The codes will be examined and grouped to form incidental themes. The incidental themes will be then used in the subsequent interviews, as well as the research questions. Upon completion of all interviews a co-investigators will validate the themes generated from the interview data analysis. Both investigators will then compare and determine the final themes. Demographic data will be analyzed with descriptive statistics such as mean, mode, range, standard deviation, and percents.

The information obtained from the subjects about their experiences may be used to guide efforts to improve and enhance the Care Partner program. It is believed that this pilot study will provide insight about the Care Partner program, increase community awareness about the Care Partner program, and increase enrollment of Care Partners, and lead to further study of patient-family centered care.

UPMC's "Condition H" Information Sheet for Admissions Team

Condition Help

Info Sheet for Admission Team

What is it? It is a "Condition Help" that patients/families can initiate in the case of:

- There is an emergency and you cannot get the attention of hospital staff
- You see a change in the patient's condition and the healthcare team is not recognizing the concern
- You have spoken to the hospital staff and you continue to have serious concerns about the patient's care
- There is a breakdown in how care is given, or uncertainty over what needs to be done

Who Responds?

Physician, Floor nurse, ANC (Nursing Supervisor), and Patient Relations Coordinator (when in house)

Why at UPMC Shadyside?

At UPMC Shadyside Hospital we are building the hospital of the future with the help of patients and families we care for. We believe in team work and ask that families/patients be a part of the team when visiting loved ones.

What is my role when I talk to patients and families?

Share information on Condition Help and nature of this type of Condition. Explain the above and also dialogue on info in the attached article. Inform family/patient of: What it is, Why it is in place, Who responds, How they call (3-3131 from any hospital phone including phone in patient room). Attached is a script for you to use. In addition, please hand out brochure to patients/families.

Condition H

(Condition Help)



The Josie King
Call Line

A safety initiative for PATIENTS



UPMC Shadyside
Part of UPMC Presbyterian Shadyside

5230 Centre Avenue
Pittsburgh, PA 15232

The Condition H Brochure is
provided by the Josie King Foundation.



Condition H

Shadyside Hospital is building the hospital of the future with the help of patients and families we care for. We believe in teamwork and ask that you be a part of our team when visiting your loved ones.

Dial # 3-3131

From Any Hospital Telephone

Dial # 3-3131

From Any Hospital Telephone

Rev 6/06

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Source: UPMC, Pittsburgh, PA.

UPMC's "Condition H" Informational Flier (cont.)

The Josie King Story

Josie King, an 18 month old little girl, died in 2001 from medical errors at one of the best hospitals in the country. Josie was the sister of Jack, Rely, and Eva and beloved daughter of Tony and Sorrel. She died as a result of a series of hospital errors and poor communication.



Listening to Sorrel King tell her tragic story left a lasting impression with me – 'if I would have been able to call a Rapid Response Team, I can't help but think Josie would be here today.' – providing the highest quality care for patients and their families is UPMC Shadyside's history. I knew that we had to bring a family life line (Condition H) to our patients.

Tami Merryman
Vice President
Center for Quality Improvement and Innovation



Condition H

At UPMC Shadyside, we are leading the national focus on eliminating system problems that affect delivery of care. As a response to providing the best care to our patients, we created a Josie King Call Line – Condition H. Josie's mother, Sorrel King, worked with UPMC Shadyside to design how this valuable resource will work in health care.)

UPMC is dedicated to making the hospital a safe place for patient care to happen.

Condition H was created to address the needs of the patient in case of an emergency or when the patient is unable to get the attention of a healthcare provider. This call will provide our patients and families a resource to call for immediate help when they feel they are not receiving adequate medical attention.

When to Call

1. If a noticeable medical change in the patient occurs and the health care team is not recognizing the concern.
2. If there is a breakdown in how care is being given and/or confusion over what needs to be done for the patient.

To access Condition H, please call 3-3131 from any hospital telephone. The operator will ask for caller identification, room number, patient name and patient concern. The operator will immediately activate a "Condition H" where a team of medical professionals are alerted and will arrive in the room to assess the situation. Additional clinical supports will be called in as needed.

In offering our families the Condition H option, we want you to know that you are our partners in care. If you have any questions, please discuss them with one of our healthcare providers.

To access Condition H, please call # 3-3131 from any hospital telephone.



UPMC's Example Script for Discussing "Condition H" with Families

Condition H (Help) Example Script for use when discussing Condition H with patients and families

Admit Team nurse:

"I want to share information with you on the newest addition to our hospital's Rapid Response Teams. (May need to explain to them what a Rapid Response Team is and share that we have teams that come to patients' rescue when hospital personnel call condition A or C in clinical crisis situations). "The new addition to the Rapid Response Teams is called a "Condition Help" that patients/families/visitors can initiate in the case of":

