PATIENT- AND FAMILY-CENTERED CARE
A Key Element in Improving Quality, Safety, Perception of Care, and Care Outcomes

2013
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**Introduction**

As hospital and health system leaders, you know that when patients are involved in their health care, the quality of that care improves, with better outcomes and increased patient cooperation. HAP is pleased to offer this guidebook to help you partner with your patients to achieve improved care outcomes and greater patient satisfaction.

This guidebook is an outgrowth of a long-time concern about the U.S. health care system: that it needs to provide more consistent, high-quality care in a way that is organized around the needs of the patient.

Developed in collaboration with HAP's Pennsylvania Hospital Engagement Network and with resources/best practices from the Institute for Patient- and Family-Centered Care, The Joint Commission, the Centers for Medicare & Medicaid Services, the American Hospital Association's Health Research and Education Trust, and several HAP member hospitals, this guidebook provides you with Pennsylvania-specific guidance to help your team implement patient and family engagement initiatives. It provides assessment tools to measure the quality of the patient experience, and it explains how to use assessment results to develop patient and family advisory groups and other patient-centered care strategies.

I encourage you to share this guidebook with key members of your management team, particularly your hospital or health system’s clinical leaders, to assure the broadest possible reach within your facility.

Our goal, ultimately, is for hospitals to be seen more than ever as comprehensive sources of care that keep people healthy, guide them through care when it’s needed, and stick with them from beginning to end. Instead of finding themselves adrift as they seek care from multiple providers, patients will be guided through, and participate in, their care to assure that it’s coming together in the right way to deliver the right result: better health and greater satisfaction.

HAP will update this guidebook periodically, so please share your case studies with HAP’s Mary Marshall or Janette Bisbee for inclusion in future editions.

Thank you for playing such a key role in providing healing, health, and hope to every patient you serve in your community.

Andy Carter
President & CEO, The Hospital & Healthsystem Association of Pennsylvania
Acknowledgements

The Hospital & Healthsystem Association of Pennsylvania (HAP) would like to thank the following organizations:

- Institute for Patient- and Family-Centered Care for allowing us to include their resource tools in our guidebook.

- HAP member hospitals and health care organizations for generously sharing their promising practices for implementing patient- and family-center care practices and strategies to improve their patients’ perception of care initiatives at their facilities:
  - Cole Memorial
  - PinnacleHealth System
  - WellSpan Health
  - Clearfield Hospital
  - Chester County Hospital
  - Mercy Philadelphia Hospital
  - St. Luke’s University Hospital–Bethlehem
  - St. Joseph Medical Center
Why Patient- and Family-Centered Care?

A long-time concern regarding the United States health care delivery system is that it fails to provide consistent, high-quality care in a manner that is organized around the needs of the patient. All too frequently, patients and their families find themselves thrust into an environment of mysterious and perplexing medical care that makes them feel disempowered, ignored, helpless, and confused. Unfamiliar terminology; lack of personal choice; little consideration given to cultural, language, or spiritual preferences; and schedules convenient to providers rather than consumers cause patients to feel that their medical care is something done to them, as opposed to with them.

Research has demonstrated that a satisfying patient experience leads to better outcomes, greater compliance with treatment, fewer unhealthy behaviors, and fewer visits to the emergency room. When patients perceive respect for their autonomy and are actively engaged as partners with the health care team, they report better physical and emotional health. Family members who are involved in their loved one’s plan of care become advocates and provide a support system that acknowledges the pivotal role caregivers play in the patient’s comfort, safety, and security. Health care professionals who are empowered to personalize the patient experience report greater workplace satisfaction, improved staff relationships, and a more cohesive working environment.

Hospital leaders who seek to engage patients and families in activities that integrate patient-and family-centered care into the fabric of the organization create unique opportunities for improving care delivery, patient outcomes, transparency, patients’ perceptions of care, and relationships with their communities. When hospital leaders, health care providers, and patients and families work in partnership, outcomes are improved, patients and families report greater satisfaction with the health care experience, and health care costs are contained via fewer readmissions, reduction of litigation, and improved performance in regulatory and compliance surveys. Primarily, patient and family engagement is about human interactions that honor the individual and provide compassionate and personalized care.

- The Joint Commission (TJC) supports the provision of care and treatment that is sensitive to the individual needs and preferences of patients via their hospital accreditation requirements. In addition to requiring hospitals to provide a safe and functional environment, TJC evaluates whether hospitals have processes in place to ensure timely and appropriate communication of medical information to patients and families (LD 03.04.01), promote patient rights (RI.01.01.01), and respect the rights of the patient to participate in decisions regarding care (RI.01.01.01).
The Centers for Medicare & Medicaid Services (CMS) developed the first national, standardized, publicly reported survey of patients’ perceptions of hospital care. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a survey that measures and publicly reports the hospital experience from the viewpoint of the patient. The Hospital Compare website summarizes how well nurses and doctors communicate with patients; how responsive hospital staff are to patients’ needs; how well staff help patients manage pain; how well staff communicates with patients about medicines; and whether the patient believes he/she has been adequately prepared to manage their health upon discharge. Two additional items address hospital environment—cleanliness and quietness of patients’ rooms—while two overarching questions report patients’ overall rating of the hospital and whether they would recommend the hospital to family and friends. Most recently, CMS included questions that ask patients how well they believe their personal preferences were take into account in planning for health care following discharge, how well they understood their medications, and whether they felt adequately prepared to manage their illness/health following hospital discharge. Finally, CMS has linked the HCAHPS scores to the Hospital Value-Based Purchasing (Hospital VBP) program. A significant portion of a hospital’s total VBP performance score depends on the hospital’s HCAHPS scores.

Title VI of the federal Civil Rights Act of 1964 protects persons from discrimination based on their race, color, or national origin in programs and activities that receive federal financial assistance. The Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS) ensures that entities that receive federal financial assistance comply with the act as well as other civil rights laws. The OCR has increasingly focused on ensuring that patients with limited English proficiency and other disabilities are provided with interpreter, translator, or other services that permit them to be full participants in their care.

Many factors contribute to racial, ethnic, and socioeconomic health disparities, including inadequate access to care, poor quality of care, community features (such as poverty and violence), and personal behaviors. These factors often are associated with underserved racial and ethnic minority groups, individuals who have experienced economic obstacles or have disabilities, and individuals living within medically underserved communities. Consequently, individuals living in both urban and rural areas may experience health disparities. Despite ongoing efforts to reduce health disparities in the United States, racial and ethnic disparities in both health and health care persist. Even when income, health insurance, and access to care are accounted for, disparities remain. Low performance on a range of health indicators—such as infant mortality, life expectancy, prevalence of chronic disease, and insurance coverage—reveal differences between racial and ethnic minority populations and their white counterparts. Patient- and family-centered care can assist hospitals and health systems in addressing health disparities in the patient populations they serve.
While there are many ways to implement patient- and family-centered care in the hospital setting, the defining characteristics include adherence to the concepts of personalized care, full collaboration and partnership between all members of the health care team, including the patient and family, and a commitment to patient safety and the highest possible quality of health care delivery. Patient- and family-centered care is care organized around the patient and is a model in which health care professionals partner with patients and families to identify and satisfy the full range of patient needs and preferences. It redefines the relationships in health care. Bringing these concepts to life requires a shift, not merely in operations, but fundamentally in organizational culture. Sustaining a patient- and family-centered culture demands dedication, flexibility, and implementation among all individuals at all levels of the organization. Hospitals making the commitment to patient- and family-centered care recognize that the goal is not to reach the destination, but to steadfastly continue to approach it.

Patient- and family-centered care applies to patients of all ages. It can be practiced in any health care setting, department, clinical area, or service line. The basic tenets of patient- and family-centered care include implementing and sustaining a patient- and family-centered culture, leadership commitment, educating the workforce regarding patient and family engagement principles, nurturing partnerships and relationships, creating patient and family advisory councils in health care settings to guide the development of policies and practices, and utilizing specific strategies to not only develop, but sustain, a culture of patient, family, provider and community involvement. This guidebook is dedicated to assisting readers in the implementation of these principles.

A change of such magnitude is not quickly or easily accomplished. The current health care system must be redesigned with the ultimate goal of integrating the patient and family perspective into all aspects of organizational operations. A partnership of all stakeholders with a shared commitment to working together with an end goal of ensuring that sustained, meaningful and complete transformation is achieved in order to accomplish the fundamentals of patient- and family-centered care is necessary. The mere existence of a shared vision can transform health care quality. Acting on the vision can revolutionize it.
**Patient- and Family-Centered Care**

**Patient- and Family-Centered Care Fundamentals: Distinguishing Between Patient- and Family-Centered Care, Patient-Focused Care, and Relationship-Based Care**

By truly partnering with patients and the loved ones who know them best, health care professionals gain the benefit of their assistance and insights in order to better plan and implement care. In this way, patients achieve improved health care outcomes, and health care organizations improve the quality of patient care and staff satisfaction. Ultimately, the core of any healing environment is the connection that people feel with one another. It is this connection that is the catalyst for cultural transformation in an organization. When clinicians are encouraged to make authentic human connections with those in their care, patients and their families feel safe, heard, understood, and respected. And, health care professionals experience clinical encounters that support their own professional and personal aspirations. This partnership as described above is often interchangeably termed “patient-and family-centered care,” “patient-focused care,” and “relationship-based care.” While each term focuses on the interaction between patients, families, and health care professionals, the meaning of each emphasizes a slightly different focus on the continuum of patient care experiences.

At its heart, patient- and family-centered care is an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among patients, families, and health care professionals. Patient- and family-centered care recognizes the vital role that families play in ensuring the health and well-being of their loved ones. Patient-focused care, is similar to patient- and family-centered care in that the family is recognized as an important part of the health care team; however, attention is paid to personal patient preferences that can impact care (such as culture, traditions, values, and lifestyles). Relationship-based care is aimed at improving every relationship within an organization. The definition of caregiver is broad and includes not only physicians and nurses, but also employees who work in ancillary departments such as dietary, housekeeping, and maintenance. The delivery of relationship-based care requires a commitment by all members of the organization to develop and maintain healthy relationships with patients, families, and one another.

The following definitions further clarify these fundamental terms of patient and family engagement:

- **Patient- and Family-Centered Care**—Patient- and family-centered care is an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care professionals, patients, and families. It redefines the relationships in health care. Patient- and family-centered care recognizes the vital role that
families play in ensuring the health and well-being of infants, children, adolescents, and family members of all ages. Patient- and family-centered care is an approach to health care that shapes policies, facility design, and staff’s day-to-day interactions with patients and families. (Source: Institute for Patient- and Family-Centered Care)

- **Patient-Focused Care**—A definition of patient-focused care includes consideration of patients’ cultural traditions, personal preferences and values, family situations, and lifestyles. It makes the patient and their loved ones an integral part of the care team who collaborate with health care professionals in making clinical decisions...[and] ensures that transitions between providers, departments, and health care settings are respectful, coordinated, and efficient. When care is patient focused, unneeded and unwanted services can be reduced. (Source: Institute for Health Care Improvement)

- **Relationship-Based Care**—Relationship-based care is a culture transformation model that improves safety, quality, patient satisfaction, and staff satisfaction by improving every relationship within an organization. In a relationship-based care culture, clinicians get reconnected with the purpose and meaning of their work; teamwork is based on deep commitment rather than surface compliance; and patients and their families feel safe and cared for as clinicians allow themselves to make authentic human connections with the people in their care. (Source: Creative Healthcare Management)

In the end, patient- and family-centered care, patient-focused care, and relationship-based care all have the same aim: the transformation of a culture of health care in which the patient and family are perceived as full partners in decision making; a system of delivery in which health care providers listen to and honor the perspectives of patients, families and co-workers; an organization where a commitment is made to communicate information in a timely and complete manner; and the establishment of an environment where patients, families, and providers collaborate in the delivery of care.
A Focus on Organizational Assessment to Improve the Experience of Care and Clinical Outcomes

Patient- and Family-Centered Culture

Creating a patient- and family-centered culture as a core component of an organization’s health care delivery system provides a strong foundation that can ultimately lead to successful outcomes for patients.

Patient- and family-centered care is an approach to health care delivery that shapes policies and programs, enhances health care professional and consumer interaction, and provides a means to identify and satisfy the full range of patient needs and preferences. To succeed, a patient-centered approach also must address the family experience, as family involvement is key to the reduction of the patient’s anxiety, uncertainty or vulnerability; and families are often a critical source of information about and support of the patient.

Rather than a “quick fix” in order to meet regulatory standards and avoid financial penalties, patient and family engagement requires that a hospital make a long-term commitment to a change of culture with the goal of sustainability. Patient- and family-centered care requires a steadfast effort towards comprehensive culture change and the understanding that a change of this magnitude is gradual and not without setbacks and challenges. Barriers to patient and family engagement do exist, and they will vary according to the customs and culture of the organization. Securing buy-in and engagement from staff, leadership, and boards may require persistence. Fully embracing a patient- and family-centered approach to care requires significant organizational commitment of resources on an ongoing basis. Policies and procedures that support patient- and family-centered care need to be developed, communicated to staff, and then continually reinforced until they become part of the fabric of the organization.

Hospitals may desire to make changes to the facility’s physical environment in order to make common areas more pleasingly aesthetic, provide privacy for patients (such as single rooms), and provide comfortable accommodations for families, but feel stymied by budget and space restraints. While patient- and family-centered care is not without its challenges, many hospitals have worked diligently to apply the principles in a manner that enhances patient safety and quality of care, significantly increases patient and family satisfaction, and strengthens employee working relationships.
The core competencies of patient-and-family centered care as developed by the Institute for Patient- and Family-Centered Care (IPFCC) are:

- **Respect and dignity**—Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care.

- **Information sharing**—Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision making.

- **Participation**—Patients and families are encouraged and supported in participating in care and decision making at the level they choose.

- **Collaboration**—Patients and families are included on an institution-wide basis. Health care leaders collaborate with patients and families in policy and program development, implementation, and evaluation; in health care facility design; and in professional education, as well as in the delivery of care.

Strategies to incorporate the voice of patients and families in the delivery of care include the implementation of patient/family satisfaction surveys; conducting daily patient rounds to engage the patients in dialogue regarding their hospital stay; and involving patients and families in hospital committees and focus groups, including ethics, safety, facility design, and even assisting in the interview and selection process of potential employees. Including patients in the interview and selection process of potential employees provides valuable insight into the type of health care professional the patient is looking for. It also conveys the message to all potential employees that the culture of the health care organization is one that promotes patient-and family-centered care.
Moving Forward with Patient- and Family-Centered Care: One Step at a Time

Establishing patient- and family-centered care requires a long-term commitment. It entails transforming the organizational culture. This approach to care is a journey, not a destination—one that requires continual exploration and evaluation of new ways to collaborate with patients and family.

Steps to set a hospital or health system on its journey toward patient- and family-centered care:

1. Implement a process for all senior leaders to learn about patient- and family-centered care. Include patients, families, and staff from all disciplines.

2. Appoint a patient- and family-centered care steering committee comprised of patients and families, along with formal and informal leaders of the organization.

3. Assess the extent to which the concepts and principles of patient-and family-centered care are currently implemented within your hospital or health system.

4. On the basis of the assessment, set priorities and develop an action plan for establishing patient- and family-centered care at your organization.

5. Using the action plan as a guide, begin to incorporate patient- and family-centered care concepts and strategies into the hospital's strategic priorities. Make sure that these concepts are integrated into your organization's mission, philosophy of care, and definition of quality.

6. Invite patients and families to serve as advisors in a variety of ways. Appoint some of these individuals to key committees and task forces.

7. Provide education and support to patients, families, and staff on patient-and family-centered care and on how to collaborate effectively in quality improvement and health care redesign. For example, provide opportunities for administrators and clinical staff to hear patients and family members share stories of their health care experiences during orientation and continuing education programs.

8. Monitor changes made, evaluate processes, measure the impact, continue to advance practice, and celebrate and recognize success.

1 Excerpt from Advancing the Practice of Patient- and Family-Centered Care in Hospitals: How to Get Started…, Institute for Patient- and Family-Centered Care
Any organizational change requires an assessment to uncover what is currently in place and to help prioritize areas for change and improvement. The next few pages provide questions that can serve as a springboard for such an assessment. Ideally, the assessment should be completed individually by hospital executives, managers, frontline staff, and patient and family advisors. Representatives of each of these groups should then convene to discuss the responses, and together craft an action plan. Organizations may elect to assess their adherence to patient- and family-centered care principles at the organization level or start with select departments, clinical areas, or services lines. There are a number of different tools that hospitals and health systems can use to inventory how well they have incorporated patient- and family-centered care into practice.

Earlier this year, the Pennsylvania Hospital Engagement Network conducted discussions with a considerable number of participating hospitals. The conversations focused on efforts to prevent patient harm, senior leadership engagement and commitment to patient safety, and patient and family engagement. Hospitals that participated in these calls were asked whether or not they met the following characteristics associated with patient and family engagement:

- Prior to admission, hospital staff provides and discusses a planning checklist with every patient that has a scheduled admission to allow for questions or comments from patients and families.

- The hospital conducts shift change huddles and does bedside reporting with patients and families in all feasible cases.

- The hospital has a dedicated person or functional area that is proactively responsible for patient and family engagement and systematically evaluates patient and family engagement activities.

- The hospital has an active patient and family engagement committee or at least one patient that serves on a hospital patient safety or quality improvement committee or team.

- The hospital has at least one or more patients who serve on a governing or leadership board and serves in the capacity of a patient representative.

The results of these conversations with the Pennsylvania hospitals that participated in these calls appear on the next page.
### Patient and Family Engagement Scores

**Pennsylvania Hospitals**  
**Spring 2013**

<table>
<thead>
<tr>
<th>Yes Responses</th>
<th>No Responses</th>
<th>Unknown</th>
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<tbody>
<tr>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td>Prior to admission, hospital staff provides and discusses a planning checklist with every patient that has a scheduled admission to allow for questions or comments from patients and families.</td>
<td>73</td>
<td>62%</td>
</tr>
<tr>
<td>The hospital conducts shift change huddles and does bedside reporting with patients and families in all feasible cases.</td>
<td>65</td>
<td>55%</td>
</tr>
<tr>
<td>The hospital has a dedicated person or functional area that is proactively responsible for patient and family engagement and systematically evaluates patient and family engagement activities.</td>
<td>49</td>
<td>42%</td>
</tr>
<tr>
<td>The hospital has an active patient and family engagement committee or at least one patient that serves on a hospital patient safety or quality improvement committee or team.</td>
<td>116</td>
<td>98%</td>
</tr>
<tr>
<td>The hospital has at least one or more patients who serve on a governing or leadership board and serves in the capacity of a patient representative.</td>
<td>79</td>
<td>67%</td>
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**Average Hospital Score = 3.24 out of 5**

The results present a snapshot of the opportunities that exist to enhance patient and family engagement in Pennsylvania hospitals. As a result of Act 13 of 2002 and Act 52 of 2007, Pennsylvania hospitals are required to have a community representative(s) on its patient safety and infection prevention and control committees. Although nearly every hospitals responded affirmatively to having at least one patient who serves on a hospital patient safety or quality improvement committee because of statutory requirements, hospitals indicated a strong interest in making patient participation on these committees more meaningful for the patient and for the organization. Discussions with hospitals also revealed considerable opportunity for the establishment of patient and family advisory councils for the majority of Pennsylvania hospitals and health systems. Other areas identified as opportunities for improvement include broadening the implementation of patient involvement in bedside reporting and team rounding, and appointing persons or functional areas to proactively implement patient- and family-centered care and actively monitor the impact of patient and family engagement on the organization.
Resources for Consideration:

- **Strategies for Leadership, Patient- and Family-Centered Care: A Hospital Self-Assessment Inventory**—The Institute for Patient- and Family-Centered Care and the American Hospital Association developed this assessment inventory. Individuals are asked to indicate how well the hospital, department, clinical area or service line is applying the concept of patient- and family-centered care for each item. Individuals also are asked to evaluate the perceived priority for change and improvement for each key indicator in the inventory. Individuals then are encouraged to share their assessments and collectively develop an action plan to address the priorities identified. The plan should include short- and long-term goals.

