Attachment B

Component 1:

Hospital-Stay Active Involvement Materials

Component 1

Strategy 1:

Communication Packet:

Communicating to Improve Quality

Strategy 1

Communicating to Improve Quality

Implementation Handbook

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The *Guide to Patient and Family Engagement in Hospital Quality and Safety* (the *Guide*) is a resource to help hospitals develop effective partnerships with patients and family members, with the ultimate goal of improving hospital quality and safety.[1]

Communication between the patient, family, and clinicians is a critical component of high quality, safe care, and the foundation of partnerships between the patient, family, and clinicians. The *Communicating to Improve Quality* strategy and its tools help facilitate this communication.

This handbook gives you an overview of and rationale for the strategy. It also provides step by step guidance to help you put this strategy into place at your hospital.

Overview of the Communicating to Improve Quality Strategy

The goal of the *Communicating to Improve Quality* strategy is to facilitate communication between the patient, family, and clinicians to improve patient safety and the quality of care.

Hospitals distribute three tools to the patient and family upon admission or prior to admission to help them understand opportunities that exist for engagement, how to be a partner in their care, and the roles of the different members of their health care team. The bedside nurse will review the materials with the patient and family on the first day of admission.

All clinicians reinforce the principles of effective communication throughout the patient's hospital stay. Tools are available to help hospitals train, observe, and provide feedback to clinicians on core communication competencies that reinforce the principles of effective partnerships.

What are the Communicating to Improve Quality tools?

This section provides an overview of the tools included in this strategy.

Tool	Use this tool to…	Description and formatting
Tool 1 **Be a Partner in Your Care**	Inform the patient and family of scheduled opportunities where they can interact with the health care team.	• This handout gives information on routine events and highlights tools the hospital uses to talk with the patient and family (e.g., white boards). • Format: 1-page handout

Tool	Use this tool to…	Description and formatting
Tool 2 **Tips for Being a Partner in Your Care**	Help the patient and family know how to interact with the health care team.	• This handout describes four tips for being a partner: (1) tell doctors and nurses about their health, (2) check to see if they understand what doctors and nurses say, (3) ask questions until they understand the answers, and (4) let health care staff know which friends and family members should be involved in their care. • Format: Tri-fold brochure
Tool 3 **Get to Know Your Health Care Team**	Help the patient and family understand the roles of different members of the health care team.	• This handout gives information on the different members of the health care team: the patient, family, clinicians and hospital staff. • Format: 2-page handout
Tool 4 **We Are Partners in Your Care**	Remind the patient, family, and clinicians the importance of being partners and what they can do.	• Designed to be posted in patient rooms or elsewhere in the hospital, this flyer summarizes the main action items from the other handouts for the patient, family, and clinicians. • Format: Poster/ flyer
Tool 5 **Communication Competencies for Clinicians**	Establish a set of behaviors to invite and support the patient and family as members of the health care team.	• Given to clinicians individually with verbal description or as a handout during the clinician training, this overview and checklist highlight behaviors that invite and support the patient and family to engage in their care. • Format: 2-page overview with 1-page observation form checklist
Tool 6 **Communication Training**	Prepare clinicians to support the efforts of patient and family engagement related to communication.	• This training could be interprofessional, coled by a physician, nurse, and patient and family advisors to a group of clinicians, who may also include other professionals besides physicians and nurses. • Format: PowerPoint presentation slides and talking points

Rationale for the Communicating to Improve Quality Strategy

The goal of patient and family engagement is to create an environment where patients, families, clinicians, and hospital staff all work together as partners to improve the quality and safety of hospital care. Patient and family engagement encompasses **behaviors** by patients, family members, clinicians, and hospital staff as well as the **organizational policies and procedures** that support these behaviors.

Why is communication important?

Communication is the foundation of partnerships between the patient, family, and clinicians, and affects the safety and quality of care received during the hospital stay. Effective communication can improve:

- **Patient outcomes.** In a review of the literature, Roter found that patient-centered care, realized through effective communication, had a positive effect on patient outcomes – specifically, emotional health, symptom resolution, functioning, pain control, and physiologic measures such as blood pressure and blood sugar levels.(1)
- **Patient safety.** One study found that more than 70 percent of adverse events are caused by breakdowns in communication among caregivers and between caregivers and patients.(2) Studies show that patients who are informed and engaged can help improve safety through "informed choices, safe medication use, infection control initiatives, observing care processes, reporting complications, and practicing self-management."(3, 4)
- **Perceptions of quality.** Research has demonstrated that patient and family members' perceptions of quality are influenced by their perceptions of their interpersonal interactions with clinicians and hospital staff. Clinicians who are perceived to be responsive, empathetic, and attuned to patients' needs are judged to be of higher quality by patients than clinicians who are perceived to be less responsive and empathetic, even if the clinical care provided is the same.(5-7)

How does the Communicating to Improve Quality strategy facilitate communication?

The *Communicating to Improve Quality* strategy identifies effective communication behaviors for patients, families, and clinicians that are the foundation for partnerships throughout the hospital stay. The strategy supports behavior change through individual tools. Specifically, the tools in this strategy:

- Invite the patient and family as full partners in their care at admission or prior to admission, setting expectations for the entire hospital stay.

- Give the patient and family background information about the hospital environment.
- Describe specific behaviors that the patient and family can do as a part of the team.
- Describe specific communication competencies for clinicians to invite and support the patient and family as partners of the health care team. These competencies are expected of all clinicians at the hospital.

(Placeholder for examples from Task 7, Implementation and Evaluation in this section in the form of patient/family/staff quotes or a case study.)

Implementing Communicating to Improve Quality

(NOTE: This is a section where we will want to incorporate information from the Task 7 Implementation and Evaluation. We will also be able to provide more specific guidance about what worked and what did not work.)

The *Communicating to Improve Quality* strategy is designed to be flexible and adaptable to each hospital's environment and culture. As such, this guidance provides choices and questions for hospital leaders about how to implement this strategy. It may be helpful to implement this strategy initially on a small scale (for example, on a single unit). After identifying lessons learned from the single-unit implementation, you can refine your approach and spread it to more units. This allows you to build on your successes as a pathway to broader dissemination and wider-scale change.

Step 1: Form a multi-disciplinary team to identify areas for improvement

As with any new activity or quality improvement effort, planning and identifying areas of improvement are important parts of the process. Below are some key considerations as you get started implementing the *Communicating to Improve Quality* strategy.

Engage patients, families, and unit staff in the process: Establish a multi-disciplinary team

A multi-disciplinary team includes hospital leaders, physicians, nurses, other key clinical and management staff, and patient and family advisors.