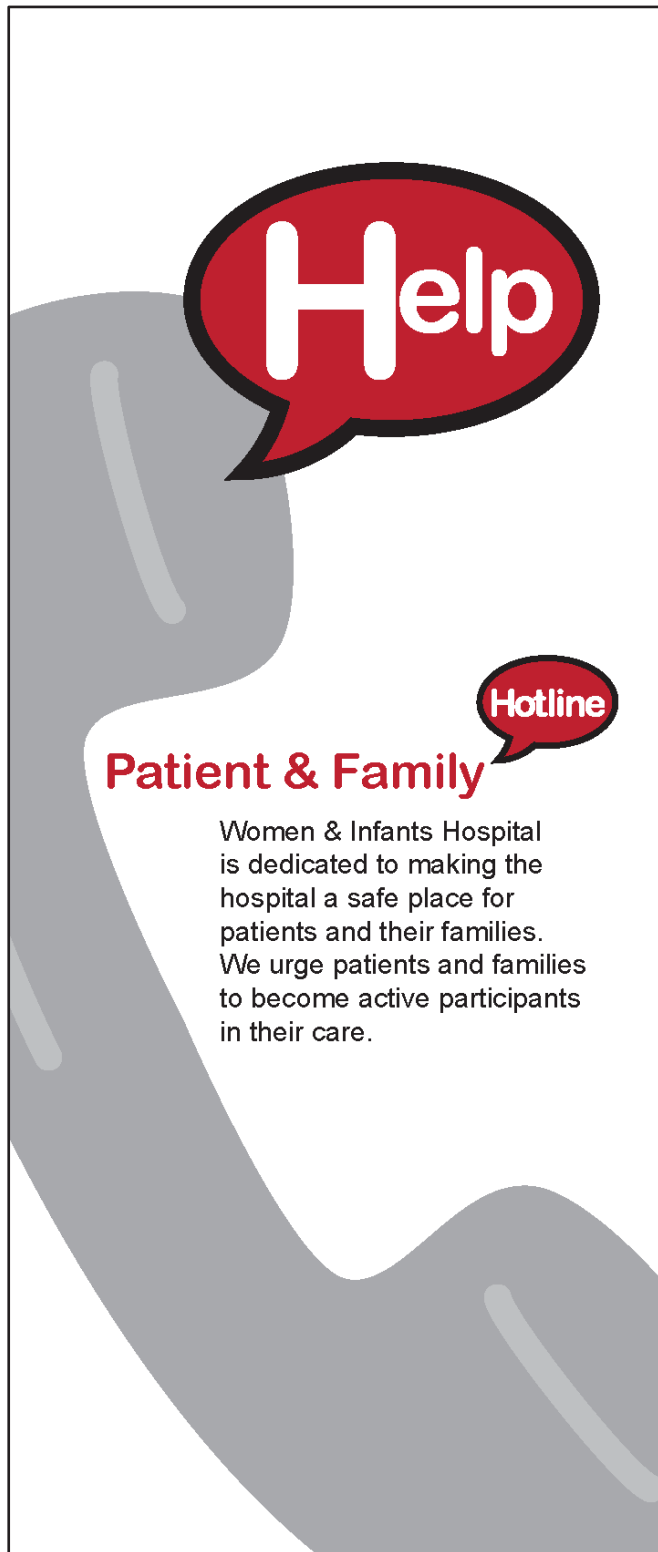
"A change you (the patient/visitor) notice in your loved one's condition when you have tried to express it to the health care team and felt you weren't listened to. Condition H can also be called if there is a breakdown in how care is being given and confusion over what needs to be done or if patients/families have conflicts with what is happening. Condition H can also be called when an emergency occurs when you (patient or visitor) is/are unable to locate hospital personnel. A condition H can be called for those situations that you would call 911 for when at home. "Please try to locate hospital staff first, but if your attempts are unsuccessful, a condition H may be called.

While in our hospital, we hope that you always receive the attention and care that you need, but we wanted to assure you that if any of the situations that I have mentioned occur during your stay, help is available and you can call for it.

To call a Condition H, call 3-3131 from a hospital telephone and inform the operator of your emergency, location and name.

Any questions?"

Women and Infants Hospital of Rhode Island's "Condition H" Brochure



Dial **1020** from any hospital telephone

Hotline

Patient & Family

When to call

- 1 Call** if you notice a change in the patient's condition and the health care team is not recognizing your concern.
- 2 Call** if there is a breakdown in the way care is being given and/or confusion over what needs to be done for the patient.

Calling the Patient & Family Hotline

To place a call to the Patient & Family Hotline, use any phone within the hospital to call ext. 1020. The operator will ask you for the patient's name, your name (if you are not the patient), and the room number.

What happens next?

Once the call is received a clinical supervisor will come to the patient's room immediately and assess the situation. The supervisor will call for additional support if necessary.

Women & Infants'

UPMC's "Condition H" Follow Up Form

Office Use Only

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UPMC Shadyside Hospital Condition H (Help) Follow-up Questionnaire

Page 1 to be completed by PRC on day of Condition H
Page 2 to be completed with help of PRC day following Condition H

Addressograph

- Date of Condition H: ____/____/____
- Time of Condition H: ____:____ (Use 24 hour clock)
- Location of Condition H:

<input type="checkbox"/> 3 East	<input type="checkbox"/> 4 East	<input type="checkbox"/> 5 Main	<input type="checkbox"/> 6 Main	<input type="checkbox"/> 7 Main	<input type="checkbox"/> CTICU
<input type="checkbox"/> 3 Main	<input type="checkbox"/> 4 Main	<input type="checkbox"/> 5 West	<input type="checkbox"/> 6 West	<input type="checkbox"/> 7 West	<input type="checkbox"/> NSICU
<input type="checkbox"/> 3 PAV	<input type="checkbox"/> 4 PAV	<input type="checkbox"/> 5 PAV	<input type="checkbox"/> 6/7 PAV	<input type="checkbox"/> ED	<input type="checkbox"/> MICU/CCU
					<input type="checkbox"/> SICU
					<input type="checkbox"/> Flex ICU

☐ Off Unit, specify: _____
- Service: _____ Teaching ☐ Yes ☐ No
- List names and positions of response team members:
- Name of Caller: _____
- Relationship to Patient:

<input type="checkbox"/> Patient	<input type="checkbox"/> Family	<input type="checkbox"/> Friend
<input type="checkbox"/> Staff	<input type="checkbox"/> Clergy	<input type="checkbox"/> Other

 Other, specify: _____
- Nature of Call:

<input type="checkbox"/> 1 Medical Management	<input type="checkbox"/> 7 Delay in Care
<input type="checkbox"/> 2 Diet Related	<input type="checkbox"/> 8 Dissatisfaction with staff
<input type="checkbox"/> 3 Psychosocial Issues	<input type="checkbox"/> 9 False Call/Cancelled
<input type="checkbox"/> 4 Discharge Planning Related	<input type="checkbox"/> 10 Communication Breakdown
<input type="checkbox"/> 5 Clarification of Orders	<input type="checkbox"/> 11 Allergy Related
<input type="checkbox"/> 6 Pain Control/Medication Related	<input type="checkbox"/> 12 Other: _____
- Attention PRC!! Briefly describe the happenings that occurred prior to initiation of Condition H.