- **Patient-Centered Care Improvement Guide**—Developed by Planetree, Inc. and the Picker Institute, this website has an extensive array of resources for use by health care organizations seeking to ensure the provision of patient- and family-centered care, including an organizational assessment that could be used by organizations to assess their current patient- and-family-centered state.
Leadership’s Role

Any significant organizational change demands commitment, involvement, and engagement from all key stakeholders, including nurses, physicians, and hospital and health system leadership. Creating a culture of collaboration and respect where everyone is valued, acknowledged, and engaged is an essential element of patient-and family-centered care.

Individuals who serve in leadership roles set the tone for the engagement of patients and families in the delivery of their health care. Actions speak louder than words and a hospital’s leadership team needs to lead by example. Leaders need to demonstrate that the patient’s experience is aligned and integrated with the hospital’s organizational priorities, including quality and safety. Leaders also need to clearly communicate a vision and plan of action for integrating patient- and family-centered care into the daily operations of the hospital.

The table on the next page depicts the essential roles and key action steps for leaders in moving toward an organization that fully embraces and demonstrates its commitment to patient- and family-centered care.
<table>
<thead>
<tr>
<th>ESSENTIAL ROLES</th>
<th>KEY ACTION STEPS</th>
</tr>
</thead>
</table>
| Leaders make an explicit commitment to patient- and family-centered care or resident-centered care and serve as role models for engaging in partnerships individuals and families. | • Build leadership commitment to partnerships.  
• Serve as role models—walk the talk. |
| Leaders provide resources and support for partnerships with the individuals and families they serve. | • Assess the current status of patient- and family-centered care or resident-centered care.  
• Establish an infrastructure to support partnerships.  
• Remove institutional and attitudinal barriers to patient- and family-centered care and resident-centered care.  
• Create opportunities for administrators, physicians, staff, patients, residents, and families to learn how to partner. |
| Leaders welcome partnerships as a pathway to improve health care quality and safety. | • Partner with advisors to develop strategies and tools to prepare patients, residents, and families to become active in ensuring the quality and safety of care.  
• Involve patient, resident, and family advisors in strengthening the capacity of an organization to ensure quality and safety. |
| Leaders oversee and encourage partnerships with patients, residents, and families in strategic initiatives. | • Partner with patients, residents, and families to change and improve care practices.  
• Partner with patients, residents, and families to enhance planning for changes to the built environment.  
• Partner with patients, residents, and families to expand the use and usefulness of information technology.  
• Partner with patients, residents, and families to improve the education of health care professionals. |
| Leaders put systems in place to measure the outcomes of collaborative processes. | • Measure the effect of patient- and family-centered care and resident-centered care on key outcomes.  
• Document the efforts and impact of patient, resident, and family advisors.  
• Share outcomes with leaders, clinicians, staff, patients, residents, families, and community members. |
| Leaders recognize that profound organizational change takes time. | • Affirm the commitment to patient- and family-centered care or resident-centered care.  
• Celebrate the successes. |
Building the Infrastructure to Support and Sustain Effective Partnerships

- Identify an executive sponsor(s) for patient- and family-centered care or resident-centered care.
- Designate a staff liaison for collaborative endeavors to facilitate the process for development of sustained partnerships with patients, residents, and families to support their involvement throughout the organization.
- Conduct an organizational assessment of patient- and family-centered care or resident-centered care and existing opportunities to partner with patients, residents, and families.
- Develop a recruitment strategy, application process, and selection criteria for potential advisors.
- Develop a variety of opportunities for patients, residents, and families to participate as advisors.
- Orient and provide support for advisors for their specific roles.
- Involve the volunteer department or other human resources-related departments to assist with recruitment, screening, selection, orientation, training, recognition, and maintenance of a database documenting advisors' contact information, skills, interests, experiences, and involvement within the organization.
- Provide training and support for administrative leaders, clinicians, and staff on how to facilitate meetings and collaborate on teams so that partnerships with advisors in policy and program development, quality and safety initiatives, educational endeavors, and evaluation and research are meaningful and effective.
- Invest in the development of patient, resident, and family leaders—individuals who can facilitate or lead councils and other collaborative initiatives as volunteers as well as those who can serve in paid positions to oversee and coordinate collaborative initiatives.
- Ensure that there is a means to monitor, measure, and track the involvement of advisors and the impact they are having on the organization.

Resources for Consideration:

- Strategies for Leadership, Patient- and Family-Centered Care: A Hospital Self-Assessment Inventory—The Institute for Patient- and Family-Centered Care and the American Hospital Association developed the toolkit that provides an introduction to the concepts of patient- and family-centered care. This material would serve as an excellent introduction to patient- and family-centered care for a wide array of audiences.

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2 Excerpt from Partnering with Patients, Residents, and Families: Guidance for Leaders of Hospitals, Ambulatory Clinics, and Long-Term Care Communities, Institute for Patient- and Family-Centered Care
- **Guidelines for Using Patient Stories with Boards of Directors**, Delnor-Community Hospital. A one page resource tool to help share a patient story with a hospital or health system board.
Engaging the Workforce

Health care organizations need to have a clear vision and strategic plan in order to be successful in the implementation of patient- and family-centered care. The mission to engage patients and families in care delivery needs to be embraced throughout the entire organization. Aspects of the strategic plan will need to be implemented by persons in every role in every department.

In order to deliver patient- and family-centered care in an effective manner throughout the organization, the health care workforce needs to understand what patient- and family-centered care means and what behaviors are required to support the delivery of patient- and family-centered care. Patient- and family-centered care is not limited to focusing on patients and families. Attention also must be paid to the health care professionals providing patient care. All employees are considered caregivers in a patient- and family-centered care environment as each employee participates in the outcome of a patient’s hospital stay. The recognition of everyone as a caregiver is an important part of staff engagement. Considering every employee as a caregiver broadens the role of every employee and it represents a significant culture shift for the organization. Creating opportunities for staff participation in developing and implementing patient- and family-centered care within the organization will encourage and promote staff ownership of this cultural change.

Some health care organizations institute a shared governance structure where they convene a committee comprised of both management and non-supervisory staff to promote and encourage participation in the organization’s patient and family engagement initiative. The provision of a retreat to introduce and reinforce the organization’s commitment to patient- and family-centered care is another way to achieve staff engagement.

Educating staff about the patient and family experience, promoting relationship-building throughout the health care organization, and empowering staff in making decisions about patient care and the delivery of that care throughout the organization will promote staff accountability and staff involvement in the organization’s patient and family engagement initiative.

The human resource functions associated with staff recruitment, selection of employees and medical staff, position descriptions, the performance appraisal process, orientation, staff development, and employee support policies and programs are integral to the successful implementation of patient- and family-centered care.
A Pennsylvania Promising Practice

Instilling a Culture of Customer Service

Cole Memorial

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(814) 274-5204

Project Description—

Cole Memorial, as part of its strategic plan and branding, has a foundational focus of earning the trust of their community by having strong customer service training for their employees.

Key Strategies—

By using the hospital's Press Ganey survey results to guide their focus, Cole Memorial conducts ongoing workforce training as a means to deliver a consistent customer-centric experience across their organization. The hospital's managers are provided training on behavioral based interviewing techniques to ensure they hire the right employees. New employee orientation includes two hours of customer service training.

Cole Memorial’s strategic plan includes a goal of conducting face to face customer service training for 85 percent of their organization. Employees receive two hour training in communication skills using Studer’s AIDET model (acknowledge, introduce, duration, explanation, thank you) as well as training on dealing with difficult customers.

The strategic plan for 2013 included a goal of implementing a robust service recovery program that included the creation of a Point of Service Team and the development of a Point of Service...
Tool Kit that empowers employees to deal with service breakdowns in the moment to maintain customer centricity.

A team of employees that represent key departments across the organization met for approximately 8 weeks and developed a service recovery training program and tool kit. The tool kit, a tackle box, contains a service recovery form to be completed with each event, an algorithm to assist employees in determining the level of compensation if needed, and various gift cards.

The team developed the acronym ACT (acknowledge and apologize; compassion and countermeasures; take action and thank) for their service recovery model of training. Housewide employee training is being conducted, with emphasis on the importance of the blameless apology, compassion, and thanking the customer in the service recovery. The team built a required yearly education on service recovery into the hospital’s net learning module. The program will also be included with new employee education. To hardwire the hospital’s program, the service recovery team will meet monthly, with a goal of tracking utilization of the kits, service breakdowns, and need for further education to support the program’s success.

Outcomes:

Cole Memorial’s Service Recovery program is currently in the educational phase. The hospital’s program goals and anticipated outcomes include:

1. All staff will complete service recovery training across the organization.
2. New employee orientation will include service recovery training.
3. Service recovery training will be a required module in net learning each year for all employees.
4. The service recovery team will meet monthly and will support staff in an ongoing learning environment, identify trends, and work with leaders to improve service breakdowns.
5. Recognition of service recovery champions will be included in the program with monthly drawings being held for any employee performing service recovery.
6. Service recovery trends will be included in reports to the Board of Directors with the hospital’s current report on patient satisfaction and grievances.
7. Press Ganey satisfaction scores will improve, especially in the areas of communication and response to questions and concerns.
**COLE Memorial**  
**Service Recovery Tracking Form**

The care and treatment of all patients through compassionate service is the top priority for Cole Memorial. In cases where there is a complaint, Cole Memorial empowers all staff to perform Service Recovery and track these occurrences through the use of this hospital approved tracking form. The format of this document is simple but enables accurate truthful recording of information.

<table>
<thead>
<tr>
<th>Name of the patient:</th>
<th>________________________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department / Area of occurrence:</td>
<td>________________________________________________________</td>
</tr>
<tr>
<td>Manager Responsible for involved area:</td>
<td>________________________________________________________</td>
</tr>
<tr>
<td>Describe the service breakdown:</td>
<td>________________________________________________________</td>
</tr>
<tr>
<td></td>
<td>________________________________________________________</td>
</tr>
<tr>
<td>Date &amp; Time of service breakdown:</td>
<td>___________ @ ______ Hrs</td>
</tr>
<tr>
<td>Names of those involved:</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>__________________________</td>
<td>__________________________</td>
</tr>
<tr>
<td>__________________________</td>
<td>__________________________</td>
</tr>
<tr>
<td>__________________________</td>
<td>__________________________</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Was Service Recovery performed?</td>
<td>Y / N</td>
</tr>
<tr>
<td>Type of compensation given:</td>
<td>Location of Tool Kit:</td>
</tr>
<tr>
<td>Would the customer be willing to share his/her phone number &amp; address for future contact?</td>
<td>Y / N</td>
</tr>
<tr>
<td>Please inner-office or deliver the completed form within 12 hrs to the drop box located outside of the Patient &amp; Community Relations office or fax to 260-5309. Thank you for your service recovery!</td>
<td></td>
</tr>
</tbody>
</table>
## Cole Memorial Service Recovery Algorithm

Using the legend below as a guide, please base the type of compensation that you are dispensing to our Cole Customer through cross checking against some potential complaint scenarios. In the above table, an emphasis on **Acting** first prior to compensation will be our beacon for all Cole team members performing Service Recovery.

### MEALS

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/10</td>
<td>Late/missed/Cold/Quality</td>
</tr>
<tr>
<td>3/10</td>
<td>Incorrect</td>
</tr>
<tr>
<td>3/10</td>
<td>Other</td>
</tr>
</tbody>
</table>

### TRANSPORT

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Rough/Bumped/dumped</td>
</tr>
<tr>
<td>3</td>
<td>Other</td>
</tr>
</tbody>
</table>

### TIME

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3</td>
<td>Wait to get into ER/Exp Care</td>
</tr>
<tr>
<td>1-3</td>
<td>Wait for room/cir. Admit</td>
</tr>
<tr>
<td>1-3</td>
<td>Wait for procedure</td>
</tr>
<tr>
<td>1-3</td>
<td>Trauma Displaced</td>
</tr>
<tr>
<td>1-3</td>
<td>Equip. Delay</td>
</tr>
<tr>
<td>1-3</td>
<td>Discharge Delay</td>
</tr>
</tbody>
</table>

### R.N./CNA/RT/OT/TECH/OFFICE

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3</td>
<td>Long response time</td>
</tr>
<tr>
<td>10</td>
<td>Rude</td>
</tr>
<tr>
<td>10</td>
<td>Long wait for meds</td>
</tr>
<tr>
<td>10</td>
<td>Didn't communicate</td>
</tr>
<tr>
<td>10</td>
<td>Didn't listen/concerns &amp; comp.</td>
</tr>
<tr>
<td>10</td>
<td>Rough/injury</td>
</tr>
<tr>
<td>6</td>
<td>Discharge problem</td>
</tr>
<tr>
<td>10</td>
<td>IV stick (multiple)</td>
</tr>
<tr>
<td>3</td>
<td>Staff reward</td>
</tr>
<tr>
<td>3</td>
<td>Other</td>
</tr>
</tbody>
</table>

### PHYSICIANS

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Didn't visit</td>
</tr>
<tr>
<td>10</td>
<td>Rushed</td>
</tr>
<tr>
<td>10</td>
<td>Didn't communicate</td>
</tr>
<tr>
<td>10</td>
<td>Unable to reach for meds</td>
</tr>
<tr>
<td>10</td>
<td>Rough</td>
</tr>
<tr>
<td>10</td>
<td>Discourteous to pt.</td>
</tr>
<tr>
<td>10</td>
<td>Discourteous to pt. family</td>
</tr>
<tr>
<td>9/6</td>
<td>Did not schedule/cancelled test</td>
</tr>
<tr>
<td>5</td>
<td>Discharge problems - Delay/Other</td>
</tr>
<tr>
<td>1-8</td>
<td>Other</td>
</tr>
</tbody>
</table>

### MISCELLANEOUS - COLE/PT FACTORS

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-6</td>
<td>Family need</td>
</tr>
<tr>
<td>1-10</td>
<td>Fear of hospital/procedure</td>
</tr>
<tr>
<td>1-10</td>
<td>HIV test due to stick</td>
</tr>
<tr>
<td>1-3</td>
<td>General frustration</td>
</tr>
<tr>
<td>6</td>
<td>Lost belongings</td>
</tr>
<tr>
<td>1-10</td>
<td>No Cole Interpreter</td>
</tr>
<tr>
<td>1-10</td>
<td>Need &quot;comfort&quot;</td>
</tr>
<tr>
<td>10</td>
<td>Held NPO and not changed</td>
</tr>
<tr>
<td>10</td>
<td>Adjacent code 99</td>
</tr>
<tr>
<td>1-10</td>
<td>Other</td>
</tr>
<tr>
<td>1A-1AA</td>
<td>Patient request for Mgr/Administrator dialogue</td>
</tr>
</tbody>
</table>

### Item # | Legend
---|---
1 | Coffee Card
2 | Dessert Card
3 | Meal Card
5 | Subway Card
6 | Wal-Mart Card
7 | Wal-Mart Baby Card
8 | Wellness Pass
9 | Sheets Fuel Card
10 | Gourmet Meal
1A | Manager
1AA | Senior Leader

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**Patient- and Family-Centered Care: A Key Element in Improving Quality, Safety, Perception of Care, and Care Outcomes**

22
Moving to Action: Patient and Family Engagement Strategies

The American Hospital Association developed a framework for categorizing various health care user engagement strategies in Engaging Health Care Users: A Framework for Healthy Individuals and Communities. This framework identifies strategies that can be used by the individual, health care team, organization, and community to engage users of health care services in information sharing, shared decision-making, self-management, and partnerships. The following graphic and table depict the framework and specific strategies. Hospitals and health systems are encouraged to consider the use of this framework in organizing their respective action plans to achieve patient- and family-centered care.

Framework for Engaging Health Care Users

Source: American Hospital Association (January 2013), Engaging Health Care Users: A Framework for Healthy Individuals and Communities
### Examples of Health Care User Engagement Strategies

<table>
<thead>
<tr>
<th>Health Care System</th>
<th>Examples of Engagement Strategies</th>
</tr>
</thead>
</table>
| **Community**      | • Providing health education and health literacy classes  
                      • Providing healthy cooking and physical education classes  
                      • Using patient navigators and peers to provide support  
                      • Making local policy changes that promote healthier lifestyles (e.g., eliminating sugary drinks from school cafeterias)  |
| **Organization**   | • Using volunteers or patient advocates to support care  
                      • Involving patients and families in patient and family advisory councils, governance and other committees  
                      • Removing restrictions on visiting policies for families  
                      • Opening access to medical records  
                      • Using email and social media technology (e.g., Facebook, Twitter)  |
| **Health Care Team** | • Using bedside change-of-shift reports  
                           • Involving patients and families in multidisciplinary rounds  
                           • Using patient- and family-activated rapid response  
                           • Providing shared decision-making tools  
                           • Using clinic-based multidisciplinary care teams  |
| **Individual**     | • Seeking health information and knowledge  
                      • Adhering to treatment plans and medication regimens  
                      • Participating in shared decision making  
                      • Using online personal health records  
                      • Engaging in wellness activities  |

Source: American Hospital Association (January 2013), Engaging Health Care Users: A Framework for Healthy Individuals and Communities
Engaging Patients and Families

Guiding principles of patient and family engagement include fostering inclusion of patient and family members as active members of the health care team and encouraging collaboration between patients, families, and health care professionals. This may be achieved in a variety of ways in the hospital setting. Prior to establishing patient- and family-centered care initiatives, many hospitals first go to the source to determine which initiatives would prove most valuable to health care consumers in their community. Patient focus groups and surveys provide a means to determine the gaps in care and identify opportunities for improvement. Patients and families are often invited to join hospital care initiatives such as quality improvement committees, safety task forces, and patient and family satisfaction work groups. Patients and families also may be asked to participate in the interview process for new hospital employees and to provide input into hospital redesign and building projects.

Many hospitals have discovered that the implementation of a patient and family advisory councils are an effective way to assist the organization to improve the design and delivery of optimal care and services. While there are many ways in which patients and families might serve in this advisory capacity, the common theme running through this collaboration is to focus on a goal of sustained and meaningful partnerships in the health care setting. Advancing the conversation to include a shared vision for improving health care with the mutual desire to work together on quality improvement initiatives intended to redesign health care is the ultimate objective. Patient and family advisory councils are essential in helping organizations conduct the assessment and then in identifying and implementing various strategies to assist the organization to move toward the provision of patient- and family-centered care.

Resources for Consideration:

- **Partnering with Patients and Families to Enhance Safety and Quality: A Mini Toolkit**—From The Institute for Patient- and Family-Centered Care, this toolkit helps organizations in beginning their work on patient- and family-centered care. There are a number of tools that organizations can use or modify as needed to assist the organization to implement patient and family advisory councils.

- **Guide for Developing a Community-Based Patient Safety Advisory Council**—From the Agency for Healthcare Research and Quality, this resource presents a step-by-step approach to develop community-based advisory councils. It encourages a broader perspective on the definition of patient-centered care by addressing community collaboration.
Provider Strategies

Health care providers are encouraged to make changes in behavior and practices in order to allow patients to more easily participate in care delivery. Recommendations include:

- **Change of Shift Reporting:** Moving the change of shift report from the nurse’s station to the bedside is a practice which provides for transparency, as patients are able to hear exactly what their plan of care entails and are free to ask questions and add any pertinent information. Additionally, bedside shift report has been noted to decrease errors as nurses have the opportunity to discuss treatment interventions without interruption and with the ability to look at equipment such as IV’s, feeding tubes, and monitors together.

- **Communication Boards:** White boards hung in patient rooms are a means to effective communication as nurses and other health care providers use them to identify themselves as that day’s caregiver, post reminders regarding upcoming appointments and tests, and share the day’s goals which are established by the care team in collaboration with the patient and family. Patients and families also are encouraged to write on the write board to share pertinent information, indicate personal preferences, make requests, and as a means to post comments or ask questions.