***Guide* Resource**	For more information about working with patient and family advisors, see *Component 2, Implementation Handbook: Organizational Partnership Materials*

Throughout the process of implementing the *Communicating to Improve Quality* strategy, patient and family advisors can:

- Give feedback on what the current admission process, communication, and overall hospital stay feel like as a patient or family member.
- Help adapt the strategy and tools for your hospital.
- Take part in training clinicians about the *Communicating to Improve Quality* strategy by participating in role plays or other small group exercises or by describing how it feels to be the patient or family in your hospital.
- Observe clinicians throughout hospital stay and give feedback about how well they meet the key elements of the communication competencies.

Assess family presence or visitation policies

The family cannot be partners of the health care team if they are not present. It is important for patients to define who their family is and for the hospital to define policies that support the active involvement of families.

Guide **Resource**	For more information about family presence policies, see *Supporting Patient and Family Engagement: Best Practices for Hospital Leaders* (in the *Component 3* materials).

Assess existing admissions materials

Use the multi-disciplinary team to review information provided during current admission process from the provider, patient, and family perspective. What, if anything, happens during admission to engage patients and families in their care? How well does this process work? What information is given? Who gives the information? What are potential barriers or challenges within the unit when distributing these materials and expectations are set for the clinician behaviors, including organizational infrastructure or staff attitudes? What are some ways to overcome those challenges? What resources are available?

Assess communication between the patient, family, and clinicians

Use the multi-disciplinary team to review how things are going with respect to communication from the clinician, patient, and family perspectives, using both formal survey measures and people’s sense of what works or does not work. The team can identify strengths related to communication –what is done well? The team can also identify areas for improvement – what can be done better?

Improving communication may require new behaviors from each member of the health care team – the patient, family, and clinicians. Each team member brings a different perspective to the communication encounter, and understanding these perspectives is important for effective communication.

Keep in mind that taking on new behaviors will be challenging. Think about what challenges might be present in your environment as you decide how to use the tools in this strategy. The multi-disciplinary team can help identify challenges and facilitators for effective communication at your hospital or unit. What factors seem to support good communication? How can you replicate them? What are the challenges that need to be addressed from the clinician, patient, and family perspectives?

Below, are some examples of communication challenges for the patient, family, and clinicians. The tools in the *Communicating to Improve Quality* strategy were designed to help address these challenges.

Examples of communication challenges for the patient and family. Some patients and family members may already feel capable of being an active partner in their care. Other patients or family members may:

- ***Feel uncertain or intimidated about taking part in their care.*** Patients and family members may be unsure how to be involved or may feel intimidated by clinicians, hospital staff, and the health care system, overall.(8, 9) The patient and family especially may feel intimidated if clinicians use professional language or medical jargon.(10, 11)
- ***Need more information to be full partners in their care.*** Clinicians can help increase the patient and family's awareness and confidence in taking part in their care by giving them information about their condition and steps in their care regularly throughout the hospital stay. Information is most helpful when it addresses the patient and family's individual needs and concerns.(12)
- ***Need an invitation and reinforcement from clinicians.*** Although information is necessary, it is not sufficient to support behavioral change. The patient and family need clinician support and reinforcement to engage in their care. Patients are more likely to take part in their care when clinicians encourage them to ask questions, respond positively to the patient's needs and views, and give patients the information they need.(13-15)

Examples of communication challenges for clinicians. The more difficult challenges underlying this strategy are changing clinicians' communication styles and behaviors to invite and support the patient and family as full partners of the health care team. Some common challenges are:

- ***Clinicians may feel that their communications are already patient- and family-centered or may not know how to incorporate new communication approaches into their care.*** Clinicians may focus on the clinical aspects of quality of care, such as skills in diagnosing, treating, and obtaining positive clinical outcomes. Although many clinicians recognize the importance of communication as a component of quality, they tend to be

overly positive in their perceptions of how effectively they communicate.(16) Even when clinicians see the need for better communication and patient-centered care, it may be difficult to operationalize those skills in practice.(17)

- ***Professional culture and practice norms traditionally have emphasized technical skills over communication skills.*** Professional culture and practice norms have traditionally been based on individual autonomy, rather than teamwork and patient-centered practices.(18) Clinicians lack experience with models that encourage collaboration with the patient and family. Traditionally, professional schools (including medical schools and academic programs that train health care leadership) have offered limited or no emphasis on patient and family engagement.(19)
- ***Clinicians may be concerned about interacting with the family.*** Concerns associated with family presence include potential interference with treatment, medical risk (e.g., exposure to infections), or the emotional response of the family member.(20) Or, clinicians may be uncertain how to act when the patient and family want different approaches to treatment.

Identify ways to overcome these challenges at your hospital or unit. Are there particular units where it might be wise to pilot this new approach, either because of staff attitudes or because there is a pressing need to improve communication for a specific group of patients?

Set aims to improve communication

Once you have a strong understanding of the existing family presence policies, admissions materials, and communication challenges and facilitators, you can identify what needs to be improved and ways to measure that improvement.

Any quality improvement initiative requires setting aims. The aim should be time-specific, measurable, and define who will be affected. For example, hospitals may want to improve patients' experience of care as measured by the CAHPS® Hospital Survey. CAHPS® Hospital Survey questions related to communication include:

> For more information on setting aims and identifying measures, see the Institute of Healthcare Improvement's Web site on improvement methods. Available at: http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/.

- Q1: During the hospital stay, how often did nurses treat you with courtesy and respect?
- Q2: During this hospital stay, how often did nurses listen carefully to you?
- Q3: During this hospital stay, how often did nurses explain things in a way you could understand?
- Q5: During this hospital stay, how often did doctors treat you with courtesy and respect?

- Q6: During this hospital stay, how often did doctors listen carefully to you?
- Q7: During this hospital stay, how often did doctors explain things in way you could understand?
- Q14: During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?
- Q16: Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?
- Q17: Before giving you any new medicine, how often did the hospital staff describe possible side effects in a way you could understand?

If a hospital wants to improve their CAHPS® Hospital Survey scores related to physician communication, an aim might be "to improve scores on CAHPS® Hospital Survey Questions 5, 6, and 7 by 5 percent within 1 year."

Step 2: Decide how to implement the Communicating to Improve Quality strategy

Once the team has set specific aims for improvement, it is helpful to identify a single point person as the primary person staff would go to with questions. This person may not have the answers to all questions, but would be able to facilitate the process of getting answers. This way, people are clear about whom to go to, and that person will hear all the questions and concerns.

Then, the single point person can coordinate with the multi-disciplinary team to decide on how to use and adapt each of the tools in this strategy.