NOTE TO PRC/ANC: Before leaving the unit, please confirm the patient's care nurse will document the Condition H in eRecord. Thank you.

UPMC's "Condition H" Follow Up Form (cont.)

To be completed within 24 hours by Condition H Caller with help of PRC/ANC.

10. PRC/ANC: _____

11. Date of Follow-up: ____/____/____

Addressograph

	Strongly Agree 5	Agree 4	Undecided 3	Disagree 2	Strongly Disagree 1
12. I felt I was given clear direction regarding Condition H					
13. I felt comfortable calling a Condition H.					
14. When I/my family called a Condition H, I/we felt my/our needs were met.					
15. I felt my needs or the needs of my loved one were met post Condition H call.					

16. Please indicate if the Condition H call resulted in any of the following:

- ☐ Change of medication regimen ☐ Condition A or C called ☐ Other
☐ Transfer to another Unit ☐ No changes made

17. Did the Condition H result in a change in the patients code status? ☐ Yes ☐ No

18. On your follow-up, please investigate & report on this sheet in the space below how the situation was stabilized & what interventions were taken to meet the patient needs on team response to Condition H. Please include the resources necessary to stabilize the situation & overall what it took to solve the problem.

19. If I had to initiate a Condition H again, would I do it? ☐ Yes ☐ No

20. Would you be willing to be contacted at a later date to share your Condition H experience? ☐ Yes ☐ No

21. Phone number where you can be reached: _____

For Sunday follow-up by ANC: Please fax this completed form to Patient Relations the day of your follow-up. Fax#: 412.623.1319 Thank you.



Northumbria Healthcare **NHS**
NHS Foundation Trust

Stroke Support Volunteer

Are you a patient or carer?

Would you like to talk to us – we are either a patient or carer living with stroke?

We understand and can listen to any worries you may have because of stroke.

We can direct you to information and support following stroke.

Let the staff know that you would like to see us!

Joe DiMaggio Children's Hospital's Family Mentor Do's and Don'ts

Global Centre for Nursing Executives Note on Use: The tips below are provided to family mentors at Joe DiMaggio Children's Hospital, to help ensure safe, productive mentor-mentee meetings and reduce the likelihood of mentor burnout.

Do's:

- Check in with Program Manager
- Limit the families you mentor to the ones assigned to you
- Share the expectations of your mentor role with your families you mentor
- Complete your mentoring reports immediately after mentoring
- Attend and participate in monthly and quarterly Parent Mentor meetings

Don'ts:

- Don't have a family to your home or go to their home
- Don't give out your personal information
- Don't give medical advice
- Don't come to mentor without the knowledge of your program manager.
- Don't ignore how you feel before and after you mentor
- Don't run errands or buy things (provide resources for the families to follow up with)

UWMC's Advisory Council Recruitment Flier



*Patient and Family Centered Care at
University of Washington Medical Center*

Become a Patient or Family Advisor at UW Medical Center!

We are looking for patients and family members to serve as volunteer Advisors to improve the experience of care at University of Washington Medical Center.

Advisors serve in many ways – on councils, committees, and one-time focus groups. Advisors help:

- ❖ Shape change throughout the medical center
- ❖ Participate in forming policies and procedures
- ❖ Improve patient safety
- ❖ Design a more welcoming environment
- ❖ Review forms and educational materials

To learn more, please join us at an information forum in 2011:

September 15

1:30 – 3:00 p.m.

For room location and to RSVP:
206-598-2697 or pfcc@u.washington.edu

Parking will be validated for the Triangle Parking Garage.

UW Medicine
UNIVERSITY OF WASHINGTON
MEDICAL CENTER

UWMC's Advisory Council Outreach Letter

UNIVERSITY OF WASHINGTON
MEDICAL CENTER
UW Medicine

August 31, 2011

Name
Address
City, State ZIP

Dear Name,:

[Staff name], Nurse Manager on the [unit], tells me that you would like to learn more about becoming an advisor. I'm glad to hear of your interest!

Here at UWMC, we recognize patients and their families as valued members of our health care team who have important perspectives, feedback, and solutions to share. As a patient advisor, you would partner with others to improve services at the medical center.

You would be joining other patients and family members, health care providers, and staff on a committee or doing work to raise issues, communicate patient and family concerns and help with problem solving, with the goal of improving our services.

To learn more about the advisory program, and to help us make good matches between organizational needs and patient and family advisors, we invite you to attend one of our information sessions. **The next regularly scheduled session is Thursday, September 15, from 1:30 to 3:00 p.m.** Please see the enclosed flyer announcing the upcoming session, and leave me a voice message (206-598-2697) or send me an e-mail (hollisr@u.washington.edu) to let me know whether you plan to attend, or not. Also, please complete and return (or bring with you) the attached application form.