- **Family Members:** The role of family however “family” is defined by the patient is essential in patient- and family-centered care, as these individuals are the people who know the patient best and are most able to support the patient through the hospitalization experience. In many instances, family members have a care giving role at home, and are therefore in a position to notice subtle changes in the patient which may signify a decline in condition. Family caregivers can provide vital information regarding medications, medical history, routines, and patient preferences. Additionally, family members may contribute to and augment care being given in the hospital, not instead of nursing care, but in addition to. In order to meet the psychological and emotional needs of the patient, many hospitals choose a policy of “open visitation” whereby any person defined by the patient to be significant to their well-being and whose presence would enhance their hospitalization is encouraged to stay with the patient at the bedside. Family members are made to feel welcome when accommodations are made for regular meals, comfortable seating in patient rooms, and sleeping arrangements which allow the family to remain close to their loved one yet provide privacy and a restful atmosphere in which to relax. Some hospitals provide amenities such as concierge services or valet parking.
• **Multidisciplinary Rounds**: Physician and medical provider rounds are a way to involve patients and families and provide an opportunity for the sharing of information, discussion of, and agreement on treatment options, as well as a chance to have questions answered. Rounds should be multidisciplinary and collaborative in spirit with two-way communication. Physicians can enhance this experience by demonstrating a “bedside manner” which is consistent with patient and family engagement principles and should be mindful of verbal and nonverbal behaviors such as making eye contact, using the patient and family members names, sitting rather than standing, and encouraging the patient and family to participate in the decision making process.

• **Medical Records**: The patient’s medical records are a wealth of information and a vital means of communication. Patient- and-family-centered care advocates recommend that patients have access to their medical records in an “open chart” policy which encourages patients to both read and write in their medical record. Patients may also permit family members or significant others to have access to their medical records. Inviting a patient to read his or her medical chart is a patient right, recognized by both federal and state law.
A Pennsylvania Promising Practice

Developing Patient/Family Advisory Councils

PinnacleHealth System

Hospital Contacts—

Barbara Terry
Vice President, Mission Effectiveness and Chief Diversity & Inclusion Officer
(717) 231-8216

Stephanie Okum
Director, Regulatory and Customer Relations
(717) 782-5950

Project Description—

Developing the PinnacleHealth Patient-Family Advisory Council: PinnacleHealth’s patients and their families are eye-witnesses and recipients of the care the hospital provides. How the organization provides and delivers that care gives the patient and family a sense that they are in “capable and competent hands.” When patient care seems to lack coordination and integration, the hospital leaves the patient and family with a perception that they are not in “capable and competent hands.” As a result, the patient and family may lack confidence and trust in their caregivers and the hospital, as a whole.

Formal invitations to participate on the Patient-Family Advisory Committee were extended to a culturally and generationally diverse group of patients, family members, friends, and other interested community leaders who had both positive as well as negative experiences at PinnacleHealth.

“Patient-centered care” is defined as care that is delivered in a manner that works best for patients. In a patient-centered approach to health care, providers partner with patients and their family members to identify and satisfy the full range of patient needs and preferences (Planetree).
Patient-Family Advisory Committee Purpose: The PinnacleHealth Patient and Family Advisory Committee is designed as a forum to engage patients and families as partners in patient care and to secure continuous patient and family input and insights into the improvement of patient delivery services, the planning and navigation of care throughout the PinnacleHealth System and facilities.

Key Strategies—

The approach the organization has taken to exceed in management of the patient experience is multifaceted. The following key strategies have been implemented across the system to provide an exceptional patient experience and improve patient satisfaction as measured by HCAHPS scores. Each strategy works in tandem to create an environment that is focused on individualized patient care.

Patient-Family Secret Shopper Experiences: Gathered and prepared groups of former patients, patient family members/friends and community leaders from diverse backgrounds as related to age, ethnicity, limited English speaking to play the role of actual patients and to present themselves to various departments with a prescription for care and treatment or as a visitor to ambulatory and in-patient care sites. The secret shoppers received 90 minutes of preparation on what to expect and/or require as related to customer service, information exchange, system values and standards of behavior. Feedback received from secret shopper participants provide a basis for continued improvements in patient care and delivery processes.

PinnacleHealth Journey to Excellence: These strategies include the following:

- **Rounding Strategies**—Clinical leaders round on patients to identify and discuss patient care, address questions the patient and family may have, and to verify patient and family understanding of their care. Hourly rounding, completed by the front line caregivers, improves patient outcomes by checking on needs for the restroom, positioning, pain management, reinforcement of patient education, and other patient needs. Hourly rounding also helps the nurses and physicians anticipate patient needs and to be proactive in their care and treatment. As a result, patients and family members sense that they are partners in their care and are more willing to share their knowledge and expertise that is essential to their care. Further, hourly rounding enhances patient satisfaction, builds confidence and trust between the patient and care givers, and improves patient health literacy levels.
Patient- and Family-Centered Care: A Key Element in Improving Quality, Safety, Perception of Care, and Care Outcomes

- **Communication Boards**—The monthly Communication Boards are designed to showcase the hospital’s Customer Satisfaction and System Goal results. The Boards are located in prominent areas across the system and provide a visual understanding for every employee to know how the organization is performing as a system, campus, and department. The system goals represented are Service, Quality, Finance, Growth, Community, and People. The boards provide each department the opportunity to showcase organizational results and to reinforce how the departments and services contribute to measurable improvements in HCAHPS scores and positive organizational metrics.

- **Key Words at Key Times**—AIDET (Acknowledge, Introduce, Duration, Explain and Thank-you) is practiced by all employees. Consistent use of AIDET is proven to decrease patient anxiety. This initiative ensures staff are demonstrating a friendly and welcoming environment for all patients and visitors. This type of atmosphere helps to make patients at-ease and comfortable in a potentially stressful situation. This also helps each employee identify themselves as a resource.

- **Teach Back Program**—A lot of people, crossing all levels of ages, race, income and educational backgrounds just do not understand what they hear from a physician or nurse. The Teach Back program enhances the patient’s ability to read, understand, and act upon health-related information and instructions. The Teach Back Program improves the patient’s health literacy and builds capacity of physicians, nurses and others to effectively communicate with the patient so that the patient can make informed decisions and take appropriate actions to protect and promote their health.

This method is a “return demonstration by the patient” of information transferred through verbal instruction by the nurse or physician. It’s not simply asking “do you understand?” and expecting the patient does. It is a concerted effort to confirm the patient understands.
Effective communication among the care providers and the patient is a major indicator of patient satisfaction. In 2003, the National Assessment for Adult Literacy found that only 12 percent of adults surveyed had proficient health literacy skills. This report also affirmed that patients with low health literacy use substantially more hospital resources due in part to low self-management skills and poor self-advocacy.

- **“Patient-Family” Teach Back to Nursing Staff**—Using the lessons learned from the patient teach back program, members of the Patient-Family Advisory Committee agreed to provide stories and patient-family experiences of their care at PinnacleHealth in-patient and ambulatory services. The advisory members share their experiences and stories by video to provide actual and just-in-time learning for nurses and other care givers.

- **Physician “Patient Centered Care” Training Video**—The ability to read, understand, and act on health information—health literacy—is a growing concern in the medical community, particularly with more than 80 percent of adult Americans not understanding how to manage their own health care competently. In response, an internal physician training video was developed to enhance awareness and educate physicians and residents on improving communication with patients. The video includes customer service practices as well as methods to improve understanding of cultural, language, social and educational needs of patients. Medical residents participating in the training are taught to find common communication terms, avoid medical jargon and to communicate in “absolutely plain” language.

- **Expressing Our Promise**—This program reinforces that each time someone enters PinnacleHealth’s facilities, staff make a promise to provide the highest quality care with compassion and concern for each and every patient and their loved ones. Staff treat everyone as a guest in our house and make a verbal commitment to each patient on what they should expect from PinnacleHealth staff. PinnacleHealth’s Journey to Excellence, quality measures, the power of “being nice,” the organization’s desire to treat everyone like a guest in our home, and the organizations various recognitions and accolades comprise these shared promises. Patients and visitors are encouraged to call the hospital’s Promise Hotline if their expectations are not met. In addition, a physician promise is placed on the over-the-bed table to treat every patient and family with respect, courtesy and sensitivity; to listen to concerns with undivided attention, and discuss treatment plans in simple, understandable terms.
Outcomes—

In comparing 2012 with 2013 trends, a significant percentage improvement has resulted in HCAHPS scores across each of the following domains:

- Cleanliness of hospital environment
- Communication about meds
- Communication with doctors
- Communication with nurses
- Discharge information
- Overall hospital rating
- Pain management
- Quietness of hospital environment
- Responsiveness of hospital staff
- Would recommend hospital

Across the system, the interdisciplinary health care team has a greater understanding that the patient is an individual, has unique and diverse needs, and not merely a diagnosis or medical condition. As a result of the patient-family centered strategies PinnacleHealth has implemented, patients and families have higher levels of health literacy, more empowered to participate as partners in their care, and take greater responsibility for their care and follow-up.
A Pennsylvania Promising Practice

WellSpan Health

Hospital Contact—

Jamie Markel
Patient-Family Experience Officer
(717) 851-3239

Project Description—

Patient-Family Advisory Councils are developed around four chronic care conditions—Behavioral Health, Cardiology and Parkinson’s disease; and five services—Inpatient, Imaging, New Mothers, Surgical and Trauma services.

Patient Partners, invited by providers, meet monthly with primary care practice staff and providers focused on improvement of clinical core measures and care experience. There are 45 patients teamed with approximately 37 practices.

WellSpan Health has also engaged patients in panels to review their care experience with medical staff and other clinicians, in process improvement committees such as patient visitation, and in Root Cause Analyses.

Key Strategies—

The Behavioral Health Patient and Family Advisory Council (PFAC) is a partnership that embraces community members that complete an application process, health care practitioners, and administration within behavioral health. Patient and family members expressed the belief that there were inconsistent educational practices for Electro Convulsive Therapy (ECT) education based upon point of entry. Problems that were identified by the group included inefficiencies in patient flow. Behavioral Health services provides ECT to both inpatient and outpatient referrals.

The PFAC determined a plan of action which included review of present educational materials at each entry point. Sub teams were developed which partnered patient and family members from the community with providers and staff of various skill sets. The areas of focus included inpatient, outpatient, and family education. Another sub team was developed to focus on data collection.
Phone calls were made to patients that had received ECTs in the past six months to gather baseline data in all areas of entry. Patient and family members assisted in the development of the survey tool. The organization was fortunate to have a doctorate prepared research community volunteer on the PFAC. Survey data was compiled and analyzed.

The results of this initiative include a new brochure, updated fact sheet, standardized review of video education, and initiation of a Patient to Patient Volunteer position to provide peer support during the discussion and decision phases. Future plans include electronic access to education materials for patients, families, and community members.

One of the members, previously dealing with a family embarrassed by her need for ECT, spoke at a community education forum about her ECT experience and reflected on how her involvement as a Patient Advisor gave her strength to advocate for her treatment needs and opened up her family’s understanding and embrace of behavioral health care.

Outcomes—

Focus is on a variety of topics and has led to improvements including service performance, clinical care, environment and process. Some examples of projects are:

- Environment of care, including cleanliness and quiet
- Design of MyWellSpan Patient Portal
- Accreditation as National Breast Center of Excellence
- Prenatal Education Booklet
- New Facility Planning—Women’s Health Center, Specialty Hospital, Emergency Department
- Revised Billing Statement, resulting in improved collections of $931,100
- Design of ICU Waiting Rooms
- Communication/picture boards in Trauma Surgical ICU
- Design of Electroconvulsive Therapy Education
- Medication Reconciliation
- Provider communications

Benefits of partnering with patients and families include:

- Better understanding of the needs and priorities of patients
- Education of patients and families as to the operations of a health system
- Increased confidence in participating in the decisions around the patient’s care
- Increased awareness of how patients can advocate for themselves and family members in need of health care services
Measuring Patients’ Perception of Care

HCAHPS Fundamentals

What Is HCAHPS—

The Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS) is a national, standardized, publicly reported survey of patients’ perceptions of hospital care. The Centers for Medicare & Medicaid Services (CMS) developed the survey in partnership with the Agency for Healthcare Research and Quality (AHRQ). Both of these agencies are part of the U.S. Department of Health and Human Services. CMS views HCAHPS as a valuable resource in:

- Understand the patient’s experience while hospitalized;
- Identifying areas ripe for hospital quality improvement;
- Developing partnerships with patients and families to improve care delivery, quality, and safety; and
- Preventing harm and hospital readmissions.

History—

The April 2013 edition of Hospital Compare marks five full years of public reporting of hospital HCAHPS scores. When these results were first shared on Hospital Compare in March 2008, 2,520 hospitals voluntarily participated and their scores reflected the experience of 1.1 million patients. Five years later, 3,904 hospitals publicly report their HCAHPS scores, representing the experience of 3 million patients. Cumulatively, the 21 cycles of HCAHPS scores on Hospital Compare represent the experience of more than 14 million discharged patients.

Value-Based Purchasing Program—

The Affordable Care Act (ACA) mandates that CMS implement an inpatient hospital VBP program, which is a pay-for-performance program that links Medicare payment to the quality performance of acute care hospitals paid under IPPS. As required by the ACA, a pool of funds will be created by reducing Medicare IPPS payments for all participating hospitals—a 1.0 percent reduction for FFY 2013, increasing by 0.25 percent each year until the reduction reaches 2.0 percent for FFY 2017 and thereafter. The funds will be distributed to hospitals based on quality performance under the VBP program. As stated above, funding for the VBP program came from a 1.0 percent withhold of hospital DRG payments in the first year of the program. For Pennsylvania IPPS hospitals, nearly $38 million dollars in Medicare payments were at risk in the first year of the VBP program. Within five years, two percent (approximately $90 million) of Medicare fee-for-service inpatient payments to Pennsylvania general acute care hospitals will be at risk in the VBP program.
The highest performing hospitals receive an incentive payment greater than the withhold amount, while the lowest performing hospitals will receive less than the withhold amount. The FFY 2013 VBP incentives were based on hospital’s Total Performance Score that included twelve clinical process measures and eight HCAHPS measures. In the first year of the VBP program, the clinical process of care scores were weighted at 70 percent of the Total Performance Score, while the HCAHPS measures were weighted at 30 percent of the Total Performance Score.

The HCAHPS measure is comprised of the following eight HCAHPS measures: (1) Communication with Nurses; (2) Communication with Doctors; (3) Responsiveness of Hospital Staff; (4) Pain Management; (5) Communication about Medicines; (6) Cleanliness and Quietness of the Hospital Environment; (7) Discharge Information; and (8) the Overall Rating of the Hospital. Each HCAHPS measure is equally weighted in the overall HCAHPS measure score. Hospitals are expected to report a minimum of 100 HCAHPS surveys annually to ensure a statistically reliable HCAHPS score. Hospitals that discharge less than five HCAHPS eligible patients per month can opt out of the HCAHPS measure.

**HCAHPS Scoring Methodology**—

For each of the measures in the VBP program, CMS establishes national benchmarks and thresholds. The benchmarks represent the highest achievement levels on quality measures; the thresholds represent the minimum achievement levels. Hospitals’ performance on individual quality measures will be compared to these national performance standards to calculate VBP “achievement” and “improvement” scores.

- **National Achievement Benchmarks**—CMS will set the national benchmark for each process measure and each HCAHPS measure at the average performance score for the top 10 percent of all hospitals during the baseline period.

- **National Achievement Thresholds**—CMS will set the national threshold for each process measure and each HCAHPS measure at the median performance score (50th percentile) for all hospitals during the baseline period.

Per the ACA requirements, CMS will calculate two scores for each measure—an achievement score and an improvement score. Hospitals can earn up to ten achievement points and up to nine improvement points for each process and HCAHPS measure. A final score for each measure will be the higher of the two scores. These scores are calculated by comparing hospital quality performance to the national performance standards.
Achievement Points—Hospitals earn between 0-10 achievement points for each of the eight HCAHPS measures for total of 80 achievement points for all measures. Hospitals can earn achievement points if their HCAHPS scores for the performance period are at or above the national achievement threshold. Scores below the achievement threshold receive 0 points; scores at or above the achievement benchmark receive 10 points. If a hospital’s scores fall in between, the hospital will receive between 1-9 points depending on their score. CMS uses the following formula to calculate achievement points:

\[
[9 \times (\text{Hospital’s performance period score} - \text{Achievement threshold}) / (\text{Benchmark} - \text{Achievement threshold})] + .5, \text{ where the hospital performance period score falls in the range from the achievement threshold to the benchmark}
\]

Improvement Points—A hospital can earn between 0-9 improvement points for each of the HCAHPS measures for a possible total of 72 improvement points for all measures. Improvement points are used to score a hospital’s performance against itself over time. Improvement points are designed to measure a hospital’s actual improvement in the performance period, as a share of its potential for improvement, which is the distance from its baseline period score to the benchmark. If there is no improvement or if the score from the baseline period was already at the benchmark, the improvement score is 0 points. CMS uses the following formula to calculate improvement points:

\[
[10 \times (\text{Hospital performance period score} - \text{Hospital baseline period score}) / (\text{Benchmark} - \text{Hospital baseline period score})] - .5, \text{ where the hospital performance score falls in the range from the hospital’s baseline period score to the benchmark}
\]

Consistency Points—Hospital also earn up to 20 consistency points. Consistency points are based on the hospital’s lowest HCAHPS measure, with points reduced proportionately if that measure falls below the achievement threshold established during the baseline period. If no HCAHPS measures fall below the achievement threshold, 20 consistency points are awarded. If any of the hospital’s HCAHPS measures are at or below the floor established in the baseline period, 0 consistency points are awarded. The consistency score is determined using the following two-step formula:

1. Determine the HCAHPS dimension that has the lowest score using the following formula:
   \[\text{Index} = (\text{Hospital’s performance period score} – \text{floor}) / (\text{achievement threshold} - \text{floor})\]
2. Use the index score derived above, calculate the hospital’s consistency points using the following formula: \[20 \times (\text{Index}) – 0.5\]
Total HCAHPS Score—The calculation of the total HCAHPS or patient experience score domain follows these steps:

1. For each of the eight HCAHPS dimensions, determine the larger of the achievement score or the improvement score
2. Sum the resulting 8 values to arrive at the 0-80 HCAHPS base score
3. Calculate the 0-20 consistency score
4. Sum the base score with the consistency score total to arrive at the total HCAHPS points earned as part of the VBP program

HCAHPS Future in the VBP Program—CMS has indicated that it will continue to place a strong emphasis on patient experience of care and outcome measures in the future. CMS proposes to weight clinical process of care at 10 percent; patient experience of care at 25 percent; outcomes at 40 percent; and efficiency at 25 percent for the FFY 2016 hospital VBP program. In addition, CMS has proposed to adopt different domains for the FFY 2017 hospital VBP program. CMS proposes to rename the patient experience of care domain to patient and caregiver centered experience of care/care coordination and weight that domain at 25 percent of the hospital total performance score.
Patient- and Family-Centered Care: A Key Element in Improving Quality, Safety, Perception of Care, and Care Outcomes

Summary of Pennsylvania HCAHPS Survey Results

<table>
<thead>
<tr>
<th>Domain</th>
<th>National Score</th>
<th>State Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication with Nurses</td>
<td>78</td>
<td>78</td>
</tr>
<tr>
<td>Communication with Doctors</td>
<td>81</td>
<td>79</td>
</tr>
<tr>
<td>Responsiveness of Hospital Staff</td>
<td>67</td>
<td>68</td>
</tr>
<tr>
<td>Pain Management</td>
<td>71</td>
<td>70</td>
</tr>
<tr>
<td>Communication about Medicines</td>
<td>63</td>
<td>62</td>
</tr>
<tr>
<td>Cleanliness of Hospital</td>
<td>73</td>
<td>72</td>
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<tr>
<td>Quietness of Hospital</td>
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<td>54</td>
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<td>Discharge Information</td>
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<td>84</td>
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<tr>
<td>Overall Hospital Rating</td>
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<td>67</td>
</tr>
<tr>
<td>Recommend the Hospital</td>
<td>71</td>
<td>68</td>
</tr>
</tbody>
</table>

Source: Scores reflect national and Pennsylvania discharges occurring July 2011 through June 2012; Summary of HCAHPS Survey Results, July 2011 to June 2012 Discharges.