Decide how to use and adapt the tools for the patient and family

As described above, the *Communicating to Improve Quality* strategy includes three tools to be distributed to the patient and family at or prior to admission.

***Guide* Resources**	*Tool 1: Be a Partner in Your Care* informs the patient and family of scheduled opportunities where they can interact with the health care team. *Tool 2: Tips for Being a Partner in Your Care* helps the patient and family know how to interact with the health care team. *Tool 3: Get to Know Your Health Care Team* helps the patient and family understand the roles of different members of the health care team.

Answer the following questions to decide how to use and adapt the patient and family tools at your hospital:

- ***Adapt the patient and family tools to hospital needs***. At a minimum, you will need to insert your hospital name, logo, and tailored information into the patient and family tools. Do clinicians, hospital staff, or patient and family advisors recommend additional changes? If so, how will these changes be made? Who needs to review and approve the final tools?

- ***Determine how to distribute the patient and family tools***. Can the tools be integrated into current admissions process? If so, how? If not, how will the current process be changed? How will interpreters be involved in the distribution process, if needed? What approvals need to be sought?

  Once ready, how will the tools be printed? Will they be distributed in a folder, online, or another way? How can the messages from the tools be incorporated or distributed via different communication methods such as video, social media such as Facebook, or cell phone text messages?

- ***Identify staff to go over tools with the patient and family*.** What staff will go over the tools with patients and families? (We recommend that this be the bedside nurse on the day of admission.) If applicable, how will temporary staff learn about the communication competencies and distributing the tools to the patient and family?

Decide how to use and adapt the tools for clinicians

As described above, the *Communicating to Improve Quality* strategy includes two tools for clinicians.

***Guide* Resources**	*Tool 5: Communication Competencies for Clinicians* establishes a set of behaviors to invite and support the patient and family as members of the health care team. *Tool 6: Communication Training* prepares clinicians to support the efforts of patient and family engagement related to communication.

Answer the following questions to decide how to use and adapt the clinician tools at your hospital:

- ***Adapt the clinician tools to hospital needs***. What changes have been made to the patient and family tools that impact the clinician communication competencies or clinician communication training? Do clinicians, hospital staff, or patient and family advisors

recommend changes to the clinician competencies or training? If so, how will these changes be made? Who needs to review and approve the final tools?

- ***Plan the clinician training.*** Which physician(s) and nurse(s) can conduct the training for their colleagues? These training facilitators should be respected by their colleagues and model the behaviors being asked of them. Which patient and family advisors can help to conduct or facilitate the training? How many sessions are needed to train all staff? When can the training be scheduled? Where can the training happen?

  Recognize that communication is a skill that can be taught and learned, but not without continual feedback and followup. A systematic review of randomized control trials found that interventions that improved clinician communication behaviors often used three or more different strategies to change behaviors, such as giving information, modeling behavior, providing feedback, and practicing skills.(21)

Step 3: Implement and evaluate the Communicating to Improve Quality strategy

Inform staff of changes

If not already involved, inform unit directors and managers what is coming and why it is important. Inform staff at staff meetings and through posters in common rooms about the changes and opportunities for training.

Train staff

Staff training can include physicians, nurses, and other clinical providers. Training includes a mix of PowerPoint and role play. The main message to emphasize is: To improve safety and quality, communication between clinicians, the patient, and family is critical. Nurses and doctors need to invite and support the patient and family to engage in their care. After the training, it is important to assess:

- Did the training happen as planned? What happened during training that could challenge or facilitate implementation?
- How did staff react to training? What about the training could be improved?

Distribute tools and incorporate key principles into practice

As defined during Step 2, the unit staff will distribute and go over tools with the patient and family. Clinicians should emphasize that the patient and family are important members of the health care team and that we want to hear from you about your care.

Keep staff aware of communication expectations by posting flyers about expectations for the patient, family, and clinicians. These flyers can be posted in all patient rooms and around staff

areas, such as the nursing station, break room, or bathrooms, or in patient rooms. Consider moving posters throughout implementation so hospital staff will continue to pay attention.

***Guide* Resource**	*Tool 4: We Are Partners in Your Care* is a flyer that reminds the patient, family, and clinicians the importance of being partners and what they can do.

Assess implementation intensely during the initial two weeks and periodically after that

Make sure that staff members have supports needed to effectively communicate and distribute the patient and family tools. Have a nurse manager or other staff leader observe interactions with the patient and family, and provide feedback to individual nurses and physicians for the first 2 to 4 weeks. Use a standardized form to keep track of the observations, such as the checklist that is a part of *Tool 5: Communication competencies for clinicians*. Identify a way to analyze data collected, such as in an Excel spreadsheet or other database.

Continue to conduct periodic observations for 2-months and 4-months after roll-out to ensure consistency of implementation among staff. Continual feedback and monitoring is needed to make sure behaviors become more natural.

Get feedback from clinicians, hospital staff, patients and families

Get informal feedback from clinicians, hospital staff, patients, and family members by asking them about how communication and the tools can be improved. What worked well? What could be improved? How could we change or adapt these tools for another unit? What was critical for success? What was not successful and what could have made is better?

Incorporate formal feedback in mechanisms already in place at hospital such as patient and family focus groups, patient and family satisfaction surveys, and staff surveys.

Refine the process

Share feedback with implementation team, problem solve, and adapt, as necessary. Using the feedback received, refine process and tools before implementing in other units.

[1]The Guide was developed for the Agency for Healthcare Research and Quality (AHRQ), in the U.S. Department of Health and Human Services, by a collaboration of partners with experience in and commitment to patient and family engagement, hospital quality, and safety. Led by the American Institutes for Research (AIR), the team included the Institute for Patient and Family-Centered Care (IPFCC), Consumers Advancing Patient Safety (CAPS), the Joint Commission, and the Health Research and Educational Trust (HRET). Other organizations contributing to the project included Planetree, the Maryland Patient Safety Center (MPSC), and Aurora Health Care.

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Be a Partner in Your Care

We work as a team to make sure you get the best care.

The health care team includes you, family or friends of your choice, doctors, nurses, other clinical providers, and hospital staff. At [insert hospital name], our staff will:

- Give you timely and complete information about your care.
- Ask about and listen to your concerns.
- Explain things in a way that you can understand.
- Encourage and support your choices.
- Involve family and friends in ways that you wish.

You are an important part of the health care team.

If anything has been less than perfect about your care, we want you to speak up.