Some of the patient and family advisor activities include:

Committees/Councils

- Patient and Family Centered Care Steering Committee
- Rehab Services Advisory Council
- Inpatient Advisory Council
- Pregnancy & Childbirth Advisory Council
- Neonatal Intensive Care Unit Advisory Council
- Patient and Family Education Committee
- Patient Safety Committee
- Patient Satisfaction Stakeholders Committee
- Service League Board
- Aesthetics Committee
- ICU Advisory Council



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

UWMC's Advisory Council Application Form

<input type="checkbox"/> Original <input type="checkbox"/> File <input type="checkbox"/> VS Date Rcd <input type="checkbox"/>	<small>UNIVERSITY OF WASHINGTON</small> MEDICAL CENTER UW Medicine
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Application Form for Patient and Family Advisors

Name: _____
(Last) (First) (MI)

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (10 digits) _____ **Cellular Phone:** (10 digits) _____

Work Phone: (10 digits) _____ **Fax:** (10 digits) _____

E-mail Address: _____

Language(s) You Speak: _____

Choose one: ☐ I am a Patient. ☐ I am a Family Member of a Patient.

☐ Yes, I will allow my contact information to be shared with other committee/advisory council members.

☐ No, I do not want my contact information shared with other committee/advisory council members.

My care provided at UWMC was primarily: (check all that apply)

<input type="checkbox"/> Hospitalization (Inpatient)	<input type="checkbox"/> Clinic Visit (Outpatient)
<input type="checkbox"/> Emergency Department Care	<input type="checkbox"/> Other _____

The dates of my active care experience at UWMC include: (check all that apply)


☐ 2010 to current year ☐ 2006-2009 ☐ 2001-2005 ☐ Before 2001

Within the past two years, what UWMC services have you or your family member used?
(check all that apply)

<input type="checkbox"/> AIDS AND HIV	<input type="checkbox"/> Gastroenterology/GI	<input type="checkbox"/> Orthopaedic
<input type="checkbox"/> Autoimmune	<input type="checkbox"/> Genetics and/or Birth Defects	<input type="checkbox"/> Pregnancy, Childbirth and Infant Care
<input type="checkbox"/> Blood and Lymphatic	<input type="checkbox"/> Intensive Care Unit (ICU)	<input type="checkbox"/> Rehabilitation
<input type="checkbox"/> Cancer	<input type="checkbox"/> Infectious Diseases	<input type="checkbox"/> Skin and Connective Tissues
<input type="checkbox"/> Cardiology	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Surgery
<input type="checkbox"/> Chest/Pulmonary	<input type="checkbox"/> Nephrology/Kidney	<input type="checkbox"/> Transplant
<input type="checkbox"/> Ear, Nose and Throat	<input type="checkbox"/> Neurology	<input type="checkbox"/> Urology
<input type="checkbox"/> Endocrinology/Diabetes	<input type="checkbox"/> Nutrition	<input type="checkbox"/> Other _____
<input type="checkbox"/> Eye		

Please list times when you are able to attend meetings: (check all that apply)

☐ Daytime: _____ ☐ Evening: _____ ☐ Weekend: _____


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

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10/2007

UWMC's Advisory Council Application Form (cont.)

I/We would be interested in helping with (identify all of your interest areas):

- ☐ Reviewing patient and family satisfaction tools.
- ☐ Developing/reviewing educational materials.
- ☐ Planning for the hospitalization (inpatient) care experience.
- ☐ Planning the design of systems of care and facilities for the surgical experience.
- ☐ Planning for the clinic (outpatient or ambulatory) care experience.
- ☐ Planning the design of systems of care and facilities for the emergency care experience.
- ☐ Ensuring patient safety and the prevention of medical errors.
- ☐ Educating medical students and residents, new employees, and other staff about the experience of care and effective communication and support.
- ☐ Participating in facility design planning.
- ☐ Improving the coordination of care and the transition to home and community care.
- ☐ Long-term advisory council membership to have impact and influence on policies and practices that affect the care and services patients receive.
- ☐ Issues of special interest (please describe).

If you have served as an advisor, been an active volunteer committee member, or done public speaking for other programs or organizations, please briefly describe this experience:

What are some specific things that health care professionals did or said that were most helpful to you and your family?

What are some specific things that you or your family would like health care professionals to do *differently* in order to be more helpful?

Do you know other individuals and/or families who have experienced care at University of Washington Medical Center who might be interested in serving as advisors? Please call them for us or list their name(s) and phone number(s) here:

Please return this form to:

Memorial Regional Hospital's Advisory Council Orientation Outline

MEMORIAL HEALTHCARE SYSTEM ORIENTATION FOR PATIENTS AND FAMILIES

When patients or their family members join an MHS Advisory Council, they receive a thorough orientation not only to the work of the Council, but also to the “culture” of the organization and the “dos” and “don’ts” of their new role.

TOPICS COVERED IN THE GENERAL ADVISORY COUNCIL ORIENTATION:

1. The vision and goals of Memorial Healthcare System.
2. An overview of the Patient and Family-Centered Care approach to healthcare.
3. The role of the Advisory Councils, and how they assist the organization in achieving its vision and goals.
4. How to be an effective Council member.
5. Serving on organizational committees:
 - Communicating effectively — techniques for getting your message across:
 - Telling your story so people listen.
 - How to ask tough questions.
 - What to do when you don’t agree.
 - Listening to and learning from other’s viewpoints.
 - Thinking beyond your own experiences.
6. Advisor Self-Study Guide & Test – required of all volunteers
7. Required documents: HIPAA & IT Security Forms, Consent to Photograph

SPECIFIC FACILITY ORIENTATION (PFCC Coordinators: Add to this as needed)

1. Who’s who in the organization.
2. Meeting attendance expectations of members.
3. The roles and responsibilities of members, officers, and staff on the Council or committee.
4. How the meeting is conducted: Robert’s Rules of Order (if they are used), committee reports, reaching consensus, and approval of minutes.
5. How to prepare for a meeting: what to wear, what to do ahead of time, what to bring.
6. Honoraria for family faculty; stipends for regular hospital committee attendance; recording time; W9 submission.