**A Pennsylvania Promising Practice**

**Creating a Culture of Always**

**Clearfield Hospital**

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**Project Description**—

**Opportunity for Improvement:** With Value Based Purchasing (VBP), hospital staff are challenged to do and say the right things always to every patient, every day, every shift. The patient’s perception of their care is now more than ever a reflection of the health care organization’s ability to provide consistent quality care. Persistently low Healthcare Consumer Assessment of Healthcare Providers and Services (HCAHPS) scores, numerous patient grievances, staff frustration over the lack of visible results, despite their efforts to improve customer satisfaction, were catalysts for this project initiative.

**Goal:** Hardwire “A Culture of Always” by adopting evidence-based tools designed to make Clearfield Hospital’s patients happier with the care they receive as reflected by an improvement in the hospital’s HCAHPS scores resulting in a score greater than the fiscal year 2013 VBP Patient Experience of Care Domain achievement threshold. An additional measure of success would be reflected by a 25 percent reduction in patient grievances. Measurable goals of consistently exceeding the FY2013 VBP Patient Experience of Care Domain (HCAHPS) achievement threshold in all eight domains and a 25 percent decrease in the number of patient grievances per quarter were chosen as measures of achievement for Clearfield Hospital’s project.
Key Strategies—

Clearfield Hospital’s strategy to create a culture of always and increase patient/family satisfaction involved investigating what was wrong, identifying a plan of correction, implementing the plan, monitoring and maintaining the gains and then celebrating the successes.

The following steps prompted the flight of the “A Culture of Always” program:

- The manager’s refusal to accept one more month of poor HCAHPS results motivated her to obtain senior management support and commitment for immediate mandatory educational in-services to introduce the hospital’s new direction of “A Culture of Always”. Management approval for the mandatory education program was granted June 2011. The four-hour training sessions began in July 2011. The commitment date for the implementation of “A Culture of Always” was August 2011.

- An education plan specifically designed to address the why, the what, and the how of hourly rounding was presented. The use of Quint Studer’s *Patient Care Strategies: Achieving Nursing and Patient Care Excellence* video was shown to demonstrate what the expectations were for hourly rounding and specifically how hourly rounding was to be conducted. Bedside Shift Report (BSR) and Individualized Patient Care (IPC) were two additional tactics to be introduced. Emphasis was placed on doing and saying the right things always to every patient, every day, every shift to create “A Culture of Always.” An overview of VBP and HCAHPS scoring was provided to the nurses to increase their knowledge of why “A Culture of Always” is so important. The message was “Only Always Counts.”

- The manager’s commitment to the success of the initiative included ongoing evaluation of staff performance, with the use of the disciplinary process to help counsel staff members that were reluctant to grow.

- Specific measurable goals of consistently exceeding the FY2013 VBP Patient Experience of Care Domain (HCAHPS) achievement threshold in all eight domains and a 25 percent decrease in patient grievances were chosen to use as measures of achievement.

- Managerial rounding would be used to prevent staff from falling back into old habits when no one is looking.

Education was provided to staff and communication tools such as Individualized Patient Care (IPC), Key Words (AIDET), scripted hourly rounding, bedside shift report and nurse leader rounding were introduced.

Monitoring and positive feedback followed.
Outcomes—

Clearfield Hospital’s results showed better scores than the national average for 8 of the 10 HCAHPS questions. The hospital’s patient grievances were cut in half. Peer to peer accountability has skyrocketed and the hospital’s staff, patients, and families love the interaction and engagement.
**HCAHPS Domains**

**Communication (Nursing and Physician):**

Communication is considered the most important characteristic of hospital quality. Nurse communication is the HCAHPS measure most highly correlated with a hospital’s overall rating. Patients report that they often rely on nurses to explain what the doctor said.

Inadequate communication between care providers or between care providers and patients/families is consistently the main root cause of sentinel events.\(^3\)

Improving communication depends on interactions with patients/families and interactions between the members of the health care team.

**HCAHPS Survey Questions—Nursing:**
The questions asked for this HCAHPS measure are:
- During this hospital stay, how often did nurses treat you with courtesy and respect?
- During this hospital stay, how often did nurses listen carefully to you?
- During this hospital stay, how often did nurses explain things in a way you could understand?

**HCAHPS Survey Questions—Physicians:**
The questions asked for this HCAHPS measure are:
- During this hospital stay, how often did doctors treat you with courtesy and respect?
- During this hospital stay, how often did doctors listen carefully to you?
- During this hospital stay, how often did doctors explain things in a way you could understand?

Possible responses for both the nursing and physicians questions are Never, Sometimes, Usually, and Always. The measure reflects the percentage of respondents who answered Always to these questions.

Source: [HCAHPS Quality Assurance Guidelines](#)

\(^3\) *Improving America’s Hospitals: The Joint Commission’s Annual Report on Quality and Safety 2007*, page 46.
Strategies:

Patients and families often report that they get inconsistent or directly conflicting answers from different physicians, nurses, and other staff. A few common strategies for getting providers on the same page include:

- Interdisciplinary rounding
- Bedside handoffs
- Huddles

Patients and families often forget their questions when the physician arrives. Consider providing bedside notepads or communication boards for the patients and their family members to record questions for the doctors and to communicate with their health providers.

Resources:

**Responsiveness:**

Patients associate quality care with responsiveness and courtesy. Responding to a patient’s needs is about proactively communicating and partnering with the patient and the patient’s family regarding their care.

It is important to demonstrate that the care of the patient is a priority. When a health care provider is responsive to a patient’s needs, they are demonstrating that they understand what is important to the patient.

Establishing a relationship of trust and comfort helps the patient feel at ease and dispels worries that they may be left waiting for someone to help with their needs.

**HCAHPS Survey Questions:**

The questions asked for this HCAHPS measure are:

- During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?
- How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?

Possible responses are Never, Sometimes, Usually, and Always. The measure reflects the percentage of respondents who answered Always to these questions.

Source: [HCAHPS Quality Assurance Guidelines](#)

**Strategies:**

**Individualized Patient Care**

- Risk assessment—identify the risks of falling, etc., to the patient based on the procedure or medication the patient has received.

- Hourly rounds—this tactic creates the expectation that a care provider will check on the patient every hour, resulting in a sense of trust for the patient. Hourly rounding can have a powerful impact and can affect many components of the patient’s perception of quality care.

- Shift changes—do bedside shift reports and handoffs in the patient’s presence. This helps the patient understand that you are sharing all of the pertinent issues regarding the patient’s care. Care providers should involve the patient in the bedside shift report and handoff by asking the patient if all of the important items regarding their care were covered. This is an opportunity to reassess and engage the patient with regards to how the staff is responding to their needs.
A Pennsylvania Promising Practice

Chester County Hospital

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Project Description—

How can care providers instill trust and help patients and families count on them for safe and individualized care while hospitalized? At The Chester County Hospital, (TCCH) one of the answers has been the hospital’s commitment to “Patient Safety and Service Rounding,” or, more simply, “Hourly Rounding.” Although Chester County Hospital first initiated Hourly Rounding in 2008, the fluctuating nature of staff commitment and patient feedback about the hospital’s inconsistency led staff to rethink how they would engage the hospital’s nursing staff in order to be seen as the true champions of Rounding.

Key Strategies—

In late 2010, TCCH launched a comprehensive plan to re-energize hourly rounding. This plan included a site visit with a large number of TCCH frontline nursing staff to a hospital with a successful program, and then the formation of a core group of Nursing “Champions” to restructure hourly rounding. During the winter of 2011, a group of nurses and nursing assistants developed a lecture with a power point, made a short film demonstrating the “right” way and the “wrong” way to perform hourly rounds, described how rounding builds trust with patients and families, and simultaneously positively impacts nursing workload. All TCCH nurses and nursing assistants were required to attend a mandatory two hour in-service taught by their peers.

In order to maintain hourly rounding in the daily practice of the nursing staff, TCCH developed “Rounding on Rounding.” Staff felt it was imperative for senior leaders to reinforce the importance of hourly rounding. The organization’s senior leaders have been engaged
throughout the revitalization. As an example, the hospital president and chief nursing officers became “avatars” and stressed the importance of hourly rounding.

Moreover, every couple of months the hospital president and chief nursing officer conduct unannounced rounds on all of the units. They interview patients to determine if hourly rounding is occurring and whether it is practiced in the manner expected of staff.

The hospital’s clinical managers also round on each patient on a daily basis. And, for about one year, the hospital used a volunteer to interview patients and query patients about whether hourly rounds were occurring. Information from these various initiatives is shared with staff during daily huddles and staff meetings.

TCCH provides a description of hourly rounding in the patient handbook. Additionally, the white boards in the patient rooms share that hourly rounds are conducted by hospital staff. All adult inpatient units initiated bedside handoff. This is where the nursing staff from the day shift introduces the oncoming evening shift staff to each patient, and simultaneously, emphasize the benefits of hourly rounding.

TCHH’s next step in maintaining a focus on hourly rounding is for the hospital president and chief nursing officer to conduct huddles on each of the nursing units to reinforce the importance of hourly rounding and to determine what barriers might still remain in consistently deploying the scripting options that the staff has to describe hourly rounds. The most notable persistent challenge has been to hardwire this important patient safety and service excellence program.

Outcomes—

Press Ganey and HCAHPS data is shared with the hospital board, leadership, frontline staff, and physicians. TCCH’s efforts improved the hospital HCAHPS score. Additionally, TCCH tracked the average number of calls bells pre- and post-revitalization efforts on one of the large medical-surgical units. Before efforts to improve hourly rounding were instituted, the call bell volume averaged 7,000. Post-implementation of more focused rounding resulted in the call bell volume dropping to 3,500.
A Pennsylvania Promising Practice

Mercy Philadelphia Hospital

Hospital Contact—

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Project Description—

Monitors were placed in the waiting area for families waiting for loved ones who were having surgery. Mercy Philadelphia Hospital developed the monitoring system to provide the patient’s family with more flexibility in the facility and an understanding that the physician would page them when the surgery was completed.

Key Strategies—

Family members are asked to wait in the 4th floor waiting room—this is where the hospital provides an electronic board informing the family member where their loved one is in the operating room process. The board changes colors depending on the status of the family member. The family is provided a monitor that will signal when the patient is ready to be picked up or the physician would like to speak to the family. Provision of the monitor provides family members the opportunity to go to the cafeteria or other areas within the hospital while waiting for the patient’s surgery to be completed. The monitor beeps when the family needs to be made aware of something. The families indicate their appreciation for this service as they are able to take care of other business without having to sit in the waiting room for hours.

The hospitality coordinator explains how the board works to the patient’s family members. The hospitality coordinator is also available to answer questions or inform families of delays in care. Once the delay has been identified, family members are given a coupon called the “Splash of Sunshine” where the family member can redeem the coupon in the café or the gift shop. This is a service recovery tool to assist in making the patient’s family experience a positive one.

As Mercy Philadelphia Hospital’s patient demographics have changed, the hospital now provides the information on the tracking board in other languages for families that do not speak English.

Outcomes—

The outcome has been very successful as the patient and their family members share their appreciation for being able to move around without missing the physician for discharge instructions. The provision of a hospitality coordinator along with the provision of the monitoring system has increased patient and family satisfaction.
**Pain Management:**

Managing patients’ pain is vital. Patients have a better perception of care based on their pain being controlled. It is important that the care provider build a relationship with each patient—this helps to improve the patient’s perception of how frequently the care provider helped control their pain.

Patients are more satisfied if they feel the care provider cared and did everything they could to help control their pain, even if the pain was not completely gone. It is essential to find out what is important to the patient and for the patient to communicate to the care provider what pain control means to them.

**HCAHPS Survey Questions:**
The questions asked for this HCAHPS measure are:

- During this hospital stay, how often was your pain well controlled?
- During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?

Possible responses are Never, Sometimes, Usually, and Always. The measure reflects the percentage of respondents who answered Always to these questions.

Source: HCAHPS Quality Assurance Guidelines

**Strategies:**

**Individualized Patient Care**

- Hourly rounds—this tactic is the best way to communicate with the patient about their pain and to take steps to proactively manage it.
- Pain scale—pain assessment is very important and the pain scale can be used to manage expectations and create an agreement on how best to manage the pain.
- Pain Poster—this is a visual reminder of the patient’s pain expectations. It provides important pain management information.
- Shift changes—address the patient’s expectations with the new staff member. Review the bedside shift report to identify when the last pain medication was administered and how the patient tolerated it.
Discharge Information:

Discharge planning should begin immediately at admission as it allows the care provider the opportunity to share, repeat, and ensure retention of important information throughout the patient’s stay. This helps to make for a smooth transition between impatient care and home care.

Care providers should continually be asking about the help that the patient will need when they leave the hospital to ensure the patient will have the help they need when they go home. It is important to have the patient identify who the primary person is that will provide their home care. Care providers can then ensure that this person is present for educational sessions regarding the patient’s care at home.

HCAHPS Survey Questions:
The questions asked for this HCAHPS measure are:

- During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
- During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?

The measure reflects the percentage of respondents who answered Yes to these questions.

Source: HCAHPS Quality Assurance Guidelines

New Questions—Care Transition: The Centers for Medicare & Medicaid Services (CMS) added three new questions related to discharge planning to the HCAHPS survey in January 2013. The new survey questions are in addition to existing discharge-planning patient-awareness initiatives, such as the requirement that hospitals inform patients about their discharge rights and the Conditions of Participation (CoP) that focus on discharge planning communication.

The new care transition questions are:

- During this hospital stay, staff took my preferences and those of my family as caregiver into account in deciding what my health care needs would be when I left.
- When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
- When I left the hospital, I clearly understood the purpose for taking each of my medications.

The measure reflects the percentage of respondents who answered Strongly Agree to these questions.
These new questions are designed to provide more visibility into the discharge process. The results from the responses to these questions can help to identify problems that lead to avoidable readmissions. Hospitals need to consider refining and improving the care transition process at their facility in order to avoid readmissions.

Strategies:

Use of Key Words
- Helps to connect information the patient receives throughout their hospital stay to what the patient will need when they go home.
- Incorporate key words into the bedside shift report.
- Obtain agreement with the patient regarding their discharge instructions to ensure that the patient understands and is comfortable with them.

Use of Whiteboards
- Post the anticipated date of discharge and the person’s name that will be providing the care at home.
- Helps to promote discussion about the goals for the day of discharge and identifies what needs to be accomplished for the patient to be discharged.

Use of Discharge Folder
- Provides written discharge instructions, reference materials, and patient-friendly educational materials for the patient.

Post-visit Telephone Calls
- Helps to reinforce the discharge instructions.
- Ensures a safe transition to home care.

Teach Back
- Confirms understanding of discharge instructions
- Empowers patient/family in discharge process

Resources:
- AHRQ Re-engineered Discharge (RED) Toolkit
- Your Discharge Planning Checklist: For Patients and Their Caregivers Preparing to Leave a Hospital, Nursing Home, or Other Care Setting, US Department of Health & Human Services, Centers for Medicare & Medicaid Services
Medication Communication:

Improving medication communication is about always informing patients and their families about what types of medications have been prescribed and the side effects that may impact them. It is also important to convey why the medication has been prescribed so that the patient is more likely to comply with the treatment plan. Proper medication communication ensures the patient’s safety and well-being.

When patients are involved in and understand their treatment plan, they are more likely to comply and their outcomes are more likely to be better. Effective medication communication represents a critical element of safe, patient-centered care that impacts the patient’s outcomes in a positive manner.

HCAHPS Survey Questions:
The questions asked for this HCAHPS measure are:

- Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?
- Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?

Possible responses are Never, Sometimes, Usually, and Always. The measure reflects the percentage of respondents who answered Always to these questions.

Source: HCAHPS Quality Assurance Guidelines

Strategies:

Use of Key Words

- Used to improve the quality of information provided and to ensure a two-way dialogue between the patient and the care provider.
- Ensures that patients are properly educated about their medications.
- This communication technique ensures that the education provided to the patient is reinforced by all appropriate staff members. This represents an important strategy to ensure all staff members who interact with the patient regarding their medications are communicating in an effective and efficient manner.
Bedside Shift Report
- Three-way conversation between the outgoing nurse, the oncoming nurse, and the patient.

Pharmacist Rounding
- Provides the patient an opportunity to discuss their medications and possible side effects with the pharmacist.

Post-Visit or Discharge Phone Call
- Provides opportunity to check in on patient and reinforce their medication needs.

Teach Back
- Confirms understanding of medication education
- Provides two-way communication which allows for discovery of misperceptions

Resource:
- [AHRQ Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation](#)
A Pennsylvania Promising Practice

St. Luke’s University Hospital-Bethlehem

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Project Description—

St. Luke’s University Hospital’s Patient Care Managers and Support Service Managers reviewed The HCAHPS Handbook, Hardwire Your Hospital for Pay-for-Performance Success By Quint Studer, Brian C. Robinson, and Karen Cook. The team identified priority area chapters for actionable items to improve processes. The hospital’s first priority chapter was Communication Regarding Medicine.

Key Strategies—

Multiple action items were discussed and implemented:

- The first action item was to utilize AIDET scripting when giving any new medication.
- The staff also distributes printed material associated with the patient’s medication to each patient. All materials regarding medications are then placed in an envelope labeled “Your Discharge Information.” This allows the patient and families easy access to the information presented to them in the hospital.
- Another action item that was implemented was to write “New Medication Reviewed Today” on patients’ white boards. This cues patients and family members to ask questions about medications.
The hospital leadership team also focuses on communication regarding medicine during daily leadership rounds. The leadership team asks the patients if the hospital team has kept the patient informed about their medications. A leadership rounding program was established to assure every patient, every day is seen by a leader.

Use the AIDET Key Words When New Medicine is Administered

**Acknowledge:**
“Hello Mr./Mrs. I have a new medication for _______ called ______________.”

**Introduce:**
“Since it’s new to you I want to take time to tell you about it.”

**Duration:**
“You will be on this medication for __________.”

**Explanation:**
“I have printed out this information about your new medication.”
“Most people don’t have problems, but possible side effects include ________.”

**Thank you!**
“I am happy to review this with you. Thank you!”

**Outcomes**—

The hospital’s combined efforts have increased the scores in the HCAHPS Communication Regarding Medicine domain. In October 2011, 73 percent of St. Luke’s patients reported that the hospital team ALWAYS told them what their medicine was for. In July 2012, this specific question’s top box score increased 9 points to 82 percent. As a result, the overall Communications Regarding Medicine jumped 10 points from 59 percent in October, 2011 to 69 percent in July 2012. The 10 point improvement nationally ranks St. Luke’s University Hospital near the 90th percentile for Communication Regarding Medicine.
Patient- and Family-Centered Care: A Key Element in Improving Quality, Safety, Perception of Care, and Care Outcomes

SLUHN: Communication Regarding Medicine

Tell what new medicine was for
**Hospital Environment (Clean and Quiet):**

A clean and quiet hospital environment impacts a patient’s perception of care and can have a profound influence on the patient’s clinical outcomes. It is important to focus on maintaining an overall clean and quiet environment. A clean and quiet environment is a healing environment.

<table>
<thead>
<tr>
<th>HCAHPS Survey Question—Cleanliness:</th>
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</thead>
<tbody>
<tr>
<td>The question related to this HCAHPS measure is:</td>
</tr>
<tr>
<td>• During this hospital stay, how often were your room and bathroom kept clean?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HCAHPS Survey Question—Quiet:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The question asked for this HCAHPS measure is:</td>
</tr>
<tr>
<td>• During this hospital stay, how often was the area around your room quiet at night?</td>
</tr>
</tbody>
</table>

Possible responses for both the cleanliness and quiet questions are Never, Sometimes, Usually, and Always. The measure reflects the percentage of respondents who answered Always to these questions.