Talk to any member of your health care team at any time. Also, there are times that hospital staff are usually available:

- **Doctors** will visit your room once or twice a day [insert time range if able]. This is a good time to raise any questions you have. The time the doctor visits may vary from day to day. If you or your family needs to talk to a doctor at any time, please let your nurse know.
- **Nurse shift changes** occur when nurses who are going off duty share information about you with nurses coming on duty. Your nurses will change shifts between 7 and 7:30 am and 7 and 7:30 pm. At [insert hospital name] this happens right by your bedside, so you can be involved. If you would like, you can invite family or friends to take part as well.
- When plans are being made for your care after the hospital stay, we will include you, family, and your caregivers. We want to make sure you have what you need to take care of yourself when you leave the hospital.
- If you have questions at any time during your stay, you can also [write them down on the **notebook** next to your bed or on the **white board** in your room].

We're in this together!

Please ask questions, share what you know, and let your health care team know about your needs and concerns. Remember, you are an essential member of your health care team!

Be a Partner in Your Care

At [insert hospital name], we want you and family or friends of your choice to be partners in your care.

> Doctors and nurses may know more about medicine, but you and your family or friends know more about you and your body. That is why working together as partners is so important.

Tip 1: Tell us information about your health

We want you to share with us what you see, think, and feel. If something is important to you, we want to know it.

When you are in the hospital, doctors and nurses will talk with you about:

- Your health before this hospital stay.
- Medicines, vitamins, and herbal supplements you are taking.
- Allergies to medicines or foods.
- How you feel during and after treatment.
- Any pain you may feel.
- Any changes in your health while you are in the hospital.
- Plans for you after you leave the hospital.

Do not assume that your doctor or nurse knows everything about you.

Tip 2: Check if you understand what your doctors and nurses tell you

To help make sense of all the information you get while you are in the hospital:

Repeat what doctors and nurses say in your own words. After your doctor or nurse tells you something, try saying "*Let's make sure I have this right*" and then repeat the main points back in your own words. This helps your doctors and nurses know right away if they did not explain something well. That way, they can explain it again more clearly.

Take notes. It can be hard to remember all of the information you get in the hospital. It is helpful to write down what the doctors and nurses tell you. Family or friends can help you do this.

Visit the hospital resource center, patient education center, or library. To get more information on your own, these areas in the hospital have information and materials that are easy to read. Also, you can also always ask your doctors and nurses about how to find more information.

Tip 3: Ask questions until you understand the answers

You and family or friends will probably have questions about your care in the hospital. Asking questions is not always easy. Use these suggestions to help:

Be prepared. Keep a notebook in your room and write down questions as you think of them. Your family and friends can help with this.

Speak up if something is unclear or confusing. It is important to let doctors and nurses know right away if there is something you do not understand. You can say, *"I'm not sure I understand what you just said. Can you tell me again?"*

Keep asking until you understand. If you got an answer, but still do not understand, please ask again. You can say, "*I still don't understand. Can you try explaining it to me in a different way?*"

Ask questions about your medicines. Ask what each new medicine is for, how often you need to take it, and if it is the right amount, or dose. If you are worried about taking any medicine for any reason, tell your doctor or nurse before you take it.

Tip 4: Tell us who and how you want your friends or family members to be involved

Your family or friends are welcome at [insert hospital name]. Family or friends can:

- Give you comfort and support.
- Help you keep track of and understand information about your health.
- Make sure your health care team is aware of any concerns.
- Tell a doctor or nurse if they notice a change in your condition.
- Find a nurse when help is needed urgently.

It is up to you to say who you want to be involved. If you do not want us to share private information about your health with them, let us know.

Remember—

You and your family or friends are a vital part of your health care team.

We want you to ask questions, understand the answers, share observations, and be an active partner in your care.

Important contact information

If you have questions or concerns about the quality or safety of your care during your hospital stay, contact our [insert Quality Coordinator name and title] at [insert phone number].

For questions about cost, insurance, or billing during your hospital stay, contact our [insert Billing Specialist name and title] at [insert phone number].

Tips for Being a Partner in Your Care

Being a partner in your care helps you get the best care possible while you are in the hospital. It also helps you learn how to care for yourself after you leave the hospital.

This brochure has four tips to help you and your family or friends work with doctors, nurses, and other members of your health care team while you are in the hospital.

Communication Tool 2: Tips for Being a Partner in Your Care

Get to Know Your Health Care Team

Getting to know your health care team helps you get the best care possible. This handout tells you about the different members of your health care team and what they do. The members of the health care team include:

- You and family or friends of your choice.
- Different types of doctors and nurses.
- Other clinical providers and hospital staff.

When they enter your room, all hospital staff should tell you their name, who they are, and what they do. If you don't know who someone is or why they are in your room, ask them!

"Different people would come into my room at different times and for different reasons while I was in the hospital. It helped that the hospital staff all wore name badges large enough for me to read. The name badges gave their name and their position in the hospital." -Jack, patient

You and family or friends of your choice

You and family or friends of your choice are part of the health care team. Doctors and nurses may know more about medicine, but you are the expert on you! It is up to you to say who is your family and how they are involved in your care. For us, families are not visitors, but a part of the team. They can give you comfort and support. They also can tell your doctors and nurses about your needs and concerns.

Doctors

Attending physicians are in charge of your care. The attending physician usually comes to see you once or twice a day while you are in the hospital. The attending physician may be your primary doctor, a specialist, or a doctor who works for the hospital. Ultimately, the attending physician is the person responsible for the quality of care delivered to each patient. If you have any questions about your care, the attending physician can answer them.

Name of attending physician: ____

Contact information: ____

[If not a teaching hospital, delete this section] **Doctors in training, called "house staff," are doctors supervised by the attending physician.** These doctors have completed medical school and are getting additional training. They will talk to you about your health history and symptoms, work with you to find the right treatments, and help do routine procedures. There are several different types of doctors in training:

- Fellows have completed their residency and have almost all responsibilities of the attending physician. They have chosen to do an advanced training in a particular specialty, called a "fellowship."
- Residents have completed medical school and passed national and state board exams, but they cannot work on their own without supervision. Most residents complete at least 3 years of training, but some doctors, especially surgeons, complete 6 or 8 years.
- Interns are first-year residents.

Nurses

Registered Nurses (RNs) take care of you at the bedside. They spend the most time with you. They can give you medicines, take care of your wounds, and make sure everything is going okay. Registered nurses can help with any questions you have. If they don't have the answers, they will find out and get back to you.

"Nurses work with everyone in the hospital. They are often the best people to ask when you have questions. If nurses don't know the answers right away, they can find out and get back to you quickly."
–Emily, family member

Licensed Practical Nurses (LPNs) [or Licensed Vocational Nurses (LVNs)] provide basic nursing services. They can perform simple medical procedures under the supervision of a doctor or a registered nurse. They may give you medicines or take your blood pressure, heart rate, and temperature.