Sample Patient and Family Advisory Council Projects

UWMC's "Rehab and Beyond" Packet

Page ix

Rehab and Beyond – Rehabilitation Services

A Note to Patients and Their Loved Ones

This *Rehab and Beyond* manual was written by patients and staff who are serving as advisors on the Rehabilitation Services Patient and Family Advisory Council.

At University of Washington Medical Center Rehabilitation Services, our main goals are to:

- Provide safe, high-quality medical care to our patients and support for their families.
- Make your hospital stay comfortable.
- Partner with you to maximize your functional recovery from your injury or ailment.

A team of doctors, nurses, allied health professionals, and other support staff will work together with you and your trusted loved ones to create a team that focuses on your care and the support you need.

With your input and guidance, our team is here to provide you and your family the best care possible. Please let us know how we can help. Thank you for choosing University of Washington Medical Center (UWMC) for your health care.

These patient advisors, along with staff, bring years of experience and have teamed up to write *Rehab and Beyond* to support your journey.

If you have ideas or suggestions for future versions, please send them to:

Rehabilitation Services Patient and Family Advisory Council
c/o Patient and Family Centered Care Program
Box 359420
1959 N.E. Pacific St.
Seattle, WA 98195
206-598-2697
pfcc@u.washington.edu

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04/2009
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Sample Patient and Family Advisory Council Projects (cont.)

UWMC's "Rehab and Beyond" Packet

Patient Education Section 1

Rehab and Beyond – Rehabilitation Services



Entry to UWMC

Admission Information
Insurance Information
Planning Worksheet
What questions should I ask?
Who can help with this process?

You will be asked for the same information many times, from the time you are admitted, throughout your course of treatment up until the time you go home. Be patient. And, try to keep the basic information somewhere where you can find it every time you need it.

~ Patient Advisor

UNIVERSITY OF WASHINGTON
MEDICAL CENTER
UW Medicine

Sample Patient and Family Advisory Council Projects (cont.)

UWMC's "Rehab and Beyond" Packet

Section 1 – Page 2

*Rehab and Beyond – Rehabilitation Services
Entry to UWMC*

Admission Information

- The first thing to know is that you will receive much information when you arrive. It is a lot to digest, whether you are already at UWMC and recently admitted to this unit, or you are admitted from another hospital.
- Depending on your case, there may be paperwork to be filled out, required information from referring doctors, and/or medical tests that will need to be done. Your eligibility for treatment options may need to be assessed.
- You do not have to process all of the information at once. It is normal to be overwhelmed by the rehab team approach to care and the rehab experience. For most, it is best just to admit this up front rather than to try to be stoic.
- Think about identifying one person – a trusted family member or friend – with whom the care team can communicate questions and concerns when you are not available or don't feel up to talking.
- Feel free to ask questions about your injury or disease process, and about what to expect on the Rehab floor. If there is anything that is explained or done that you do not understand, ask questions until you understand.
- Use a system that works for you to keep track of and organize the large amounts of information you will receive throughout your stay.
- There is a lot of admission paperwork. The information you supply helps your care team start to develop a plan of care for you. The admissions documentation items include questions about your health history, evaluation of your vital signs, and many questions to help you work with your care team to develop a care plan for your treatment during your stay.

Sample Patient and Family Advisory Council Projects (cont.)

UWMC's "Rehab and Beyond" Packet

Section 1 – Page 3

Rehab and Beyond – Rehabilitation Services
Entry to UWMC

- This initial stage of your care is often called the **assessment phase**. From the beginning, you will be asked to think about your rehab goals – what do you want to accomplish to feel more independent? You'll be encouraged to start putting together a supportive group of family and friends who can help you while you are in the Rehab Unit and beyond. See Section 5, "Your Plan of Care and Setting Goals" and Section 6, "Support from Others" for help with these parts of your care experience.

Insurance Information

If you have not already researched these issues, it will be helpful to do so as soon as possible. You may have health insurance, dental insurance, a vision care plan, or disability insurance. So, you may have more than one insurance provider or carrier to coordinate payments for your care.

These are some insurance-related questions that you will want to ask:

- *Does my insurance have preferred providers for service?* You will need to contact your insurance company(s) to understand if they have a list of preferred providers that will yield better financial coverage for your care.
- *What is my deductible?* The deductible is what you pay before the insurance pays.
- *What is my out-of-pocket expense?* Out-of-pocket expense can be any combination of your deductible, co-pays, and the amount you pay for items not covered by your insurance.
- *Does my insurance company have a stop-loss clause?* A stop-loss clause is a type of insurance that provides coverage for certain benefits when total claims during a specified period exceed a specified amount. Most times, this clause specifies the maximum payment that will be made for a particular type of coverage or service.

Sample Patient and Family Advisory Council Projects (cont.)

UWMC's "Rehab and Beyond" Packet

Section 1 – Page 4

Rehab and Beyond – Rehabilitation Services
Entry to UWMC

- *Does my insurance offer case management? What is provided and what does it do for me?* Case management is a service delivery approach. The approach assumes that patients with complex and multiple needs will access services from a range of providers. The goal is to achieve seamless service delivery. Check with your insurance company, as each one takes a slightly different approach.
- *Does my insurance cover home care? If so, what type of therapies and care are covered for home care (such as speech therapy, nursing care, physical therapy, occupational therapy, etc.)?* Home care services may include high-tech pharmacy services, skilled professional care, paraprofessional care, *custodial care* (non-medical care to help with activities of daily living such as bathing and preparing food), home medical equipment, community support, and/or hospice care.
- *Does my insurance cover medical equipment?* You may need to rent or purchase medical equipment. As you approach your date to go home from the hospital, talk to your team members about your medical equipment needs.