*Source: HCAHPS Quality Assurance Guidelines*

**Strategies:**

**Environmental Services Rounding**
- Leaders from environmental services can check in with nursing leaders and patients to verify that the patient’s room is clean.
- Provides patients with the ability to directly communicate with the environmental services team.

**Restore Quiet Time**
- Implement quiet hours
- Provide visual cues to staff, patients, and visitors (e.g. signs, dimmed lights, electronic noise level monitoring)
- Acknowledge preserving sleep as a core function of staff
Reduce Unnecessary Sounds
- Eliminate or reduce overhead paging
- Conduct a "squeak" patrol
- Avoid loud maintenance at night
- In facility renovations, consider effect on noise level in decision-making
- Ask patients what noises kept them awake
- Have a staff member sleep on the unit

Preserve Sleep Rituals
- Inquire about patients sleep patterns (early riser/night owl) and unwinding rituals
- Preserve the ritual when possible (e.g. provide a cup of tea, reading material, a snack; minimize disruptions during sleep time)
- Offer to close the door
- Offer a sleep kit (e.g. ear plugs, sleep mask, aromatherapy)
- Replace noise with soothing sounds
A Pennsylvania Promising Practice

Mercy Philadelphia Hospital

Hospital Contacts—

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Hospitality Coordinator
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Director Patient & Guest Relations
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Project Description—

Mercy Philadelphia Hospital utilizes a Hospitality Coordinator, who serves as another resource for staff to assist with their patients’ needs. The Hospitality Coordinator focuses specifically on the patient’s room environment and identifies what service recovery is needed. The coordinator also assists in locating patient belongings and they contact specific support departments when a need is identified.

Key Strategies—

Mercy Philadelphia Hospital assigns a Hospitality Coordinator to look specifically at the patient room environment. Duties of the coordinator include determining if there is dirt or dust in the room that needs to be cleaned or if the placement of the curtains needs to be adjusted. The coordinator will notice the patient’s proximity to their call bell and any food issues. If the patient has a concern or complaint, the Hospitality Coordinator will then contact the staff who is responsible for that unit, and notify them if there is a problem. A monthly report is generated based on the issues reported by the patient/family, and that report is forward to all nurse managers and senior leaders. The coordinator also makes staff aware of a patient’s birthday, so that staff can go to the patient’s room to acknowledge the patient’s birthday by bringing balloons, a card, a birthday mug, and a piece of cake. Staff also sing one verse of “Happy Birthday” to the patient.
The nurses have come to rely on the Hospitality Coordinator to help meet their patient’s needs in a timely manner. The coordinator rounds in all of the waiting rooms as well as the operating room. The coordinator assists family members on how to read the patient tracking system. If a delay is identified on the tracking system, the coordinator will make contact with the family and at certain times, the coordinator will give the family a meal voucher to allow them to have a meal while they are waiting for the patient.

Environmental Services staff leave tent cards in the rooms with the name of the staff person who cleaned the room. If the patient has an issue, they can speak to the staff person about their room condition. The hospital uses chimes hourly to remind the clinical staff to round in the patient’s room as well as when it is time to turn a patient. The hospital also offers ear plugs if a patient requests them. The hospital is monitoring the noise level near patients’ rooms.

Outcomes—

Mercy Philadelphia Hospital’s patient satisfaction scores increased and the hospital exceeded their 2nd quarter goal of 61.4 percent. The hospital’s 2nd quarter score was 61.7 percent for a CHE facility. The hospital’s current score is 60 percent.
Overall Rating and Willingness to Recommend:

When a patient feels that they did not receive an overall positive experience, it is because the care provider failed to learn what was important to the patient. Health care providers must do everything possible to ensure that every patient perceives every aspect of their care to be the best.

If a patient does not score you high on the overall rating, it is certain that they will not recommend your facility to their family and friends. Patient responses to the survey really measure your quality and your efficiency at delivering individualized patient care.

HCAHPS Survey Question—Overall Rating:
The question asked for this HCAHPS measure is:

- Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?

The measure reflects the percentage of respondents who answered 9 or 10 to the question.

HCAHPS Survey Question—Willingness to Recommend:
The question asked for this HCAHPS measure is:

- Would you recommend this hospital to your friends and family?

The measure reflects the percentage of respondents who answered Definitely Yes to this question.

Source: HCAHPS Quality Assurance Guidelines

Strategies:

Promote Consistency

- Every patient must have a consistently good experience no matter what unit or department of the hospital they are in.
- All levels of the health care organization must align goals and have the same sense of urgency when it comes to quality outcomes.
- Everyone must follow the same processes and procedures and work toward the same results.
Hold Everyone Accountable
- Leaders and staff members need to understand why they are being asked to perform in a certain way and they need to be held accountable for doing what they are asked to do.

Focus on Effective Communication
- Effective communication between care providers promotes employee teamwork and trust.
- Utilizing effective communication strategies with patients prevents medical errors and promotes trust and quality outcomes.
A Pennsylvania Promising Practice

St. Joseph Medical Center

Hospital Contact—

Tina Citro, MSN, RN
Nurse Executive
(610) 378-2000

Key Strategies—

Practices that were implemented at St. Joseph Medical Center that helped to achieve outstanding scores for Overall Rating and Likelihood to recommend are:

- **Touch Base Rounding**—An interdisciplinary group that includes the patient’s nurse, case manager/social worker, resource (charge) nurse, nurse manager and nursing director who round daily on all patients. The group enters the patient’s room, reviews the plan of care and discusses discharge planning and educational needs with the patient. The anticipated day of discharge is written on the communication board hanging in the patient’s room.

- **Bedside Shift Report**—All staff provide a report at the bedside using an SBAR format (Situation, Background, Assessment, Recommendation). The patient is included in this report. A brief assessment is completed that includes the IV site, dressings and any other clinical concerns. Environmental assessment is conducted assuring safety measures are in-place and bed alarms are activated if necessary.

- **Discharge Instructions**—Because patients are anxious to go home, they do not always realize the discharge information that is being reviewed with them. To help the patient remember they have discharge instructions, staff place the discharge instructions in a red envelope. “These are your Written Discharge Instructions” is written on the envelope in bold lettering. The instruction, “Please be sure to take this packet to your first doctor visit after discharge,” is also written on the envelope in bold lettering. English and Spanish versions of the envelopes are available. When the patient is taken to their car, staff from the hospital’s patient transport department reinforces the red discharge envelope by asking the patient if they have the red envelope with their belongings.
• **Communication Boards**—Information provided on these boards includes the caregiver’s names, key telephone numbers, and the meal ordering service that patients use when they are ready to eat. Other information provided on the communication board includes the patient’s pain score and goal, the patient’s plan of care, any scheduled tests, expected discharge date, a turning clock, any safety issues and assistance requirements. The boards are updated during Touch Base Rounds.

• **Patient Safety Huddles**—Every staff member on the unit attends the patient safety huddles, which are conducted on every shift. The Resource Nurse or Manager leads the huddle. Information discussed includes identifying the patients at risk for falls—including patients who are in low beds and on bed alarms, elopement risks, any drug shortages, identifying patients with one on one/sitters, equipment updates and any pain management issues.

• **Quietness at Night Campaign**—This staff-driven initiative resulted in patient satisfaction scores related to “quietness” improving from 58% to 80% post roll-out. The campaign focused on unit routines, controllable noises, and staff accountability. Sleep aid kits are offered to patients, lights are dimmed, noisy equipment is identified and repaired and staff offers each other visual cues when they are being too loud.

• **Patient Hourly Rounding**—Initiated in conjunction with the fall prevention program, patients are visited at least hourly. The staff use “AIDET” to greet the patient and they are asked about the following: pain, position, bathroom needs, possessions; the patient’s environment and their comfort level also are assessed. Hourly rounding has significantly impacted the inpatient fall rates, and overall patient satisfaction has risen.

Hospital staff continue to work on next steps, such as communication about medications, leadership rounding and staff purposeful rounding. In an effort to keep staff updated on progress, a stop light report is being implemented to communicate those updates.

**Outcomes**—

The hospital’s ranking continues to be in the celebrate category within the HealthStreams database. The hospital also is in the top ranking within the health care system (Catholic Health Initiatives). Individual unit patient satisfaction scores are discussed at staff meetings. Hospital staff takes pride in our scores and they continue to strive to do the best to make sure our patients are happy and satisfied with their care at St. Joseph Medical Center.

**Resources**—

• **Profiles of Change**—Institute for Patient- and Family-Centered Care’s website shared profiles of hospitals across the country and how they have focused on ensuring the provision of patient- and family-centered care.
Appendices

Appendix A: Resource Tools

Assessment Example 1: An Assessment Tool for Hospital Trustees, Administrators, Providers, and Patient and Family Leaders

An effective action plan for moving forward with patient- and family-centered care is based on a thoughtful assessment of the degree to which a hospital has already incorporated key principles of this approach to care, and of the areas in which progress remains to be made.

Here are some questions that can serve as a springboard for such an assessment. Ideally, the assessment should be completed individually by hospital executives, managers, frontline staff, and patient and family advisors. Representatives of each of these groups should then convene to discuss the responses and together, develop an action plan.

Organizational Culture and Philosophy of Care

☐ Does the organization’s vision, mission, and philosophy of care statements reflect the principles of patient- and family-centered care and promote partnerships with the patients and families it serves?
☐ Has the organization defined quality health care, and does this definition include how patients and families will experience care?
☐ Has the definition of quality and philosophy of care been communicated clearly throughout the health care organization, to patients and families, and others in the community?
☐ Do the organization’s leaders model collaboration with patients and families?
☐ Are the organization’s policies, programs, and staff practices consistent with the view that families are allies for patient health, safety, and well-being?

Patient and Family Participation in Organizational Advisory Roles

☐ Is there an organizational Patient and Family Advisory Council?
  ☐ If there is a Patient and Family Advisory Council, is patient safety a regular agenda item?

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4 Excerpt from Advancing the Practice of Patient- and Family-Centered Care in Hospitals: How to Get Started..., Institute for Patient- and Family-Centered Care

Patient- and Family-Centered Care: A Key Element in Improving Quality, Safety, Perception of Care, and Care Outcomes
Assessment Example 1: An Assessment Tool for Hospital Trustees, Administrators, Providers, and Patient and Family Leaders, continued

☐ Do patients and families serve on committees and work groups involved in:
  o Patient safety?
  o Quality improvement?
  o Facility design?
  o Use of information technology?
  o Pain management?
  o Patient/family education?
  o Discharge/transition planning?
  o Palliative/End-of-life care?
  o Staff orientation and education?
  o Service excellence?
  o Ethics?
  o Diversity/cultural competency?

Architecture and Design

☐ Does the health care organization’s architecture and design:
  o Create welcoming impressions throughout the facility for patients and families?
  o Reflect the diversity of patients and families served?
  o Provide for the privacy and comfort of patients and families?
  o Support the presence and participation of families?
  o Facilitate patient and family access to information?
  o Support the collaboration of staff across disciplines and with patients and families?

Patterns of Care

☐ Are family members always welcome to be with the patient, in accordance with patient preference, and not viewed as visitors?
☐ Are patients and families viewed as essential members of the health care team? For example, are they encouraged and supported to participate in care planning and decision-making?
  o Do physician and staff practices reinforce that care will be individualized for patient and family goals, priorities, and values?
☐ Are patients and families, in accordance with patient preference, encouraged to be present and to participate in rounds and nurse change of shift?
☐ Is care coordinated with patients and families and across disciplines and departments?
Assessment Example 1: An Assessment Tool for Hospital Trustees, Administrators, Providers, and Patient and Family Leaders, continued

Patient and Family Access to Information

☐ Are there systems in place to ensure that patients and families have access to complete, unbiased, and useful information?
☐ Do patients and families, in accordance with patient preference, have timely access to medication lists, clinical information (e.g., lab, x-ray, and other test results), and discharge or transition summaries?
☐ Are informational and educational resources available in a variety of formats and media and in the language and at the reading levels of the individuals served?
☐ Are patients and families encouraged to review their medical records and work with staff and physicians to correct inaccuracies?
☐ Are patients and families provided with practical information on how to best assure safety in healthcare?
☐ Are there a variety of support programs and resources for patients and families, including peer and family-to-family support?

Education and Training Programs

☐ Do orientation and education programs prepare staff, physicians, students, and trainees for patient- and family-centered practice and collaboration with patients, families, and other disciplines?
☐ Are patients and families involved as faculty in orientation and educational programs?

Research

☐ In research programs, do patients and families participate in:
  o Shaping the agenda?
  o Conducting the research?
  o Analyzing the data?
  o Disseminating the results?

Human Resources Policies

☐ Does the organization’s human resources system support and encourage the practice of patient- and family-centered care?
☐ Are there policies in place to ensure that:
  o Individuals with patient- and family-centered skills and attitudes are hired?
  o There are explicit expectations that all employees respect and collaborate with patients, families, and staff across disciplines and departments?
☐ Are there strategies in place to reduce the cultural and linguistic differences between staff and the patients and families they serve?
**Advancing the Practice of Patient- and Family-Centered Care in Hospital and Clinics**

### OUTLINE

| I. A Climate of Change for Hospitals and Clinics for More than a Decade |
| A. Public Perceptions of Health Care |
| • The system is a nightmare to navigate; |
| • Caregivers don’t provide enough information; |
| • Patients are not involved in decisions about their health care; and |
| • Hospital caregivers are not emotionally supportive (American Hospital Association and the Picker Institute, 1996). |
| B. Institute of Medicine — Crossing the Quality Chasm: A New Health System for the 21st Century, 2001 |
| • Health care should be based on continuous healing relationships. |
| • Care should be individualized. |
| • It is important for patients to be involved in their own care decisions. |
| • Patients and families should have improved access to information. |
| • Health care should become more transparent. |
| C. Commonwealth Fund — Mirror, Mirror on the Wall: Looking at the Quality Of American Health Care Through the Patient’s Lens, 2004 |
| In 2007, the Commonwealth Fund released findings of a study that compared six English-speaking countries on how well they were meeting the Six Aims of the Institute of Medicine’s Crossing the Quality Chasm report. New Zealand ranked first in patient-centered measures such as patient engagement and patient preference, communication, and continuity. The U.S. was second to last. |

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D. Other Agencies Advancing the Practice of Patient- and Family-Centered Care

- AIMS program within the Canadian Council on Health Services
- Agency for Healthcare Research and Quality (AHRQ)
- American Academy of Pediatrics (AAP)
- American Association of Medical Colleges (AAMC)
- American Board of Internal Medicine Foundation
- American College of Healthcare Executives (ACHE)
- American Hospital Association (AHA)
- Association of Maternal and Child Health Programs
- Bureau of Medicine and Surgery, U.S. Department of Defense
- Calgary Health Region
- Center for Health Design
- Centers for Medicare and Medicaid Services
- Child Health Network for the Greater Toronto Area
- Health Canada
- HIV/AIDS Bureau, U.S. Department of Health and Human Services
- Institute for Healthcare Improvement
- Joint Commission
- Maternal and Child Health Bureau, U.S. Department of Health and Human Services
- National Association of Children’s Hospitals and Related Institutions (NACHRI)
- National Association of Emergency Medical Technicians
- National Committee for Quality Assurance (NCQA)
- National Institute on Disability and Rehabilitation Research
- National Patient Safety Foundation (NPSF)
- Society of Pediatric Nurses (SPN)
- Substance Abuse and Mental Health Services (SAMHSA), U.S. Department of Health and Human Services
- TRICARE Management Activity, U.S. Department of Defense
- University of South Florida Rhea and Lawton Chiles Center

E. Organizational Changes

- Culture of Safety
- Managed Care and Other Changes in Health Care Financing
- Work Redesign/Reengineering
- Networks and Mergers
- Medical Education Reform—ACGME Outcome
  Project is one example of changes occurring in medical education. Upon graduation, residents are expected to demonstrate competences in the areas of:
  - Patient care;
  - Medical knowledge;

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- Practice-based learning and improvement;
- Interpersonal and communication skills;
- Professionalism and
- Systems-based practice.

• Medical Home for Primary Care
• Evidence-Based Design
• The Use of Information Technology

F. Changes in the Relational Aspects of the Health Care System

• Patient and Family-Centered Care
• Family-Centered Care
• Patient-Centered Care
• Mother-Baby Care
• Individualized Developmental Care for Fragile Infants
• Chronic Care Model
• Collaborative Self-Management Support for Long-Term Conditions
• The Planetree Model
• Relationship-Centered Care
• Healing Environments
• Resident-Centered Care in Long-Term Care Facilities

II. Patient- and Family-Centered Care: The Core Concepts

A. A Definition for Patient- and Family-Centered Care

Patient- and family-centered care is an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families. It redefines the relationships in health care.

Patient- and family-centered practitioners recognize the vital role that families play in ensuring the health and well-being of infants, children, adolescents, and family members of all ages. They acknowledge that emotional, social, and developmental support are integral components of health care. They promote the health and well-being of individuals and families and restore dignity and control to them.

Patient- and family-centered care is an approach to health care that shapes policies, programs, facility design, and staff day-to-day interactions. It leads to better health outcomes and wiser allocation of resources, and greater patient and family satisfaction.

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B. Core Concepts of a Patient- and Family-Centered System of Care

- **Dignity and Respect.** Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.

- **Information Sharing.** Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete and accurate information in order to effectively participate in care and decision-making.

- **Participation.** Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.

- **Collaboration.** Patients, families, health care practitioners, and hospital leaders collaborate in policy and program development, implementation and evaluation; in health care facility design; and in professional education, as well as in the delivery of care.

C. Key Words

- Respect.
- Strengths.
- Choice.
- Flexibility.
- Information.
- Support.
- Collaboration.
- Empowerment.

D. Why Patient- AND Family-Centered Care?

The individuals who are the most frequent users of hospital care or care in ambulatory settings are also those who are most dependent on their families—the very young, the very old, and individuals with chronic conditions.

E. A Broad Definition of Family

The patient defines the family and how they will be involved in caregiving and decision-making.
III. Patient- and Family-Centered Care: An Evolving Approach to Health Care

A. An Evolving Philosophy of Care

1. System-Centered Care.
2. Patient-Focused Care.
3. Family-Focused Care.
4. Patient- and Family-Centered Care.

B. A Paradigm Shift

Patient- and family-centered care represents a profound change in culture for many health care organizations. Traditional approaches for the most part have been based on a model of health care delivery that:

- Focuses on deficits;
- Has a restrictive definition of the family;
- Disempowers patients and their families;
- Relies heavily on technology and biomedical science and undervalues the importance of human interactions in health care experiences;
- Is driven by the system.

With patient- and family-centered care there is a philosophical shift from:

- Deficits → Strengths
- Control → Collaboration
- Expert Model → Partnership Model
- Information Gatekeeping → Information Sharing
- (−) Support → (+) Support
- Rigidity → Flexibility
- Dependence → Empowerment

IV. Patients and Families as Advisors in Policy and Program Planning, Implementation, and Evaluation

Collaboration at all levels of care among patients, families, and health care professionals is essential to the practice of patient- and family-centered care. Each bring expertise and perspectives important to shaping hospital and clinic policies, programs, practices, and facility design.

Patients and families served by the hospital or clinic are involved in advisory activities such as:

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• A patient and family advisory council;
• Formal committees and task forces about quality, safety, the experience of care, patient/family information and education, and the use of information technology;
• Informal workgroups and discussion groups about quality, safety, the experience of care, and patient/family information and education;
• Education and orientation for health professionals and trainees.

V. Application of Patient- and Family-Centered Concepts in Hospitals and Clinics

A. Mission, philosophy of care, and definition of quality

Mission, philosophy of care, and the definition of quality are key documents that set the tone and direction for the institution and the care it provides.

Key questions to ask:

• Do mission, and philosophy of care statements convey an explicit commitment to patient- and family-centered care?
• Does the hospital or clinic have a definition of quality that includes the patient and family experience of care?
• Do these statements convey that the beliefs, values, and priorities of patients and families are key considerations in determining hospital and clinic policies, programs, practices, and facility design?
• Do these statements convey respect for families and their pivotal role in promoting the health and well-being of patients and families?