Certified Nurses' Aides help licensed nurses but do not have a license for patient care. Nurses' aides help patients with their basic needs such as eating, drinking, walking, bathing, and going to the bathroom.

Nurse supervisors are responsible for the nursing care on your unit. Nurse supervisors can be charge nurses or nurse managers.

- Charge nurses supervise the bedside nurses on the unit. Charge nurses may also be called shift leaders or clinical team leaders.
- Nurse managers supervise charge nurses. They help to make sure that the hospital meets all standards and regulations.

Other clinical providers

Physician assistants are not doctors, but are licensed to provide care, and are supervised by doctors. They help doctors by doing many things the doctor does. They may talk to you about your health history and symptoms, order lab tests, help with surgery, and write prescriptions.

Advanced Practice Nurses can take greater responsibility for patient care than other nurses. These nurses have completed school beyond nursing school. They can prescribe medicine and help you make treatment decisions. They may also be called Clinical Nurse Practitioners or Clinical Nurse Specialists.

Other members of your health care team

Other clinical providers are pharmacists, lab technicians, dieticians, phlebotomists (someone who is trained to draw blood), physical therapists, occupational therapists, respiratory therapists, and others.

Other staff members include social workers, case managers, interpreters, patient advocates, patient safety officers, housekeeping staff, librarians, chaplains or clergy, volunteers, admissions staff, and financial staff.

Other members of your health care team help with your care in different ways. Ask the nurse in charge of your care if you want to talk with them.

We are partners in your care!

We work to make sure you get the best care possible. We will:

- Give you timely and complete information.
- Ask about and listen to your concerns.
- Explain things in a way that you can understand.
- Encourage and support your choices.
- Involve family and friends in ways that you wish.

What can you do?

- **Tell doctors and nurses about your health.** Tell us what you see and feel. Don't assume we know everything about you.
- **Check if you understand what doctors and nurses tell you.** Repeat back what they say in your own words.
- **Ask questions**. Ask questions until you understand the answers. Make sure you get the information you need.
- **Tell us who you want involved in your care.** You get to decide if you want family or friends to take part in conversations about your health.

Communicating to Improve Quality: Communication Competencies

Overview of Communication Competencies

Effective communication between clinicians, patients, and families can lead to better health care outcomes and improved quality and safety. The following list identifies behaviors to help clinicians build partnerships with patients and families, leading to better health care quality and safety.

When you enter the room...

- ☐ **Read patient information before entering the room.**
- ☐ **Make eye contact with the patient, not a machine or other medical professional in the room.**
- ☐ **Smile, if appropriate**. Your smile should be genuine and not forced.
- ☐ **Introduce yourself by name and your role in the patient's care.**

  Hi, Mrs. Smith. It's your nurse, Mary. Is there anything I can do for you now?

- ☐ **Introduce any new people in the room, their role, and what they will do.**

  I'd like you to meet Dr. Nancy Burns. She's a specialist that is going to help manage your sugar. If it's okay with you, she is going to talk with you.

- ☐ **Have conversations at eye level**.

When you assess the patient...

- ☐ **Ask how the patient prefers to be addressed** (for example, by first or last name).
- ☐ **Identify family that should be "team members" or "partners in care" and put their names on the white board in the patient's room.** Let the patient define who family is. Family can give you information that you don't know about the patient. They also need to know about the patient's health so they can take care of the patient at home.

  You may want family or friends to take part in conversations about your health or health care. Who would you like to be involved?

  Who is going to help you once you get home? Do you want that person/these people to take part in this talk? How would you like these people to be involved in conversations about your care while you're in the hospital?

- ☐ **Make sure the patient has Communication Tools 1-3 and highlight the main points.**

  We are here to help you. I know the technical stuff, but I am not an expert about you. When it comes to you, you're the expert.

  Please tell us what you want and need, ask questions, and share any concerns you have about your health.

- ☐ **Invite the patient and family to use the white board as a communication tool.**

  The white board can help us talk with each other. Please feel free to write notes, questions, or concerns on the white board. Here is the pen.

Throughout the hospital stay

	Invitation behaviors: Invite patients and families to engage	**Supportive behaviors: Support patients and families**
Include the patient and family as members of the health care team	• Welcome the patient and family as partners of the health care team. Acknowledge their expertise. – *We may know more about medicine, but you know more about you and your body. We want you to share what you are feeling and experiencing with us, so that we can provide the best care possible.*	• React positively when people ask questions, volunteer information, share concerns, or want to participate in treatment decisions. – *Don't say: Don't worry – we have done this hundreds of times. Say: This procedure takes a picture of how your knee is looking after surgery. It helps us follow your progress. It does have a small amount of radiation, but should not hurt you.*
Ask about and listen to the patient and family's needs and concerns	• Use open-ended questions to encourage the patient and family to share information about their health. – *What is going well right now? What problems are you having?* – *What has been less than perfect in your care?* – *What questions do you have?* • Try to see the experience through their eyes. Curiosity and judgment cannot exist in the same space.	• Listen to, respect, and act on the observations and values of the patient and family. – *Thanks for letting us know about that drug allergy, Mrs. Jackson. Let me note this in your record. We'll find another medication.* • Help people articulate their concerns when needed. – *I see something is bothering you. Please feel free to share it with me. I may be able to help.*
Help the patient and family understand the diagnosis, condition, and next steps in their care	• Give timely and complete information about the patient's condition. Review information with the patient and family at every opportunity - during rounds, shift report, medication administration, and discharge planning meetings. • Check that patients *really* understand by using "teach back" – *Don't say: Do you understand? Say: I want to make sure I explained that clearly. Do you mind repeating what I just said in your own words?* • Share as much information as they want; find out how much they want to know: – *Is there anything else you would like to know? Are you the kind of person who wants the overall picture, or do you want to get the details?*	• Slow down. • Use plain language. Use words everyone can understand. Break messages into shorter statements. • Invite the patient or family to take notes. • When you can't answer a question, let them know you will find someone with the answer. Also let them know when to expect the answer. – *I don't have that information, but I will talk with the pharmacist about it and get back to you, or have him come and talk to you by this afternoon. Will that work?*

Building Partnerships for Safe Care: Observation Form and Checklist

Clinician Name: ____

Entering the room	Initial assessment	Throughout encounter
______Made eye contact with patient ______Smiled, as appropriate ______Introduced self by name and role ______Introduced new people in the room, their role, and what they will do ______Had conversations at eye level	______Asked how patient prefers to be addressed ______Identified family or friends who are team members, names written on white board ______Highlighted main points of Communication Tools 1-3	Invitation behaviors: Inviting patients and families to engage ______Welcomed patient and family as part of health care team ______Used open-ended questions ______Gave complete information about the patient's condition ______Used "teach back" ______Found out how much the patient/family wanted to know Supportive behaviors: Supporting patients and families as they engage ______Reacted positively when people engaged ______Listened to and respected observations and values of patient and family ______Helped people articulate their concerns when needed ______Used plain language ______Invited patient and family to take notes ______Identified others to answer questions if needed
Notes:		

Communicating to Improve Quality: Clinician Training

[Insert hospital name, presenter name and title, date of presentation]

Today's session

- What is patient and family engagement?
- What is the patient and family experience in our hospital?
- Communicating to Improve Quality
  - What are we asking patients and families to do?
  - What are we asking you to do?
- Practice exercises

What is patient and family engagement?