Other questions you will want to ask include:

- *Does my insurance cover inpatient, hospital-based rehabilitation care?*
- *Is there a maximum dollar amount allowable for inpatient rehabilitation care?*
- *Is there a limit to the length of stay, or how many days will my insurance cover my inpatient or hospital stay?*
- *What criteria does one have to meet to qualify for inpatient rehabilitation care?*
- *Does there have to be a referral for me to be in a rehabilitation care unit? If so, from whom?*

See the Section 7, "Financial Issues," for more details about medical insurance and income insurance options.

Sample Patient and Family Advisory Council Projects (cont.)

UWMC's "Rehab and Beyond" Packet

Section 1 – Page 5

Rehab and Beyond – Rehabilitation Services
Entry to UWMC

Planning Worksheet

Some people like to plan using a tool like this worksheet. Use it to record suggestions made by staff and others, your own ideas, and contact information.

What Do I Need, and How Do I Get It?

Need	Suggestion	Your Idea	Who do I turn to?
Personal Care			
Business Issues			
Social Issues			

Sample Patient and Family Advisory Council Projects (cont.)

UWMC's "Rehab and Beyond" Packet

Section 1 – Page 6

Rehab and Beyond – Rehabilitation Services
Entry to UWMC

Who can help me and my family with this entry process?

- We all plan in different ways and seek support in different ways. First, you must help with the recovery and rehabilitation process. Take time to get clear about what you want. This is often not an easy time to be clear. That's okay. Do the best you can and know that you can change your mind about what's important, what your goals are, and even about who can help you.
- The rehab psychologist is trained to help you with this process. The rehab psychologist has years of experience helping patients in situations similar to yours.
- The social worker is trained to help you with discharge planning issues. See Section 8, "Care After Discharge."
- Take a look at Section 6, "Support from Others," in this manual.
- One tip from a former patient is to ask others for their one best idea. This decreases the amount of ideas you have to filter through. Of course, some people process best when they review a range of ideas.

What questions should I ask?

It can be hard to know what to ask if you are not sure what information you need. It is okay to ask others about what information they think is important. It may help to brainstorm a list of topics to ask about (such as home care, transportation, support, legal forms). We have strived to fill *Rehab and Beyond* with much of the information you might need.

You might want to ask questions about:

- What to expect about your care and living on the Rehab Unit.
- Your disease process or injury and how it will affect you and your family.
- Anything you do not understand. This is how you can

Sample Patient and Family Advisory Council Projects (cont.)

UWMC's "Rehab and Beyond" Packet

Section 1 – Page 7

Rehab and Beyond – Rehabilitation Services
Entry to UWMC

Questions?

Your questions are important. Talk to your doctor, nurse, or other health care provider if you have questions or concerns.

While you are a patient on Inpatient Rehab, call: 206-598-4800

After discharge, call your primary care provider or UWMC's Rehabilitation Clinic: 206-598-4295

become an expert on your care and make the best decisions for you and your family.

- Resources from staff, former patients, insurance companies, and on the Internet to help your recovery.
- The ways information can be given. We want to give information in the way you prefer to learn – *reading* (written materials), *seeing* (videos or watching someone), or *doing* (demonstrations).

If you think of a question when no one who can answer it is around, write it down, record it, or ask someone else to write it down for you. If you had a question and forgot to ask it, we encourage you to ask later when you remember it.

UNIVERSITY OF WASHINGTON
MEDICAL CENTER
UW Medicine

Rehabilitation Services
Box 356071
1959 N.E. Pacific St. Seattle, WA 98195
206-598-4800

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Sample Patient and Family Advisory Council Projects (cont.)

UWMC's Patient and Family Guide



Patient and Family Guide

*Units 7-Northeast, 7-Southeast, and 8-Northeast at
University of Washington Medical Center (UWMC)*

This Guide is written for you by the Patient and Family Advisors on UWMC's Inpatient Oncology Advisory Council. It is for you to keep as a reference to improve the comfort of your care experience at UWMC.

This Guide identifies the services and facilities that patients and families may use while at University of Washington Medical Center. It will also help you learn some new terms that you may hear during your stay. Your health care team is always happy to answer any other questions you may have.

Welcome

Welcome to UWMC's cancer care units, located on 7-Northeast, 7-Southeast, and 8-Northeast. Our primary goal is to provide you with exceptionally safe and compassionate care.

There are many people who are part of your health care team who will provide your care while you are at UWMC. Your care team is made up of medical, nursing, allied health professional, and other support staff. You and your family are also important partners on your health care team.

You will be able to identify care providers because they will be wearing a nametag. Please feel free to ask staff members who they are and what role they have in your care.

Your Health Care Team

Patients and Families

The partnership between you, your family, and the rest of your care team is important for your well-being and comfort. We encourage you to introduce yourself to your team members and let them know your concerns and needs, so they can make your stay as comfortable as possible. Please feel free to ask questions of any member of your team. No question is too simple or too complex.

Medical Staff

A team of doctors and nurses will work together to provide you with the full care and support you need while you are at UWMC. These are the care providers you will meet while you are in the hospital.

Attending Physician/Surgeon

Your attending physician or surgeon is a faculty member at University of Washington Medical School and an experienced clinician. This doctor directs your care, works closely with all of the team members, and supervises the training of residents.