B. Facility design and allocation of space to support patient- and family-centered care

The physical environment of the hospital or clinic can support or hinder the practice of patient- and family-centered care. Knowledge of evidence-based design findings can inform design planning and decision-making.
Key questions to ask:

- Do parking facilities, the lobby, and entrances to specific units and departments convey positive, welcoming first impressions?
- Are there supportive spaces in examination and treatment areas, in patient rooms, and in critical care areas that encourage family presence and participation in care?

C. Patient and family participation in care

The wording of hospital or clinic policies and dissemination of information about participation in care can have a significant impact on:

- A patient’s and family’s participation and decision making in health care;
- The attitudes of patients and families about health care and relationships with physicians and other health care providers over the long-term.

Key questions to ask:

- Are patients asked to define their family and how they will be involved in care and decision-making?
- Are patients, and according to patient preference, families recognized as important members of the health care team?
- Are patients and families encouraged and supported in care planning and decision-making?
- Are patients encouraged and supported in collaborative goal setting as a part of health promotion, disease prevention, and the management of chronic conditions?
- Are patients supported in involving their families and/or friends in their health experiences in ways they choose?
- Are family members considered visitors?
- Do hospital/clinic policies and guidelines convey that family members are welcome at all times, regardless of rounds, change of shift, or other events on the unit or in the clinic?
• Are families encouraged and supported in being with their family member during procedures and treatments, if this is the preference of the patient?

• Are words that convey flexibility and a positive tone, such as offer, choose, and support, used in written policies instead of the negative and controlling words, such as allow, permit, and require?

D. Sharing information with patients and families

Sharing information, in ways that patients and families determine as helpful, empowers and supports them in decision-making and managing care and the transitions in care.

Key questions to ask:

• Do patients and families have easily accessible opportunities to ask questions of doctors and nurses?

• Is written information provide a primary languages and in appropriate reading levels of patients and families served by the hospital or clinic?

• Do patients and families, in accordance with patient preference, have timely access to medication lists, clinical information (e.g., lab, x-ray, and other test results) and discharge summaries?

• Are patients and families involved in shaping the variety of ways that the hospital/clinic and its staff share information with patients and families?

• Is there a patient and family resource library in the facility?

• Do patients and families have open access to the hospital/medical library?

E. Facilitating peer and family-to-family support

For many patients and families, the opportunity to meet and learn from others who have had similar experiences provides a unique and important kind of support that supplements and is different from the kind of support provided by professionals.

Key questions to ask:

• Are patients and families routinely given information about peer support or family-to-family support and how to access it?
• Does the hospital hire patients or family members who have had similar health care experiences to facilitate peer support or family-to-family support?

• Has the hospital created patient or family liaison/consultant positions?

F. Documentation and charting

Documentation and charting policies and the forms themselves can encourage a deficit view of patients and families and foster their dependence, or they can facilitate the identification of patient and family strengths and priorities and encourage patient and family participation.

Key questions to ask:

• Does the language used in forms and electronic health records promote the identification of the strengths, goals, values, and priorities of patients and families?

• Are patients and families (with a patient's permission) encouraged to read the chart and record their observations, comments, and questions in the chart or electronic health records?

G. Linkages to home and community resources

The transition to and coordination of a comprehensive set of services are important aspects of health care delivery.

Key questions to ask:

• Is there a single, identified person to assist patients and families with discharge or transition planning?

• Are the patient and family provided with a written discharge/transition plan before they leave a facility?
  - Did the patient and family participate in the development of this plan?
  - Did the patient and family have an opportunity to learn about the plan and follow-up care and communicate this understanding to a staff person?

• Does the hospital provide or link patients and families with any of the following:
  - Community-based health providers.
  - In-home health services.
  - Wellness centers.
  - Mental health services.

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- Substance abuse services.
- Community-based peer and family-to-family support
- Respite care.
- Hospice care.
- Transportation assistance.
- Other services identified by patients and families.

H. Recruitment and selection of personnel, job descriptions, performance appraisals

The policies and practices of the personnel department can ensure that there are staffs, across all disciplines and departments, with the knowledge and skills to work in patient- and family-centered ways.

Key questions to ask:

- Are job descriptions and performance appraisals written in ways that are consistent with patient- and family-centered principles, especially regarding communication skills and patient/family/professional collaboration?
- Are there orientation and continuing education programs that convey information about the hospital’s and clinic’s philosophy and promote the acquisition of knowledge and skills relevant to patient- and family-centered care?
- Do patients and families participate as faculty for orientation and continuing education for staff?

I. Approaches to assist students and professionals-in-training in acquiring patient- and family-centered knowledge, skills, and attitudes

To acquire patient- and family-centered knowledge, skills, and attitudes, students and professionals-in-training need opportunities to learn directly from patients and families, to work in hospitals, clinics, and community programs, and to have opportunities for candid dialogue with patients and families in non-clinical settings.

Key questions to ask:

- Do patients and families participate as faculty for students and professionals-in-training?
- Do students and professionals-in-training participate in home visiting programs and do they work in community agencies during their specialty rotations?
J. Quality improvement

With a patient- and family-centered approach to health care, there is a shared definition of quality.

Key questions to ask:

- How are patients and families who have experienced care in the hospital or clinic involved in planning, and implementing and evaluation, and continuous quality improvement initiatives?

- Do patients and their families served by the hospital and/or clinic, participate in designing, implementing, and evaluating specific quality improvement initiatives?

- Is a patient and family advisory council included in the hospital’s or clinic’s quality improvement plan?

- Are there systematic procedures for gathering information about patients’ and families’ perceptions of care and satisfaction with hospital or clinic policies, programs, and practices?

- Are patients and their families involved in the collection and analysis of information about experiences and perceptions of care?

- Are patients and families involved in responding and finding solutions to the ideas, suggestions, and concerns expressed by consumers?

VI. The Benefits of Patient- and Family-Centered Care

Moving toward a patient- and family-centered model of health care delivery:

- Improves clinical outcomes;

- Leads to hospitals and clinics that are more responsive to patient- and family-identified needs and priorities;

- Enhances patient and family satisfaction and staff and physician satisfaction as well;
• Creates a supportive workplace environment that encourages recruitment and retention of staff and physicians;

• Creates more effective learning environments for nurses and physicians-in-training in the hospital and community;

• Reduces healthcare costs;

• Ensures that scarce resources are used more wisely;

• Builds a cadre of patients and families able to advocate for quality in healthcare and the resources to support quality care; and

• Positions the hospital and clinic more effectively in the marketplace.

VII. Lessons Learned from Experience in Advancing the Practice of Patient- and Family-Centered Care

• Have senior leadership make an explicit commitment to collaboration with patients and families.

• Designate a staff member, with patient- and family-centered knowledge and skills, as liaison for collaborative activities with patients and families.

• Invest in orientation and training in patient- and family-centered care for patients, families, staff, and physicians.

• In collaborative endeavors, foster mutual respect among staff, physicians, patients, and families.

• Invest in learning and planning together.

• Use the patient and family experience as a driver for quality improvement.

• Include patient- and family-centered goals in unit, clinic, and/or departmental annual plans and provide incentives to directors/managers for achieving these goals.

• Begin with easily achievable projects.

• Have both short-term and long-term projects.

• Celebrate small steps and other successes.
- Monitor the impact of patient- and family changes on the patient and family experience, staff and physician satisfaction, and relevant clinical, organizational, and fiscal outcomes.
- Create a variety of ways for patients and families to serve as advisors.
- Remember, one patient or family member on a committee or task force is not enough.
- Recruit patient and family advisors continually.
- Support the development of patient and family leaders.
- Select patient and family leadership wisely.
- Trust the process and work on the process.
Personnel Practices to Advance the Practice of Patient- and Family-Centered Care: A Self-Assessment Inventory

This assessment inventory is designed to assist managers and staff for Human Resources think about how they integrate patient- and family-centered principles and strategies in department policies, programs, and practices. It is designed for use with an interdisciplinary team that includes patients and families served by the hospital. The tool will assist those who complete it in determining priorities for change and improvement. Many who have used this inventory have found that even the process of completing the tool has educational value, because it helps inform participants about the core concepts and strategies of patient- and family-centered care.

The assessment inventory is divided into seven sections:

- Recruitment Process
- Selection Process
- Position Descriptions
- Appraisal Process
- Orientation for New Employees
- Staff Development
- Employee Support Policies and Programs

Advancing the practice of patient- and family-centered care is not a program to be “rolled out.” It is a long-term journey and commitment that evolves with the changing needs and priorities of the organization and the individuals, families, and communities it serves. By completing this tool and discussing the issues it reveals, hospital and health systems teams can take the first step in this important work.

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Patient- and Family-Centered Care: A Key Element in Improving Quality, Safety, Perception of Care, and Care Outcomes
Instructions

**Step 1: Assemble Team**
Successful culture change of an organization requires the commitment and involvement of senior leadership. For this reason, it is recommended that some of the senior leaders—such as the chief operating officer, chief nursing and medical officers, directors for quality, safety, and planning—participate on the team completing the initial assessment for the Human Resources Department. Human Resources Department leadership, front-line staff, clinical and departmental managers, patients, and families should also participate on this initial team. On the basis of its structure and staff, each hospital will need to decide how best to configure this team.

**Step 2: Complete Assessment Inventory**
There are several different ways to complete this inventory. Some organizations find it helpful for each team member to complete the tool individually and then discuss as a group. Other organizations ask all team members to review the tool individually and then discuss as a group to discuss their ideas and formulate a group response. Participants should set aside several hours for completing the checklist.

The tool asks you to complete four tasks:

**A. Rate the status of patient- and family-centered care.**
Please circle the number within the status column that indicates how well you think your Human Resources Department is applying the concepts of patient- and family-centered care. This 5-point scale is not an attempt to obtain a precise numerical rating, but rather it is a way to develop understanding for where your Human Resources Department is along a continuum of integrating patient- and family-centered concepts and strategies in its policies and practices.

**B. Rank perceived priority for change or improvement.**
Circle the number in the perceived priority column for what you believe should be the level of priority for change or improvement for each key indicator. This ranking will help prioritize change activities to undertake over time at your hospital.

**C. Provide notes and examples.**
The fourth column provides space to list examples of policies, programs, practices, or practices. This space can also be used for clarifying notes that correspond to the responses in the columns to the left. This information will be useful for future planning.
D. Complete open-ended responses.
The last page asks for narrative responses related to participants’ experiences in implementing patient- and family-centered care, the benefits and outcomes of these changes, and challenges encountered. In addition, it asks participants to describe in writing any insights they have derived from completing the assessment inventory and to state whether or not they believe that patient- and family-centered care should be an organizational priority.

---

**Step 3:**
**Reflect on Findings**
Plan time to review findings and discuss them within the context of the department’s and the hospital’s health system’s strategic priorities and quality and safety agendas.

**Step 4:**
**Develop Action Plan**
After completing the assessment, the Human Resources Department should develop an action plan to analyze the results and begin to address the priorities identified. The plan should include both short- and long-term goals. Many hospitals and health systems have found it useful to appoint a steering committee for patient- and family-centered care to oversee and coordinate the change process, encourage collaborative initiatives, and ensure that these efforts are integrated with their quality and safety agendas.

**Step 5:**
**Repeat Assessment Process**
Human Resources leadership should plan to repeat the assessment process every 12-18 months.
<table>
<thead>
<tr>
<th>Key Indicators</th>
<th>Status</th>
<th>Perceived Priority for Change/Improvement</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recruitment Process</strong></td>
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</tr>
<tr>
<td>Recruitment strategies used to attract individuals with patient- and family-centered knowledge, skills, and attitudes include:</td>
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<tr>
<td>– Appreciation of patient and family strengths.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>– Knowledge of human development and family dynamics.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>– Effective interpersonal and communication skills.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>– Cultural competency.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>– Ability to collaborate and participate on a team with patients, families, and staff across disciplines and settings.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>– Flexibility and creativity.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>Recruitment strategies are used to attract individuals who reflect the cultures of the people served by the hospital.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
</tbody>
</table>

**Perceived Practices to Advance the Practice of Patient- and Family-Centered Care: A Self-Assessment Inventory**

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Patient- and Family-Centered Care: A Key Element in Improving Quality, Safety, Perception of Care, and Care Outcomes

84
### Key Indicators

<table>
<thead>
<tr>
<th>Selection Process</th>
<th>Status</th>
<th>Perceived Priority for Change/Improvement</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients and families served by the hospital participate in the search or selection process for key administrative, managerial, and faculty positions.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>Patients and families help identify key criteria for the selection of personnel.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
</tbody>
</table>
### Position Descriptions

The following expectations for behaviors are reflected in position descriptions for both clinical and non-clinical staff:

- Conveys respect for values, preferences, and expressed needs of the patient and family:
  
<table>
<thead>
<tr>
<th>Status</th>
<th>Perceived Priority for Change/Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
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</tbody>
</table>

- Recognizes the patient, and family according to patient preferences, as important members of the health care team:
  
<table>
<thead>
<tr>
<th>Status</th>
<th>Perceived Priority for Change/Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
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</table>

- Collaborates with the patient, and family according to patient preferences, in planning, implementing, and evaluating care:
  
<table>
<thead>
<tr>
<th>Status</th>
<th>Perceived Priority for Change/Improvement</th>
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</thead>
<tbody>
<tr>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
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- Welcomes the presence and participation of family members at all times according to patient preferences, regardless of rounds, change of shift, or other events on the unit:
  
<table>
<thead>
<tr>
<th>Status</th>
<th>Perceived Priority for Change/Improvement</th>
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<tbody>
<tr>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
</tr>
</tbody>
</table>

- Communicates effectively with patients, families, and other staff across disciplines and settings:
  
<table>
<thead>
<tr>
<th>Status</th>
<th>Perceived Priority for Change/Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
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</tbody>
</table>

- Recognizes and builds on patient and family strengths to enhance competence and confidence:
  
<table>
<thead>
<tr>
<th>Status</th>
<th>Perceived Priority for Change/Improvement</th>
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<tbody>
<tr>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
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</tbody>
</table>

- Provides information to patients and families in ways that are useful and that build on their capacity to manage care and promote their health and well-being:
  
<table>
<thead>
<tr>
<th>Status</th>
<th>Perceived Priority for Change/Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Key Indicators</td>
<td>Status</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>- Makes appropriate provisions for pain management and physical comfort in collaboration with the patient and family.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>- Facilitates access to emotional and practical support including peer support, spiritual support, and counseling within the hospital and community.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>- Collaborates with other staff, faculty, and hospital departments.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>- Collaborates with community-based providers.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Position descriptions for key administrators, managers, and faculty convey the expectation for working collaboratively with patients and families in planning, program development, evaluation, education, research, and policy formulation.</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

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**Patient- and Family-Centered Care: A Key Element in Improving Quality, Safety, Perception of Care, and Care Outcomes**

87
### Key Indicators

<table>
<thead>
<tr>
<th>Key Indicators</th>
<th>Status</th>
<th>Perceived Priority for Change/Improvement</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Appraisal Process</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appraisal criteria reflect patient- and family-centered behaviors described in position descriptions.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>The appraisal process encourages employees to identify their own strengths and areas for growth and improvement in patient- and family-centered care,</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>The appraisal process promotes reflective practice.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>Resources and opportunities for professional growth are offered.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>Key Indicators</td>
<td>Status</td>
<td>Perceived Priority for Change/Improvement</td>
<td>Notes</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>--------</td>
<td>-------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Orientation for New Employees</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>All new employees learn about patient- and family-centered care and the hospital’s mission, vision, definition of quality, and philosophy of care during orientation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The orientation process conveys that the core concepts of patient- and family-centered care apply in very tangible ways to an employee’s day-to-day practices.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>New employees learn directly from patients and families about what it is like to experience care at the hospital.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>New employees learn about effective approaches to communication and collaboration with patients, families, and other staff.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>The orientation process helps new employees see the benefits of working in patient- and family-centered ways.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>Key Indicators</td>
<td>Status</td>
<td>Perceived Priority for Change/Improvement</td>
<td>Notes</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>--------</td>
<td>------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
<td>OK</td>
<td>Very Well</td>
</tr>
<tr>
<td>Staff Development</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employees have opportunities to improve their communication skills for the following:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Conveying respect to patients, families, and other staff.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>- Communicating effectively with patients, families, and other staff.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>- Gathering information from patients and families.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>- Sharing “bad news” in a supportive manner.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>- Providing medical and other information in ways that are understandable and useful to patients and families.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>- Sharing information with patients and families about errors, whether or not adverse events occur.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>- Fostering the confidence and competence of patients and families.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>- Respecting patient and family choices.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>- Fostering the participation of families in caregiving and decision making.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>- Reducing the stress of illness and health care experiences.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>- Overcoming linguistic, cultural, and other barriers to effective collaboration.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
<tr>
<td>- Collaborating with patient and family advisors in policy and program planning, implementation, and evaluation.</td>
<td>1 2 3 4 5</td>
<td>1 2 3</td>
<td></td>
</tr>
</tbody>
</table>

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Patient- and Family-Centered Care: A Key Element in Improving Quality, Safety, Perception of Care, and Care Outcomes
### Key Indicators

#### Staff Development (cont.)

<table>
<thead>
<tr>
<th>Status</th>
<th>Perceived Priority for Change/Improvement</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>OK</td>
<td>Very well</td>
</tr>
<tr>
<td>Example/Clarification of response</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All current employees have opportunities to learn from patients and families about what it is like to experience care at the hospital.

Patients and families are part of the faculty for staff development programming—planning, making presentations, participating in discussions, and evaluating programming.

Staff development programs assist employees in becoming comfortable and competent in working with the diversity of patients and families served by the hospital.

The concepts and strategies of patient- and family-centered care are integrated in the hospital or health system's service excellence or customer service initiatives.

Administrators, managers, and faculty have opportunities to acquire skills in working collaboratively with patients and families to:

- Plan and evaluate policies and programs.
- Teach students and professionals-in-training.
- Conduct research.

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Patient- and Family-Centered Care: A Key Element in Improving Quality, Safety, Perception of Care, and Care Outcomes

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### Key Indicators

<table>
<thead>
<tr>
<th>Employee Support Policies and Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employees are offered opportunities to candidly reflect and receive feedback from a trained mentor regarding their work with patients and families.</td>
</tr>
<tr>
<td><strong>Status</strong></td>
</tr>
<tr>
<td>Not at all</td>
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<tr>
<td>1</td>
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</tbody>
</table>

| Policies and programs are in place to support employees and their families and offer programs and resources to meet the challenges and stresses of working in a health care environment. |
| **Status** | **Perceived Priority for Change/Improvement** |
| Not at all | OK | Very Will | Low | High |
| 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 |

| Rewards and incentives are available to employees that: |
| - Foster long-term commitment to patient- and family-centered care. |
| - Recognize excellence in patient- and family-centered care practice. |
| - Encourage collaboration with patient and family advisors to enhance practice and programs. |
| **Status** | **Perceived Priority for Change/Improvement** |
| Not at all | OK | Very Will | Low | High |
| 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 |
Open-Ended Responses

Are there other ways that the Human Resources Department demonstrates a commitment to advancing the practice of patient- and family-centered care?

What are benefits/outcomes evolving from these innovations?

What are the biggest challenges the Human Resources Department faces in applying patient- and family-centered concepts and strategies to its policies and practices?

What are the opportunities to further the integration of patient- and family-centered concepts and strategies in your Human Resources Department at this time (e.g., a desired culture change, a contract negotiation with the union, new data regarding patients’ and families’ perceptions of care, new data regarding staff satisfaction and perceptions of care)?

Reflect on the finding of this assessment and their relevance and importance to your hospital’s strategic priorities and quality and safety standards.
Name of hospital: 

<table>
<thead>
<tr>
<th>Person(s) completing the assessment inventory:</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Name</td>
<td>Discipline/Department/Patient/Family Member</td>
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**Staff Liaison to Patient and Family Advisory Councils and other Collaborative Endeavors**

**Staff Liaison to Patient and Family Advisory Councils and other Collaborative Endeavors**

**Staff Liaison:** Any role that enables consumers to have direct input and influence on the policies, programs, and practices that affect the care and services that individuals and families receive.