Hospital quality

- Patients get care that is safe
- Patients get the right care for their condition
- Patients get care they need when they need it
- Patients get care that makes wise use of resources
- No differences in treatment based on race, ethnicity, income, education, or social status
- Care is patient- and family-centered

Patient- and family-centered care

- Mutually beneficial **partnerships** among clinicians, hospital staff, patients, and families
- Core concepts:
  - Dignity and respect
  - Information sharing
  - Participation
  - Collaboration

What is patient and family engagement?

- Critical component of patient- and family-centered care
- Patient and family engagement means involving patients and family members as:
  - Members of the health care team
  - Advisors working with clinicians and leaders to improve policies and procedures

Goal of patient and family engagement

- To create an environment where patients, families, clinicians, and hospital staff all work together as partners to improve the quality and safety of hospital care

Why engage patients and families?

- Research shows patient-centered communication can improve:
  - Patient safety
    (Coulter and Ellins 2007, Charmel and Frampton 2008, Joint Commission 2007)
  - Patient outcomes, including emotional health, functioning, and pain control
    (Roter 1989)
  - Patient experience
    (Iacono 2001)

What is the patient and family experience at our hospital?

What is it like being a patient?

Clinicians and hospital staff	Patients and family
• Know how the hospital works and how to get things done	• Are strangers in this environment • Don't understand the system or culture • Know about their body and life situation better than hospital staff
• Know who hospital staff are and what they do	• Don't know who different staff are and what they do • May want family or friends to support them
• Are busy and under a lot of stress	• Are often in pain or uncomfortable, vulnerable or afraid. • Family members are worried and want to do what they can for the patient • Aware that hospital staff are busy and may not want to bother you
• Want to provide high quality and safe care	• Trust hospital staff to provide safe and high quality care

What is it like being a patient?

- [Insert 1 to 2 experiences from real patients or family members:
  - Live presentation / story
  - Video
  - Vignette or quote]

Communicating to Improve Quality

Process and tools

What is the communication packet?

- Give three tools to the patient and family prior to or at admission:
  - Tool 1: Be a Partner in Your Care
  - Tool 2: Tips for Being a Partner in Your Care
  - Tool 3: Get to Know Your Health Care Team

What you will need to do?

- When you enter the room:
  - Read chart before entering
  - Smile, if appropriate
  - Introduce yourself by name and role
  - Introduce new people in room by name, role, and what they will do
  - Have conversations at eye level

What you will need to do?

- When you first assess the patient:
  - Ask how patient prefers to be addressed
  - Identify family that should be team members
  - Highlight main points of communication tools
  - Invite the patient and family to use the white board to "talk" with clinicians

What you will need to do throughout the hospital stay?

1. Include the patient and family as members of the health care team:
   - Welcome the patient and family
   - Acknowledge their expertise
   - React positively when people ask questions, volunteer information, share concerns, or want to take part in treatment decisions

What you will need to do throughout the hospital stay?

2. Ask about and listen to the patient and family's needs and concerns:
   - Use open-ended questions
   - Try to see the experience through their eyes
   - Listen to, respect, and act on what the patient and family says
   - Help people articulate their concerns when needed

What you will need to do throughout the hospital stay?

3. Help the patient and family understand the diagnosis, condition, and next steps in their care:
   - Give timely and complete information
   - Take every opportunity to educate patient and family
   - Use Teach Back to make sure you explained clearly
   - Find out how much information they want to know

What you will need to do throughout the hospital stay?

4. Help the patient and family understand the diagnosis, condition, and next steps in their care:
   - Slow down
   - Use plain language
   - Invite the patient or family to take notes
   - If you can't answer a question, find someone who can

How does this benefit you?

- Helps make sure your patients have better outcomes
- Helps improve quality and safety by making sure patients and families share important information
- Ensures the patient and family have a better transition from the hospital

Practice exercises

Vignette 1

- Jack has just been wheeled into his room in the med-surg unit, after having a TURP. He is very about happy finally getting through the surgery and being on this unit, but he is still in pain and uncomfortable and is anxious to see his wife Emily as soon as possible.
- The first person who comes into his room after his arrival is his bedside nurse, Angela. In this exercise, Angela comes in to do her initial nursing assessment, but Jack interrupts to ask her who she is and what can she do about his pain and discomfort; he also wants to know when his wife can visit him. He is clearly a bit nervous.
- Let's form pairs to do this exercise. One person plays Angela the nurse, the other plays Jack. Take about 5-8 minutes.

Vignette 1

- Debrief “Angela” and “Jack”:
  - How did you each feel during this interaction?
  - What really went well?
  - What could have been done differently?
  - Anything else?

Tips for effective engagement

- Slow down
- Use plain language
- Reassure patient and family by giving information
- Thank patient or family for calling attention to any issue they raise; don’t act annoyed
- Invite them to continue asking questions
- Remember non-verbal communication says just as much as verbal communication

Vignette 2

- The Attending Physician, John Gladstone, after hearing from Angela about Jack's pain and discomfort, has just told Jack that he is putting him on a stronger dose of a different pain medication.
- Jack expresses worry because he had bad side effects of a similar medication in the past. Emily, Jack's wife, who is there at the time, reinforces that experience.
- This time we will break into groups of three. One of the doctors should play Dr. Gladstone, and two other people play Jack and Emily. Play out this scene for 5-8 minutes.

Vignette 2

- Debrief:
  - How did each of you feel during this interaction?
  - What really went well?
  - Did you use any of the tips? If so which ones and how did they work?
  - What could have been done differently?
  - What’s your biggest “take home” from these exercises?