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MEDICAL CENTER
UW Medicine

Sample Patient and Family Advisory Council Projects (cont.)

UWMC's Patient and Family Guide

Fellow

A fellow is a doctor who has finished his or her training and is now working on further studies or research, or is developing specialty skills.

Resident

A resident is a doctor who has graduated from medical school and is **in training** in a special medical or surgical area. An R1 is an intern or resident in the first year of training. There is a range of four to six years of residency (R2, R3, R4, etc.). The highest level for each specialty is known as the "chief resident."

Medical Student

A medical student works closely with a resident to learn about caring for patients in the hospital.

Physician Assistant

A physician assistant is a faculty member who partners with a group of attending physicians to help provide continuity of care during your stay in the hospital.

Nursing Staff

To provide 24-hour care, our nurses work in three 8-hour or two 12-hour shifts. Shift changes are typically at 7 to 7:30 a.m., 3 to 3:30 p.m., and 11 to 11:30 p.m. for 8-hour shifts. Nurses on 12-hour shifts change at 7 to 7:30 a.m. and 7 to 7:30 p.m.

Nurse Manager

The nurse manager oversees the nurses and the overall operations of your inpatient unit.

Charge Nurse

There is a charge nurse 24 hours a day who helps oversee your care, and is in charge of keeping the many services within your inpatient unit running smoothly.

Primary Nurse/Staff Nurse

Some patients have a primary nurse who provides bedside care and coordinates all aspects of daily care with other teams and services. A staff nurse provides day-to-day nursing care under the direction of a doctor. All nurses at UWMC and SCCA are Registered Nurses (RNs), and most have a bachelor's or an advanced degree in nursing.

Hospital Assistant

A hospital assistant performs patient care as directed by an RN. A hospital assistant may also be called a nurse's aide or orderly.

Allied Health Professionals

Pharmacist

A pharmacist gives information to medical and nursing staff about the uses, dosage, and effects of medicines. Clinical pharmacists at UWMC and SCCA have a Doctor of Pharmacy degree. Pharmacists also teach patients about the medicines they will use after they leave the hospital.

Dietitian

A dietitian is an expert in food and nutrition. Your dietitian will assess your needs and advise your care team about the best diet for you. Dietitians also teach patients how to follow any special diets when they return home.

Sample Patient and Family Advisory Council Projects (cont.)

UWMC's Patient and Family Guide

Physical Therapist

A physical therapist (PT) checks how well you can move and may suggest exercises, therapies, and/or medical equipment to help you move more easily and become stronger. A PT may be asked to join your care team through a referral process begun by your doctor.

Occupational Therapist

An occupational therapist (OT) checks how well you handle daily tasks such as dressing, bathing and cooking. These chores are also called "activities of daily living," or ADLs. An OT may provide aids and devices to help a patient perform ADLs that are hard to handle. An OT may be asked to join your care team through a referral process begun by your doctor.

Respiratory Care Practitioner

Your respiratory care practitioner (RCP) will work closely with your doctor and nurse to provide the best oxygen therapy and pulmonary diagnostic monitoring while you are in the hospital. If needed, your RCP will also arrange for you to have oxygen and other equipment when you go home. A RCP may be asked to join your care team through a referral process begun by your doctor.

Social Worker

A social worker checks on and helps with your emotional and physical needs. This includes helping you and your family adjust to a new diagnosis, learn about caregiving, create a safe plan for when you go home, and cope with loss and grief. This team member may also assist with or provide referral to a financial services counselor. If a patient or family member has a need for a social worker outside regular business hours, ask a staff nurse to help you contact an on-call social worker. All social workers on our care teams have a master's degree.

Support Staff

Spiritual and Religious Care

As part of your care team, chaplains provide respectful spiritual and emotional care to persons of all faiths and spiritual beliefs. To speak with a chaplain, ask your nurse or social worker to contact a chaplain for you, or call 206-288-6265.

Patient Service Specialist

A patient service specialist (PSS) works at the front desk on the unit and can answer basic questions, identify resources, and issue parking validation stickers.

Financial Services Counselor

A financial services counselor can help you and your family understand your hospital bills and complete insurance forms. Ask your social worker to help you contact our financial counselors. If needed, they can also help you apply for Medicaid.

Environmental Services/Housekeeping Staff

The environmental services and housekeeping staff cleans your room every day. They also clean and maintain all public spaces in the medical center.

Kingston General Hospital's Hand Hygiene Poster

Clean hands save lives



The illustration shows two hands, one in the foreground and one slightly behind it, being washed. Water droplets are depicted as small blue circles spraying from the right side of the hands. The hands are rendered in a light skin tone with red outlines for the fingers and palms.



Kingston
General
Hospital

Outstanding care, always™

Hand Hygiene this month in our hospital

%

Stay safe and keep others safe by washing
your hands and using sanitizer often.

Approved by the Patient and Family Advisory Council.

Melbourne Health's Evaluation of Consumer Participation in Root Cause Analyses

Staff Interview Questionnaire

Do you believe consumers add value to the Root Cause Analysis Process?

Did the consumer(s) provide useful information to RCAs about what is important from a consumer perspective?

How would you best describe what consumers bring to RCA discussions?

A different point of view to that of health professionals

An independent voice ie outside the management and administrative processes of the health service. Is this good or a disadvantage?

A patient and family centred approach

A chance on staff to reflect how they think about issues

Other

Were staff (refer subgroups below) on the RCA working group(s) responsive to the views of consumers?

The Chair

Medical Staff

Other

Do you think all RCA working groups should include a consumer? If yes, why.