- Key attitudes and qualities for the staff liaison to a Patient and Family Advisory Council.
  
  Patience, perseverance, flexibility, listening skills, openness to new ideas and ways of working, willingness to learn, willingness to educate and to be educated, ability to work positively and proactively, ability to see strengths in all people and in all situations and to build on those strengths, and a sense of humor.

- Get to know the culture of the organization and its staff.
  - Learn how decisions are made.
  - Identify and get to know the formal and informal leaders of the organization.
  - Look for supporters of patient- and family-centered care.
  - Be alert for strategic opportunities to introduce patient- and family-centered concepts or to integrate them in new or ongoing initiatives.

- Lay the groundwork with all possible individuals who might be involved in patient- and family-centered initiatives.
  - Meet with individuals and groups — use these meetings to learn about the people in the organization and the organization itself. These meetings are also an opportunity to educate about patient- and family-centered care.
  - Seek support from key individuals or groups such as hospital administration, managers, family support groups, and other patient groups. Challenge them to bring forward their ideas and take action.
  - Identify individuals on the staff who might “champion” the ideals of patient- and family-centered care — provide them with support and encouragement.

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• Educate, formally and informally, about the principles and benefits of patient- and family-centered care, advisory councils, and other collaborative endeavors. Be candid and constructive about the challenges as well.

• Help staff develop a patient- and family-centered definition of “family” — the family as self-defining — and make the distinction between families and visitors.

▼ Assist staff and faculty across all disciplines in understanding the roles of patients and families at meetings, or on committees and task forces.

• Develop clear guidelines for the participation of patients and families and what can be asked of them.

• Help staff realize appropriate boundaries for patients, families, and staff.

• Offer suggestions and assist staff, patients, and families in dealing with conflicts.

• Be prepared to support staff who have been confronted by angry patients/families and are unprepared to deal with their angry feelings.

• Challenge them to identify opportunities to include patients and families in policy and program planning, implementation, and evaluation.

▼ Seek opportunities to enhance staff’s ability to collaborate and their understanding of and commitment to patient- and family-centered care.

▼ Be available to staff who are resistant to patient/family participation in hospital activities, committees, or task forces.

• Find constructive ways for them to see this type of collaboration “in action.”

• Create opportunities for them to interact with patients and families. Patients and families are often the best sales people for the concept.

• Explore with staff ways for them to work with patients or families — continually encourage/remind staff to invite patients and families to participate in hospital activities.

▼ Identify opportunities for patient/family/professional collaboration — must be meaningful, not token participation.

• Encourage staff to always have more than one patient or family member attend meetings, task forces, or other endeavors.

▼ Assist with development of a Patient or Family Advisory Council.

• Provide guidance for determining structure, size, meeting frequency, operating procedures, and bylaws.

• Clearly define the role of a council, its place in the organization, and the reporting relationships.

• Determine senior hospital leadership’s expectations for council activities and reports.
• Consider developing a patient and family workgroup as a precursor to a more formal council.
  - The workgroup is a quick way to get patient and family participation in hospital activities.
  - The informal structure of a workgroup may be less threatening to staff.
  - The workgroup can be facilitated by someone internal or external to the organization. The latter provides an opportunity for staff, patients, and families to become comfortable over time with new ways of working together.
  - The workgroup is a place where staff, patients, and families can learn and practice new collaborative skills and a place to gain confidence in the collaborative process.
  - The workgroup provides an opportunity for natural leaders to emerge.
  - The workgroup can provide invaluable information to staff until a permanent council and/or a variety of other collaborative endeavors are established.

▼ Develop strategies for recruiting patient and family members.
  • Identify patients, families, staff, and community organizations that can recommend potential members.
  • Seek patients and families who reflect the diversity of those served by the hospital — racial, cultural, religious, socioeconomic, age, educational background, and a variety of family structures.
  • Seek patients and families who represent a variety of clinical experiences such as type of illness, facilities, and programs utilized.
  • Participate in the process to select council members, helping staff, patients, and families discuss applicants and what they bring to the council.

▼ Ensure that an orientation is given to new council and/or new staff members. The orientation should include:
  • The role of the council;
  • The roles and responsibilities of members;
  • The roles and responsibilities of officers;
  • Meeting attendance expectations for members;
  • The roles and responsibilities of staff on the council;
  • How to be an effective council member;
  • How to present issues effectively; and
  • How to be most effective in collaborating with hospital staff and faculty.
- Encourage patients and families to actively “own” the council.
  - Patient or family chair or co-chairs lead meetings.
  - Patient or family chair or co-chairs establish meeting agendas.
  - Council members take responsibility for minutes with support of hospital staff.
  - Council members recruit new members — identifying appropriate potential members, involving them in a variety of activities, and developing their skills and interest in council membership.
  - Assist other staff in understanding the importance of patient/family members “owning the council.”

- Track accomplishments.
  - Celebrate successes.
  - Publicize information about council activities and other activities that involve patients and families.
  - Identify situations where patient/family input made a difference.
  - Consider broad dissemination of Patient and Family Advisory Council or workgroup meeting minutes to staff, faculty, and families who are interested in serving as advisors but not currently on the council.

- Sustain positive momentum.
  - Be alert to group dynamics and council productivity.
  - Provide guidance or support to ensure that the council:
    - is engaged in meaningful work;
    - works in a constructive manner;
    - fosters collaborative relationships between staff, patients, and families;
    - remains representative of the population served; and
    - functions in a manner that promotes investment by patients and families in ownership of the council.

Developed by Madeline Foudrick and Beverley H. Johnson. Institute for Patient- and Family-Centered Care, Bethesda, MD, 1998.
A PATIENT AND FAMILY ADVISORY COUNCIL WORKPLAN: GETTING STARTED

A. Initial Steps for Starting a Council

1. Staff/stakeholders you need to help define the purpose of your advisory council and get support and/or commitment.

   a. Physicians
      
      | Name | Role | Contact Info |
      |------|------|--------------|
      |      |      |              |

   b. Nurses
      
      | Name | Role | Contact Info |
      |------|------|--------------|
      |      |      |              |

   c. Social Workers
      
      | Name | Role | Contact Info |
      |------|------|--------------|
      |      |      |              |

   d. Therapists
      
      | Name | Role | Contact Info |
      |------|------|--------------|
      |      |      |              |

   e. Pharmacists
      
      | Name | Role | Contact Info |
      |------|------|--------------|
      |      |      |              |
f. Others

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Contact Info</th>
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2. Draft a purpose for your advisory council here (These should be your preliminary ideas about a purpose. The council members should be engaged to draft a purpose for the council so they own it):

- 
- 
- 

B. Next Steps for Starting a Council

1. What Stakeholders Want a Patient and Family Advisory Council?

   - Be specific. Those listed are examples.
   - a. Board of Directors:
   - b. Senior leaders:
   - c. Clinical service leaders:
   - d. Staff:
   - e. A blend of patients/family members who receive the following types of care:

2. Meeting Logistics

   - a. How might the group meetings be structured?
• Time of Day – ask patients and staff about times that work:

b. Meeting time – frequency (monthly, quarterly, etc.)

c. Meeting place – where:

d. Parking:

e. Refreshments:

3. What Support Does Your Advisory Council Need?

a. Staff co-liaison/co-leads (list names):

b. Secretarial – who might provide this?

c. Parking covered by?

d. Budget – Consider developing a budget to cover the following: (list dollar amount estimates, if possible)

   • Food/Beverages
   • Printing
   • Postage
   • Interpreter/translation services
   • Parking/Transportation
   • Childcare support (if needed)
   • Stipends for members (not all councils wish to have stipends)

4. Advisory Council Subcommittees

a. Some councils identify work that could be done by a subgroup of the council. They will do the work and bring their plans to the council for input and sometimes, approval. Are there any subcommittees that you might need or wish to have? Examples are:
Patient-and-Family-Centered Care: A Key Element in Improving Quality, Safety, Perception of Care, and Care Outcomes

5. Operating Guidelines
   a. Draft a set of bylaws or operating guidelines might be provided for those putting the council together. They need to be tailored by your advisory council to the needs of the council.

   b. What do you want included in the guidelines?

6. Membership
   a. Number of council members.
      - Patient and family members (suggest 12 – 15)
      - Staff members (suggest 4)

   b. Member terms – define the number of years you expect someone to commit as a member (both staff and patient/family members).
      - Example: 50/50 mix of 1 year and 2 year terms

   c. Attendance expectations – define how often you expect members to attend.
      - Example: 75% of meetings or 3 out of 4 meetings/year.

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7. Recruitment – Where and how you find members for the advisory council

a. Where will you maintain the list of potential advisors for the advisory council and other collaborative initiatives? It is wise to maintain a computerized database of names, addresses, interests, etc. so you can easily track additional patients and family members who become involved.

b. Sources/contact persons for the recruitment of patient and family advisors.

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<th>Name</th>
<th>Role</th>
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</table>


7. Selection of Members

a. Selection criteria to consider:

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Able to listen to differing opinions and share different points of view.

Positive and supportive of the mission of the hospital.

Share insights and information about their experiences in ways that others can learn from them.

See beyond their own personal experiences.

Show concern for more than one issue or agenda.

Respect the perspectives of others.

Speak comfortably in a group with candor.

Interact well with many different kinds of people.

Work in partnership with others.

List other criteria you will use:

- Diagnosis - have a variety of diagnoses dependent on the purpose of the council:
- What services have the patients and family members used:
- Diversity of backgrounds:

9. Orientation of Advisory Council Members

Many new members may never have served on a council or participated in collaborative projects with health care staff. Preparation and support are key factors to success.

a. Advisory Council Specific Orientation may include:

- Participant introductions.
- The hospital's history, mission and values.
- Overview of facilities and services.
- Brief presentations by administrators or other key persons.
- Brief presentations by family leaders who have served as council members or in other advisory roles.
- The role of the council.
- Roles and responsibilities of officers, staff liaison, family members, and staff members.
- Overview of a typical meeting structure – minutes, committee reports, typical agenda.
- Practical details – where to park, what to wear, what to bring to meetings.
- Attendance expectations.
C. Maintaining and Ensuring Success with Your Advisory Council

1. Tracking accomplishments

   a. How will you track your advisory council accomplishments?
      - Specific goals defined and achieved.
      - Minutes.
      - Agenda planning with clear closure transition at the end of each meeting.
      - Good attendance at meetings.

   b. Celebrating success is a way to sustain a council. List ways you might celebrate successes.
      - Celebratory and acknowledgement activities should be provided with genuine feeling, match accomplishments, and be meaningful to persons involved.
      - Thank you’s at meeting when appropriate.
      - Small token gift at the end of a member’s term.

2. Planning for Barriers and How to Overcome Them

   a. What barriers do you expect to encounter with establishing and maintaining your advisory council? List barriers and possible strategies to overcome them:
3. Agenda Ideas for Your First 2-3 Council Meetings

4. Timeline

<table>
<thead>
<tr>
<th>Activity</th>
<th>Targeted Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Initial Steps for Starting a Council</td>
<td></td>
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<tr>
<td>2. Next Steps to Starting a Council</td>
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<tr>
<td>Meeting logistics</td>
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<tr>
<td>Membership</td>
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<tr>
<td>Recruitment</td>
<td></td>
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<tr>
<td>Selection of Members</td>
<td></td>
</tr>
<tr>
<td>Plans Developed for Preparing and Supporting New Council Members</td>
<td></td>
</tr>
<tr>
<td>Project Dates for First Council Meeting</td>
<td></td>
</tr>
<tr>
<td>3. Maintaining and Ensuring Success with Your Advisory Council</td>
<td></td>
</tr>
<tr>
<td>Tracking Accomplishments</td>
<td></td>
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<tr>
<td>Planning for Barriers</td>
<td></td>
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</tbody>
</table>
Application Form for Patient and Family Advisors

APPLICATION FORM FOR PATIENT AND FAMILY ADVISORS

Please print:

Name: ________________________________

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: _____________________

Will you allow your contact information to be shared with other committee/advisory council members? □ Yes □ No

I am: □ A patient. □ A family member of a patient.

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

□ Hospitalization (inpatient) □ Emergency Department care

□ Clinic visit (outpatient) □ Other programs, departments, or services

□ Both inpatient and outpatient

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

□ 2006 to current year □ 2004-2005 □ 2002-2003 □ 2001 or before

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

□ AIDS AND HIV □ Gastroenterology/GI □ Orthopaedic

□ Autoimmune □ Genetics and/or Birth Defects □ Pregnancy, Childbirth and Infant Care

□ Blood and Lymphatic Defects □ Intensive Care Unit (ICU) □ Rehabilitation

□ Cancer □ Infectious Diseases □ Skin and Connective Tissues

□ Cardiology □ Mental Health □ Surgery

□ Chest/Pulmonary □ Nephrology/Kidney □ Transplant

□ Ear, Nose and Throat □ Neurology □ Urology

□ Endocrinology/Diabetes □ Nutrition □ Other ____________________________

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Why would you like to serve as an advisor?

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

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 was 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 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:

APPLICATION FORM FOR PATIENT AND FAMILY ADVISORS

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Patient-to-Family Support: Questions to Ask

FAMILY-TO-FAMILY SUPPORT: QUESTIONS TO ASK

When families who have similar needs and issues share experiences, information, concerns, and strategies with each other, they find essential comfort and support and learn new ways of coping. The following questions offer a framework for thinking about how to facilitate family-to-family support in hospitals.

Do we...

▼ Routinely offer families opportunities to meet and talk with other families sharing similar experiences?
▼ Routinely offer opportunities for family-to-family support to all family members:
  • Mothers?
  • Fathers?
  • Brothers and sisters?
  • Grandparents and other extended family?
In a variety of settings:
  • In NICUs and PICUs?
  • In inpatient units?
  • In outpatient clinics?
  • Through referrals to community-based support groups and statewide or national family-to-family networks?
▼ Ensure that family-to-family support is available to families in their preferred language?
▼ Ensure that families are involved in developing peer support programming for the unit, clinic, or hospital?
▼ Hire family members to staff to coordinate and facilitate family-to-family support?
▼ Ensure that training is offered to families who wish to provide peer support?
▼ Offer families opportunities to communicate with each other in a variety of ways:
  These may include:
  • In-house family-to-family newsletters
  • Phone networks
  • Social gatherings such as “coffee hours” or pizza nights
  • Spaces in the hospital for informal conversations, such as outdoor areas and family lounges
  • Family-to-family bulletin boards
  • Access to computers and email
▼ Provide space and logistical support including child care and transportation for family support groups who want to meet?
▼ Encourage families to build linkages with community-based support and advocacy organizations?
▼ Help organize information exchanges or resource fairs in the hospital or in the community?

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109
**Are Families Considered Visitors in Our Hospital or Unit?**

In advancing the practice of family-centered care—changing the concept of families as visitors and recognizing families as partners in the care of patients—it is important to examine staff practices and the infrastructure of a hospital to determine how well family presence and participation is supported. This checklist may be useful in understanding current policies and practices and prioritizing action steps for a plan for change.

<table>
<thead>
<tr>
<th>Philosophy of Care</th>
<th>Yes</th>
<th>No</th>
<th>Perceived Priority for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the philosophy of care statement to the hospital or unit acknowledge the importance of families to the care and comfort of patients?</td>
<td>☐</td>
<td>☐</td>
<td>1</td>
</tr>
<tr>
<td>Were patients and families involved in developing the philosophy of care statement?</td>
<td>☐</td>
<td>☐</td>
<td>1</td>
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<table>
<thead>
<tr>
<th>Policies</th>
<th>Yes</th>
<th>No</th>
<th>Perceived Priority for Change</th>
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</thead>
<tbody>
<tr>
<td>In written policies, is there an acknowledgment of varied family structures and composition, and an acknowledgment of a patient's right to self-define family?</td>
<td>☐</td>
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<td>1</td>
</tr>
<tr>
<td>In written policies, is there a distinction made between families (however family is defined by the patient) and visitors, those friends, colleagues, or distant relatives who may wish to visit the patient or the patient's family?</td>
<td>☐</td>
<td>☐</td>
<td>1</td>
</tr>
<tr>
<td>Are policies regarding family presence and participation written as guidelines to foster flexibility and the individualization of staff practices to each patient's priorities and preferences?</td>
<td>☐</td>
<td>☐</td>
<td>1</td>
</tr>
<tr>
<td>Do hospital or unit guidelines (or policies) welcome families 24 hours a day, even during rounds, shift changes, a code, or emergency situations?</td>
<td>☐</td>
<td>☐</td>
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This checklist has been adapted from other self-assessment inventories developed by the Institute for Family-Centered Care. Additional checklists are included in each of the Best Practice Series publications produced by the Institute for Family-Centered Care.

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### Environment and Design

**Are first impressions of the hospital and each of its clinical areas welcoming to families?**

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<th>Yes</th>
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**Is the signage in the unit and throughout the hospital?**

- Welcoming to families?
- Worded positively and respectfully?
- Written in languages and at a reading level understandable to families served?

**At the bedside and in inpatient and outpatient treatment areas, is there:**

- Comfortable seating for families?
- Adequate space for family presence?
- Adequate space for family members to provide care?
- Adequate space for staff to work with families present?

**In inpatient settings, do families have access to:**

- Comfortable sleeping arrangements in the patient’s room?
- Secure storage space for personal belongings?
- Showers?
- Food storage areas? (refrigerator/cabinet)
- Food preparation areas?
- Laundry facilities?
- Computer/Internet access?

---

**Are families considered visitors in our hospital or unit?**

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### Patterns of Care/Collaboration in Caregiving

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<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Perceived Priority for Change</th>
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<tbody>
<tr>
<td>Do patients and families have access to:</td>
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<tr>
<td>• Gardens and outdoor spaces?</td>
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<td>• Places for spiritual support?</td>
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<td>Is there space for young children visiting a family member to play safely?</td>
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<td>Do staff members view families as key participants or partners in care?</td>
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<tr>
<td>Do staff practices encourage the patient to define their family and how</td>
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<tr>
<td>family members will be involved in care and decision-making?</td>
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<tr>
<td>Do staff members welcome families 24 hours a day, including during:</td>
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<td>1 2 3</td>
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<tr>
<td>• Admissions?</td>
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<td>• Rounds?</td>
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<td>• Change of shift report?</td>
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<td>• Treatments and procedures?</td>
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<tr>
<td>• Anesthesia induction and post-anesthesia?</td>
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<td>• Resuscitation?</td>
<td></td>
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<tr>
<td>Do staff members:</td>
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<tr>
<td>• Recognize and support the strengths and competencies of all families?</td>
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<td>• Support families as full members of the health care team?</td>
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<tr>
<td>• Offer family members training and practice in new care skills?</td>
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<tr>
<td>• Respect family choices regarding how they wish to participate in the</td>
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<tr>
<td>care of their loved one?</td>
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<tr>
<td>Are the concerns, priorities, and needs of families elicited and respected in the care planning process?</td>
<td>Yes</td>
<td>No</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Do documentation procedures/forms obtain information about the family's strengths, preferences, concerns, and goals for their family member?</td>
<td>Yes</td>
<td>No</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Do patients and families have the opportunity to participate in discussions relating to care, discharge planning, and transitions to new settings?</td>
<td>Yes</td>
<td>No</td>
<td>1 2 3</td>
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### Information and Decision Making

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<th>Question</th>
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<th>Perceived Priority for Change</th>
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<tbody>
<tr>
<td>Does all written information given to patients and families (including pre-admission packet, patient/family handbook) express the belief that patients and their families are viewed as members of the health care team?</td>
<td>Yes</td>
<td>No</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Do families receive the information they need and want regarding their family member and his or her care?</td>
<td>Yes</td>
<td>No</td>
<td>1 2 3</td>
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</tbody>
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<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Perceived Priority for Change</th>
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<tbody>
<tr>
<td>Do patients and family members have the opportunity to share insights, observations, and questions:</td>
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<tr>
<td>• In the patient’s chart?</td>
<td>☐</td>
<td>☐</td>
<td>1 2 3</td>
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<tr>
<td>• During rounds and other discussions regarding care?</td>
<td>☐</td>
<td>☐</td>
<td>1 2 3</td>
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<tr>
<td>• With individual care providers?</td>
<td>☐</td>
<td>☐</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Do patients and families collaborate with the nursing staff in the development of the nursing care plan?</td>
<td>☐</td>
<td>☐</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Is there continual open and honest communication between families and professionals about medical, psychosocial, and ethical issues relevant to the patient and family?</td>
<td>☐</td>
<td>☐</td>
<td>1 2 3</td>
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<td>Does the hospital provide access to and support families in using:</td>
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<tr>
<td>• A patient and family resource library?</td>
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<td>☐</td>
<td>1 2 3</td>
</tr>
<tr>
<td>• The medical library?</td>
<td>☐</td>
<td>☐</td>
<td>1 2 3</td>
</tr>
<tr>
<td>• A skills training lab for learning and practicing care procedures?</td>
<td>☐</td>
<td>☐</td>
<td>1 2 3</td>
</tr>
<tr>
<td>• The Internet (in the patient’s room and the resource center)?</td>
<td>☐</td>
<td>☐</td>
<td>1 2 3</td>
</tr>
<tr>
<td>• Educational resources in audiovisual and other media formats?</td>
<td>☐</td>
<td>☐</td>
<td>1 2 3</td>
</tr>
<tr>
<td>Is information made available to families in the language and formats (verbal, written, other) they can use most comfortably?</td>
<td>☐</td>
<td>☐</td>
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**Family Support**

Does the staff involve the patient and family in identifying visiting preferences, such as:

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<th>Perceived Priority for Change</th>
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<tbody>
<tr>
<td>• Other family members and close friends who will support them?</td>
<td>☐</td>
<td>☐</td>
<td>1 2 3</td>
</tr>
<tr>
<td>• Sibling or child visitation?</td>
<td>☐</td>
<td>☐</td>
<td>1 2 3</td>
</tr>
<tr>
<td>• Preferences regarding frequency and timing of visiting by others?</td>
<td>☐</td>
<td>☐</td>
<td>1 2 3</td>
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Are young children offered developmentally appropriate preparation and support for visiting a hospitalized family member?