Final thoughts

- Our hospital is committed to patient and family engagement – everyone plays a critical part
- Patients and families won’t engage if they believe that you don’t want them to – it is simply too risky for them
- Your job is to make it safe for them to be here, not just as patients, but as partners in their care

Thank you!

- For questions or more information

  [Insert name, phone number, and email]

<u>Component 1</u>

Strategy 2:

Bedside Change of Shift Report

Strategy 2

Nurse Bedside change of shift

Implementation Handbook

Implementation Handbook: Nurse Bedside change of shift

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Implementation Handbook: Nurse Bedside change of shift

The *Guide to Patient and Family Engagement in Hospital Quality and Safety* (the *Guide*) is a resource to help hospitals develop effective partnerships with patients and family members, with the ultimate goal of improving multiple aspects of hospital quality and safety.[1]

Nurse shift changes require the successful transfer of information between nurses to prevent adverse events and medical errors. Patients and families can play a role to make sure these transitions in care are safe and effective.

This handbook gives you an overview of and rationale for nurse bedside change of shift. It also provides step by step guidance to help you put this strategy into place.

Overview of Nurse Bedside change of shift Strategy

The goal of this strategy is to help ensure the safe handoff of care between nurses by involving the patient and family. The patient defines who their family is and who can take part in bedside change of shift.

Hospitals train nurses on how to conduct change of shift report at the patient's bedside. Nurses or another hospital staff member invite patients and families to be part of the bedside change of shift process and hand out the brochure explanation to the patient on the day of admission.

At each shift change, shift report happens at the patient's bedside, and the nurses invite the patient and family or friends of their choice to take part in the report.

What are the Nurse Bedside change of shift tools?

This section provides an overview of the tools included in this strategy.

Tool	Use this tool to…	Description and formatting
Tool 1 **Nurse Shift Changes at Your Bedside: How You Can Get Involved**	Inform the patient and family about what bedside change of shift is and how they can take part.	• Given to patients on the day of admission, this handout explains what bedside change of shift is, what patients and family or friends should expect, and what they need to do. • Format: Tri-fold brochure

Tool	Use this tool to…	Description and formatting
Tool 2 **Bedside change of shift Checklist and Notes Sheet**	Remind nurses of the critical elements of bedside change of shift.	• Made available at all shift changes and at admission, this checklist highlights the six elements required to complete bedside change of shift. As they would like, nurses can write on the form during bedside change of shift. • Format: 1-page handout
Tool 3 **Bedside change of shift Nurse Training**	Prepare nurses to conduct bedside change of shifts.	• Slides and talking points for a training to prepare nurses to do bedside change of shift and to help them understand how to engage patients and family members in the process. • Format: PowerPoint presentation, with embedded video [video treatment included as a separate document in this draft]

Rationale for Nurse Bedside change of shift

The goal of patient and family engagement is to create an environment where patients, families, clinicians, and hospital staff all work together as partners to improve the quality and safety of hospital care. Patient and family engagement encompasses **behaviors** by patients, family members, clinicians, and hospital staff, as well the **organizational policies and procedures** that support these behaviors.

Bedside change of shift is a clinical expression of engaging patients and families as essential partners in the health care team.

Why is bedside change of shift important?

Communication during transitions in care, such as nurse shift changes, is extremely important for ensuring that the handoff is safe and effective. Allowing the patient and family to be involved in the change of shift report gives them the opportunity to hear what has occurred throughout the shift and the next steps in their care. It also gives them the chance to ask questions and provide input into the care process. Bedside change of shifts can improve:

- **Patient safety and quality.** One study found that more than 70 percent of adverse events are caused by breakdowns in communication among caregivers and between caregivers and patients.(2) Bedside change of shift is another opportunity to make sure there is effective communication between patients and families and nursing staff. Studies have shown that bedside change of shift improves patient safety and service delivery (3, 4) as well as the nurse-patient relationship.(5)
- **Patient experience of care.** After implementing bedside change of shift, hospitals reported an increase in patient satisfaction scores.(1)
- **Nursing staff satisfaction.** Bedside change of shift has improved nursing staff and physician satisfaction.(1, 3, 4)
- **Time management and accountability between nurses.** After implementing bedside change of shift, nurses have reported better ability to prioritize their work or cases during their shift and an overall decrease in staff time. One study noted a decrease in overshift time by 100 hours in the first two pay periods on a 32-bed general surgical unit.(1)

Bedside change of shift and patient satisfaction

Increased patient satisfaction was seen with the implementation of bedside change of shift. By involving the patients in their plan of care and keeping all caregivers updated on that plan, patients feel more secure, and are more likely to participate in their own care and follow recommended healthcare options.

Cherri Anderson and Ruthie Mangino, Banner Desert Medical Center, Arizona, 2006 (1)

How does the Nurse Bedside change of shift strategy facilitate bedside change of shift?

The *Nurse Bedside change of shift* strategy identifies critical elements of bedside change of shift and supports the patient, family, and nurse in taking part in bedside change of shift through individual tools. Specifically, the tools in this strategy:

- Give the patient and family an opportunity and an invitation to take part in their care.
- Explain to the patient and family what bedside change of shift is and what they can expect.
- List the critical elements of bedside change of shift that nurses should carry out.
- Address nurse concerns about doing bedside change of shift.

- Standardize the process of bedside change of shift.

(Placeholder for examples from Task 7, Implementation and Evaluation in this section in the form of patient/family/staff quotes or a case study.)

Implementing Nurse Bedside change of shift

(NOTE: This is a section where we will want to incorporate information from the Task 7 Implementation and Evaluation. We will also be able to provide more specific guidance about what worked and what did not work.)

The *Nurse Bedside change of shift* strategy is designed to be flexible and adaptable to each hospital's environment and culture. As such, this guidance provides choices and questions for hospital leaders about how to implement this strategy. It may be helpful to implement this strategy initially on a small scale (e.g., a single unit). Identify lessons learned from the single-unit pilot implementation, refine your approach, and then spread to more units. In this way, you can build on your successes as a pathway to broader dissemination and wider-scale change.

Step 1: Form a multi-disciplinary team to identify areas of improvement

As with any new activity or quality improvement effort, planning and identifying areas of improvement are important parts of the process. Below lists some key considerations as you get started implementing the Nurse Bedside change of shift strategy.

Engage patients and families and unit staff in the process: Establish a multi-disciplinary team

This team should include hospital leaders, nurses, other key clinical and management staff, and patient and family advisors.