You are happy with the process for recruiting a consumer to RCA reviews? If no, how could it be improved?

Do you think consumers need formal training about the RCA process to participate effectively?

What other guidance and/or support do you think consumers need to participate?

Have you had any concerns or issues with consumers participating in RCA's?

Do you think it is appropriate for consumers to be present when discussing the RCA findings with the staff/management concerned?

Does the consumer influence the recommendations of the RCA?

What do you feel could be done to improve consumer participation in the RCA process?

UWMC's Patient Advisor Editing Guidelines

University of Washington Medical Center

Patient and Family Education Services

Patient Education Material – Advisor Feedback

Please take a few minutes to read and review this new patient education handout:

Title: _____ Subject: _____

I am a (check one): ☐ Patient ☐ Family member of a patient ☐ Other (describe): _____

Please read this new education handout and then rate it using this scale. Check the box in the column that best describes your opinion: **Poor**, **Okay** or **Great**. Check **Does Not Apply** if the item does not apply to the handout.

	Does Not Apply	Poor	Okay	Great
1. The title describes the content of the handout.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The introductory paragraph tells about the content of the handout.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The information is clearly presented and well organized.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The material is easy to read.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The diagrams, drawings, tables or checklists are easy to understand.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Medical terms are explained.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Overall, what did you think of this handout?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Would you recommend this material to your family or your friends? ☐ Yes ☐ No

9. If no, why not?

10. Do you have any other comments or suggestions?

Please use back of page if you need more room, or go to a new page if you are filling this out electronically.

Your Name: _____ Today's date _____

Thank you for your feedback.

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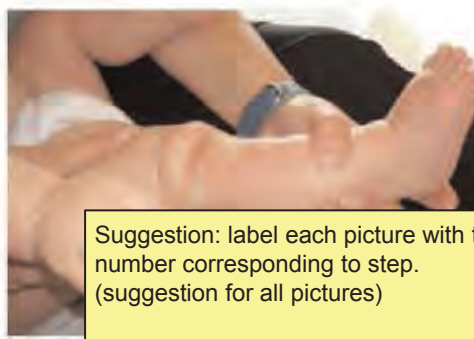
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Range of Motion for Your Baby: Legs and Trunk

For the Hip Flexion and Extension



1. Lay your baby on his back.
2. Put one hand on the back of his leg.
3. Gently move his knee towards his chest so his hip bends.
4. Slowly straighten his leg. This stretches the front of his hip.



Suggestion: label each picture with the number corresponding to step.
(suggestion for all pictures)

Some pictures could have more than one step assigned (e.g., 1-3).



Here is another way to stretch the front of his hip.

1. Put your baby on his belly.
2. Put one hand on his bottom.
3. Gently pull his leg up while you have your hand on the front of his thigh.
4. To isolate the muscle on the front of his thigh, put one hand on his knee.
5. Gently bend his knee so his heel moves toward his bottom.



Question: Should there be another step here instructing caregivers to do the exercise on the other side? This is of note because most of the demonstrations shown are on the left side of the body.
(suggestion for all exercises)

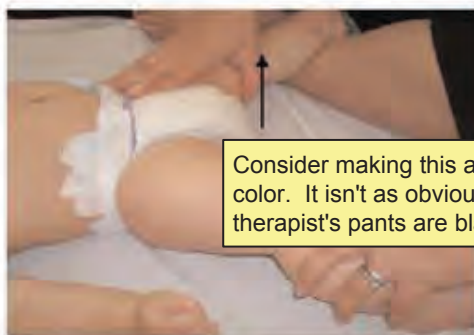
Question: How many times should this exercise be done? On each side?
(suggestion for all exercises)



Riley Hospital for Children
Indiana University Health

Riley Hospital for Children at IU Health's e-Advisor Edits on Educational Material (cont.)

For the Hip Abduction and Adduction



Consider making this arrow a different color. It isn't as obvious because the therapist's pants are black, too.



1. Gently spread your baby's legs apart. This stretches his inner thighs.
2. Put one leg out to the side.
3. Move the other leg toward it to stretch the outside of his hip.

For the Hip External and Internal Rotation



1. Bend your baby's knee halfway up to his chest.
2. Turn his leg so his foot moves toward his face.
3. Turn his leg the other way. His foot will move outward.

Riley Hospital for Children at IU Health's e-Advisor Edits on Educational Material (cont.)

For the Knee Flexion and Extension



1. Put one hand on the front of your baby's thigh.
2. Put the other one on the front of his lower leg.
3. Gently bend his knee.
4. While keeping his hip bent, slowly straighten his leg. This stretches the back of his knee.

For the Ankle Dorsiflexion and Plantarflexion



1. Put one hand on your baby's knee to keep it straight.
2. Put the other hand around the bottom of your baby's foot.
3. Gently pull his foot up to stretch his calf.
4. Put one hand above your baby's knee to hold his upper leg still.
5. Put the other hand around the top of his foot.
6. Gently push down to stretch the front of his ankle.

Riley Hospital for Children at IU Health's e-Advisor Edits on Educational Material (cont.)

For the Toes Flexion and Extension



1. Keep your baby's foot and ankle straight.
2. Gently curl his toes with your fingers.
3. Slowly bend his toes the other way.

For the Trunk Flexion and Rotation



1. Cradle your baby in your arms.
2. Slowly bring his knees toward his chest. This stretches his spine.
3. With him sitting in your lap, hold his legs still.
4. Gently twist his upper body to each side.

Riley Hospital for Children at IU Health's e-Advisor Edits on Educational Material (cont.)

Sidebending



1. While holding your baby in your lap, hold his legs still.
2. Gently have him lean to one side. This stretches the sides of his torso.



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