Are financial supports offered to families to increase the amount of time they can spend with their family members, such as:

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<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Perceived Priority for Change</th>
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</thead>
<tbody>
<tr>
<td>• Parking?</td>
<td>☐</td>
<td>☐</td>
<td>1 2 3</td>
</tr>
<tr>
<td>• Meals?</td>
<td>☐</td>
<td>☐</td>
<td>1 2 3</td>
</tr>
<tr>
<td>• Transportation?</td>
<td>☐</td>
<td>☐</td>
<td>1 2 3</td>
</tr>
<tr>
<td>• Nearby lodging?</td>
<td>☐</td>
<td>☐</td>
<td>1 2 3</td>
</tr>
<tr>
<td>• Supervised childcare services at the hospital?</td>
<td>☐</td>
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<tr>
<td>Are means provided for family members to keep in touch with staff when they are not on the unit (e.g., beepers, telephones, teleconferences, e-mail, personalized Web sites)?</td>
<td>Yes</td>
<td>No</td>
<td>Perceived Priority for Change</td>
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<tr>
<th>Are emotional supports offered to families, such as:</th>
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<tr>
<td>Social worker or counselor?</td>
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<tr>
<td>Chaplains or other clergy?</td>
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<tr>
<td>Family-to-family support?</td>
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<td>Community support groups?</td>
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<tr>
<th>▼ Patients and Families as Advisors</th>
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<tbody>
<tr>
<td>Is there a systematic procedure for gathering information about patient and family satisfaction with policies and practices related to family presence and participation?</td>
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</table>

Are patients and their family members involved in:

| • Developing, implementing, and evaluating policies, programs, practices, and facility design relevant to family presence and participation? | ☐ | ☐ | 1 2 3 |
| • Responding to and finding solutions for concerns and suggestions about family presence and participation shared by other families? | ☐ | ☐ | 1 2 3 |
| • Developing, implementing, and evaluating quality improvement initiatives related to family presence and participation? | ☐ | ☐ | 1 2 3 |

Are patients and families involved in hospital/unit committees and workgroups focused on issues related to the experience of care? | ☐ | ☐ | 1 2 3 |

<table>
<thead>
<tr>
<th>▼ Personnel Practices</th>
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<tbody>
<tr>
<td>Are policies and practices in place that encourage recruiting and hiring individuals who are committed to working collaboratively with families?</td>
</tr>
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</table>

Do position descriptions and performance appraisals for staff clearly articulate the necessity of working in respectful and collaborative ways with patients and families? | ☐ | ☐ | 1 2 3 |

Are orientation and in-service programs offered for staff to develop skills relating to family presence and participation in care, and collaboration with families? | ☐ | ☐ | 1 2 3 |

Do patients and/or their family members participate as faculty in orientation and continuing education programs for staff, faculty, and trainees? | ☐ | ☐ | 1 2 3 |

Are there systems and supports in place to help staff during the process of change in policies related to family presence and participation? | ☐ | ☐ | 1 2 3 |

Are there systems and supports in place to help staff cope with challenges that may arise when working collaboratively with patients and families? | ☐ | ☐ | 1 2 3 |

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Patient- and Family-Centered Care: A Key Element in Improving Quality, Safety, Perception of Care, and Care Outcomes
Applying Patient- and Family-Centered Concepts to Bedside Rounds

The manner in which rounds are conducted is changing. Increasingly staff and faculty are including patients and families in the process of rounds. The following serve as guidelines for conducting rounds to accomplish a variety of purposes successfully within a context of respect and support for patients and their families.

▶ Develop practices for the process of rounds that respect privacy and confidentiality.

- Think through the definitions of privacy and confidentiality and the implications for rounds.

- In order to comply with HIPAA regulations especially when conducting rounds in semi-private or multi-bed rooms, a hospital or a clinical unit should have a written philosophy of care that acknowledges the importance of patient and family access to information and affirms that their participation in care planning and decision-making is essential to the best clinical outcomes and to quality, safe health care. This statement documents that patient and family participation in rounds is a standard operating procedure.

- The term “family” is broadly defined. Ask the patient at the beginning of a hospital stay to define his/her family and how they will be involved in care and decision-making. The patient should be asked to identify family members who should or should not be included in these discussions. For patients who are not able to participate in planning and decision-making, family members should be asked.

- In addition, at the beginning of a hospital stay, ask the patient and family if there are key issues that should be protected.

- Include information about the hospital's policy regarding patient and family participation in rounds on routine consent forms. This provides an opportunity to encourage patients and families to take an active role in their health care and to tell them of the possibility of incidental disclosures.

- Consider adaptations in the configuration of the unit or patient rooms that might enhance privacy.

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Patient- and Family-Centered Care: A Key Element in Improving Quality, Safety, Perception of Care, and Care Outcomes

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- Structure the format and setting for planning and teaching clinical care so that bedside rounds are used in a way that addresses the needs and priorities of all constituencies—patients, families, staff, physicians-in-training, and faculty. Separate “sit down” rounds or other teaching formats may be more appropriate for some aspects of education and daily communication about patients and, thus, can be targeted more specifically for students and residents.

- Decide and clarify whether this is the primary time for the patient or family to ask questions and obtain information.
  - If this is not the primary time for this communication, determine the alternatives.
  - If this is the primary time for communicating with patients and families, consider the timing of rounds and its convenience to families.

- Consider the process of rounds as an opportunity to model open communication and clear and supportive language with patients, families, and health professionals from all disciplines.
  - Set a tone from the beginning that everyone is a learner.
  - Avoid language that is patronizing ... “my unit ...”
  - Convey respect for the individuality, capacities, and vulnerability of each patient.
  - Convey respect for patients and families and recognize them as members of the care team. Include them in the rounding process. Affirm the positive contributions that patients and families can make to care planning and decision-making.
  - Do not use a family’s participation in rounds as a way to evaluate “family involvement.”

- Briefly explain the purpose of rounds to the patient and family—clarifying whether the purpose is primarily teaching or the coordination of clinical care or both.
  - In addition, at the time of admission, have staff or patient/family advisors prepare patients and families for the way that rounds are done. Written or audiovisual materials may be helpful as well.
  - With the primary purpose of the rounds clear, choose the appropriate language, topics, and level of detail to use at the bedside.
• Greet the patient and family upon entering the room. When necessary, remind students and professionals-in-training to greet the patient and family.

• In discussions with the rounding team, refer to the patient or family by name, rather than as a disease, or a room number, or Mom or Dad. Avoid discussing the patient in the third person—this 63-year-old patient...."

• When the patient’s condition permits, help the patient in bed to be at eye level with the rounding team.

• Ask for insights and observations from the patient, when the patient’s condition permits, and from the family. These questions could relate to the patient’s condition and treatment or they could focus on other kinds of issues, such as their experiences at the hospital and any suggestions for improvement.

• When examining the patient during rounds, ask the patient and/or family if this is an appropriate time.

• Provide patients and families with an opportunity to debrief or process what they have heard on rounds.

• When leaving, ask if the patient or family have questions. If they do, either respond to them then or have a plan as to how to respond to them later.

▼ Choose language that sets the tone for partnership.

• Introducing the concept of rounds as part of the admission process:

  During your hospital stay, Mrs. Brown, doctors, nurses, and other health care providers spend time together as a team to plan and coordinate your care. You and, if you wish, your family are a very important part of this team. We call this process “rounds.” You can decide how you will be involved in rounds, and if there are sensitive issues that we should not discuss in your room.

  Rounds is a time for you to receive and share information about your care. It is not the only time that you can talk with us about your care.

  Rounds is sometimes a time for teaching residents and students. You can help us in teaching.

  Rounds is a time of learning for everyone. You will learn things about care. You can ask that the teaching time be limited if you wish. Sometimes teaching rounds involves a physical exam. You can also ask for this exam to be delayed or limited.
Sometimes doctors make rounds very early, around 6 a.m. Do you want to be awakened? If you wish to sleep, you can leave us a note with questions or with information that you would like us to have.

Are there family members or a friend who you would like to be with you during rounds or spend time with you in the hospital and help you when you go home?

You and your family are very important members of your health care team … partners in care and decision-making. Your observations, concerns, and preferences will help us make the best decisions together.

We have shared rooms on this unit. We ask all of our staff and doctors, as well as our patients and families to respect the privacy of each patient. You may hear things about other patients during your hospital stay. We ask you to respect their privacy as we try to respect yours.

* Suggestions for the conversation during bedside rounds:

Good morning, Mrs. Brown. Mr. Brown we are glad you are here today. I am Dr. James, the doctor following Mrs. Brown’s care. There are other members of the team who will introduce themselves … I am Susan Blake, the unit nurse manager; I am Dr. Hernandez, the resident; I am Christine Wor, the medical student; I am Dr. Jenkins, the attending doctor; and we have already met, I am Meredith, the nurse who will be taking care of you today.

We are going to talk now about the changes that were made yesterday and you can help us understand how things went and how you are feeling today. Before we begin, do you have any concerns and worries that you want us to discuss first.

Mrs. Brown, you are a 68-year-old woman, who was admitted three days ago with pneumonia and high blood pressure. You have had a fever for the last 24 hours. You are receiving 2 liters of nasal oxygen and IV Ceftriaxone to treat your pneumonia. How is your breathing today? We have added a new medication for your blood pressure…Benzapril. Have you noticed any difference since you started taking Benzaepril?

Yesterday we stopped giving you extra IV fluids. Are you eating and drinking now? You have been getting a regular diet. Is that correct, Mrs. Brown?

Let’s review the plan for the day. You will be getting a chest x-ray. We will wean you off the oxygen. Let us know if you get short-winded or have trouble breathing.

**APPLYING PATIENT- AND FAMILY-CENTERED CONCEPTS TO BEDSIDE ROUNDS**
Mrs. Brown, we think you may be able to go home tomorrow. As we discussed earlier this week, we want to see that your temperature stays down, and that you are comfortable without oxygen before you go home. Let’s see how you do today without the nasal oxygen. Tell your nurse how you feel when you walk to the bathroom. Have you ever had a pneumonia? It will be important for you to have this vaccine before you go home to prevent pneumonia in the future. We will also make plans for you to follow-up with your regular physician to make sure that you are doing well.

Have we addressed your worries and concerns? Are there goals that you would like to accomplish before you go home?

Were there any glitches in care yesterday? Any ways that we could have improved care?

In teaching rounds: Thank you for helping with our teaching process OR Thank you for letting our medical student listen to your lungs.

If the patient or family asks many questions or a question requiring a response that will take considerable time, one possible response is: That is a really good question that will take more time than I have right now. I can come back when we finish rounds about 9:30. Will that work for you? OR A nurse or one of the other physicians will come back and discuss this issue with you.

Resources

For the most recent references on this topic, please see the Bedside Rounds Bibliography in the Institute’s Compendium of Bibliographies at http://www.ipfcc.org/ advance/supplementing.html. Additional resources for applying patient- and family-centered care concepts to rounds are available from the Institute for Patient- and Family-Centered Care and include the following:

For information about HIPAA and patient and family participation in rounds, see the summer 2004 issue of Advances in Family-Centered Care, “Responding to HIPAA: Hospitals Confront New Challenges, Devise Creative Solutions.” One of the articles in this issue, “HIPAA-Providing New Opportunities for Collaboration,” is available on the Institute’s website at http://www.ipfcc.org/ advance/hipaa.pdf

The video, Patient- and Family-Centered Rounds, presents interdisciplinary teaching rounds at the VA Medical Center in Atlanta, Georgia. It follows an intern who is presenting in a collaborative manner at the bedside with the patient for the first time. The video captures concepts important to transition planning for this patient who has a serious chronic condition and the perceptions of the patient and the staff about the collaborative rounds process.

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Patient- and Family-Centered Care: A Key Element in Improving Quality, Safety, Perception of Care, and Care Outcomes
The video, **Collaborative Rounds in Cardiology**, presents a non-hierarchical process for including adult patients, families, and staff and physicians from a variety of disciplines in the rounds process. In addition to portraying collaborative care planning, a model for identifying problems and solutions is shared.


The video, **Partnerships with Families in Newborn Intensive Care: Enhancing Quality and Safety**, highlights how family-centered concepts can be integrated within a NICU, beginning with a philosophy of care developed collaboratively by families, staff, and faculty. Family participation in rounds is featured along with other collaborative endeavors. This video won first place in the “Working Together” category of the 2003 Dartmouth Clinical Microsystems Film Festival.

The video, **Newborn Intensive Care: Changing Practice, Changing Attitudes**, has two discrete segments titled “A Neonatologist’s Thoughts” and “Rounds.”

**Parent Participation in Rounds: The Reflections of a Pediatric Intensivist** is a 9-minute video that captures the perspectives of the former Director of Pediatric Intensive Care at the Children’s Hospital at Dartmouth for including parents in rounds in a PICU. It describes his change in practice, potential benefits, the value of parent observations and learning from parents, and the importance of collaboration to formulation of the accurate “patient story.”

The above videos are available through the Institute for Patient- and Family-Centered Care, at www.ipfcc.org.

Selected References:


Additional resources:

Cincinnati Children’s Hospital Medical Center has implemented family-centered rounds and serves as a national leader in helping organizations and physicians in adopting this practice: [http://www.cincinnatichildrens.org/professional/referrals/patient-family-rounds/default/](http://www.cincinnatichildrens.org/professional/referrals/patient-family-rounds/default/)

*Navigating Patient- and Family-Centered Rounds: A Guide to Achieving Success* is available from the Georgia Health Sciences University Center for Patient- and Family-Centered Care in Augusta at: [http://georgiahealth.edu/centers/cpftcc/FFCCRoundsGuidebook.html](http://georgiahealth.edu/centers/cpftcc/FFCCRoundsGuidebook.html)

The Institute for Patient- and Family-Centered Care developed a section of its website, "Supporting Family Presence and Participation," to highlight health care systems, providers, and patient and family leaders who are changing the concept of families as visitors. Sample articles from the literature, policies, procedures, and guidelines are included. Visit [www.ipfccc.org/advance/topics/family-presence.html](http://www.ipfccc.org/advance/topics/family-presence.html).
## Appendix B: Additional Resources

<table>
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<tr>
<th>Resources from Institute for Patient- and Family-Centered Care</th>
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<tbody>
<tr>
<td>• A Patient and Family Advisory Council Work Plan: Getting Started</td>
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<tr>
<td>• A Patient and Family Resource Center: Some of the Benefits</td>
</tr>
<tr>
<td>• Advancing the Practice of Patient- and Family-Centered Care in Hospitals: How to Get Started</td>
</tr>
<tr>
<td>• Applying Patient and Family Centered Concepts to Bedside Rounds</td>
</tr>
<tr>
<td>• Are Families Considered Visitors in Our Hospital or Unit?</td>
</tr>
<tr>
<td>• Partnering with Patients and Families to Enhance Safety and Quality: A Mini Toolkit</td>
</tr>
<tr>
<td>• Personnel Practices to Advance the Practice of Patient- and Family-Centered Care: A Self-Assessment Inventory</td>
</tr>
<tr>
<td>• Profiles of Change</td>
</tr>
<tr>
<td>• Staff Liaison to Patient and Family Advisory Councils and Other Collaborative Endeavors</td>
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<tr>
<td>• Strategies for Leadership: A Hospital Self-Assessment Inventory</td>
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### Other Patient and Family Engagement Resources

- **Achieving an Exceptional Patient and Family Experience of Inpatient Hospital Care**—A report developed by the Institute for Healthcare Improvement that identifies five primary drivers and fifteen secondary drivers of patient and family experience

- **Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals**—A report by The Joint Commission that contains recommendations for how to improve care in various components of the care continuum, including admissions, assessment, and discharge

- **Guide to Patient and Family Engagement in Hospital Quality and Safety**—A guidebook from the Pennsylvania Health Care Quality Alliance that contains information on working with patients and families as advisors, communicating to improve quality, nurse bedside shift reporting, and IDEAL discharge planning

- **Guidelines for Using Patient Stories with Boards of Directors**—Governance tool from the Delnor-Community Hospital

- **How-to Guide: Governance Leadership (Get Boards on Boards)**—Governance tool from the Institute for Healthcare Improvement

- **Patient-Centered Care Improvement Guide**—A guide that includes a crosswalk of patient-centered strategies for HCAHPS improvement categorized by domain

- **Patient-Centered Care: What Does It Take?**—A report that identifies seven key organizational factors that contribute to patient-centered care

- **Post-Discharge Tool**—Point of care tool from the National Patient Safety Foundation

- **Strategies for Leadership—Patient- and Family-Centered Care**—A toolkit developed by the American Hospital Association in collaboration with the Institute for Patient and Family-Centered Care

- **Your Discharge Planning Checklist: For patients and their caregivers preparing to leave a hospital, nursing home, or other care setting**—Point of care tool from U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services
<table>
<thead>
<tr>
<th>HCAHPS</th>
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<tr>
<td>• <strong>Health Care Leader Action Guide to Effectively Using HCAHPS</strong> — A guide that identifies how HCAHPS data should be used</td>
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<tr>
<td>• <strong>Information About Hospital Value-Based Purchasing</strong> — CMS website that provides information about the Hospital Value-based Purchasing Program for hospitals, clinicians, and other stakeholders</td>
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<tr>
<td>• <strong>HCAHPS Online</strong> — The HCAHPS website that houses a series of tables, including a summary of HCAHPS survey results by state; an HCAHPS percentiles tables; and an HCAHPS hospital characteristics comparison chart</td>
</tr>
<tr>
<td>• <strong>The Beryl Institute</strong> — A website that includes resources and benchmarking studies on improving the patient experience</td>
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<tr>
<td>• <strong>LEP Patients</strong> — Information about Title VI compliance and developing language access plans for patients with limited English proficiency (LEP)</td>
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