***Guide* Resource**	For more information about working with patient and family advisors, see *Component 2, Implementation Handbook: Organizational Partnership Materials*

Throughout the process of implementing the bedside change of shift strategy, patient and family advisors can:

- Give feedback on what the current process of shift report feels like as the patient or family.
- Can help adapt the patient and family tool, *Tool 1: Nurse Shift Changes at Your Bedside: How You Can Get Involved*, for your hospital.
- Can help adapt the standardized handoff tool, *Tool 2: Bedside change of shift checklist and notes sheet*, for your hospital.

- Take part in training nurses about bedside change of shift – by participating in role plays or other small group exercises or by describing how the old way and new ways of shift report feel like to the patient or family.
- Observe nurses doing bedside change of shift and give feedback.

Assess family presence or visitation policies

The family cannot be partners of the health care team if they are not present. It is important that the patient can define who their family is and that these members of the health care team are encouraged and supported.

***Guide* Resource**	For more information about family presence policies, see *Supporting Patient and Family Engagement: Best Practices for Hospital Leaders* in *Component 3*

Assess current nurse shift change communication and processes

Use the multi-disciplinary team to review the process of shift change report and how communication occurs between nurses and from nurse to patient. The team can identify strengths related to shift report – what is done well in terms of involving the patient and family, giving information between nurses and from the nurse to the patient and family. The team can also identify areas for improvement.

As with any change, some nursing staff members may be resistant to doing bedside change of shift. Keep in mind that taking on new behaviors can be challenging. Some examples of challenges and ways to address them are:

- ***Acknowledging the "other" meanings of shift report for nurses***. The official purpose of nursing report is to transfer the accountability and responsibility of the patient between nurses. But, shift report may also serve as a way for nurses to connect to other staff, share emotional issues over the course of a shift, take a "break" from the family to focus on the patient, and socialize. When shift report is done at the bedside, it will be important to acknowledge the "other" meanings of shift report for nurses and identify alternative methods or outlets for nurses to talk with one another.
- ***Violating HIPAA or patient privacy***. Nurses may be concerned about violating HIPAA – especially when family members are present at shift report or if they work in semi-private rooms. Using examples from the Office of Civil Rights' Web site, the *Tool 3: Bedside change of shift Nurse Training PowerPoint Slides* describe how bedside change of shift is not a violation of HIPAA because it is part of treatment and normal operations.
- ***Taking longer to do shift report.*** Although nurses may voice concerns about it "taking too long," bedside change of shift should be quick – about 3 to 5 minutes. As noted in the previous section, after doing bedside change of shift, nurses have reported less time spent

on shift report and better time management because they have seen all of their patients at the start of the shift and can prioritize patient needs and concerns.

- ***Negotiating interactions with family members***. Families are complicated, and it may be difficult for nurses to know which family members should be present at bedside change of shift and how to interact with those family members. As part of shift report, it will be important for nurses to ask patients which family or friends would they like to participate.
- ***Dealing with sensitive information***. Sometimes, the patient or family may not be aware of certain information or diagnosis. Bedside change of shift is not an appropriate venue for discussing "bad news." For example, the doctor may not have had a chance to communicate a test result with the patient, or a mother may not know that her son has HIV. This type of sensitive information may not need to be discussed at shift change. When it does, the information can be exchanged between nurses before entering the room, or nurses can point to relevant information on the chart during the bedside change of shift.
- ***Fearing change***. Some nurses may fear losing control of the shift report process or may not feel confident in doing shift report at the bedside. Often, if consistent use of bedside change of shift is not monitored, nurses may revert back to familiar habits and ways of doing things. It is important to let nurses know that bedside change of shift is not optional. Acknowledge that change is hard, but stress the importance of adhering to the new processes and procedures.

It is important for hospitals to identify the challenges that are most likely to arise in your environment and to identify ways to overcome these challenges. For example, are there particular units where it might be wise to "pilot" this new approach, either because of staff attitudes or because there is a pressing need to improve nurse communication or transitions in care?

Set aims to implement nurse bedside change of shift

Any quality improvement initiative requires setting aims. The aim should be time-specific, measurable, and define who will be affected. For example, an aim related to implementing nurse bedside change of shift could be "to have 95 percent of nurses implementing bedside change of shift within 6 months."

> For more information on setting aims and identifying measures, see the Institute of Healthcare Improvement's Web site on improvement methods, available at: http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/.

As another example, hospitals may want to improve patients' experience of care as measured by the CAHPS® Hospital Survey. CAHPS® Hospital Survey questions related to nursing shift report include:

- Q1: During the hospital stay, how often did nurses treat you with courtesy and respect?
- Q2: During this hospital stay, how often did nurses listen carefully to you?
- Q3: During this hospital stay, how often did nurses explain things in a way you could understand?

If a hospital wants to improve their CAHPS® Hospital Survey scores related to nurse communication, an aim might be "to improve scores on CAHPS® Hospital Survey Questions 1, 2, and 3 by 5 percent within 1 year."

Step 2: Decide how to implement the Nurse Bedside change of shift strategy

Once the team has set specific aims for improvement, it may be helpful to identify a single point person as the primary person staff would go through with any kind of question. This person may not have the answers to all questions, but can facilitate the process of getting answers. This way, people are clear about whom to go to, and that person will hear all the questions and concerns.

Then, the single point person can coordinate with the multi-disciplinary team to decide how to use and adapt each of the tools in this strategy.

Identify the logistics of bedside shift for hospital

What would nurse bedside change of shift look like at your hospital? Several hospitals that have implemented bedside change of shift do a 10 minute overview or safety briefing on all patients before going to individual rooms and bedside. Would this be important to include on your unit? Also, consider how work flows to make sure that bedside change of shift is an efficient process.

Decide how to use and adapt the tools in this strategy

As described above, the Nurse Bedside change of shift strategy includes three tools.

Guide Resources	*Tool 1: Nurse Shift Changes at Your Bedside: How You Can Get Involved* informs the patient and family about what bedside change of shift is and how they can take part. *Tool 2: Bedside change of shift Checklist and Notes Sheet* reminds nurses of the critical elements of bedside change of shift. *Tool 3: Bedside change of shift Nurse Training* prepares nurses to conduct bedside change of shifts.

Answer the following questions to decide how to use and adapt the tools in this strategy at your hospital:

- ***Decide how to use and adapt the bedside change of shift checklist.*** First, decide which elements of bedside change of shift are important for your unit or hospital to make sure that bedside change of shift is implemented in a standard way. Ask nurses and patient and family advisors about possible changes. Adapt *Tool 2: Bedside change of shift Checklist and Notes Sheet* to fit your hospital environment. Once this tool is adapted, who will review it? What approvals are needed?
- ***Decide how to use and adapt the brochure for the patient and family*****.** Next, adapt the patient and family brochure, *Tool 1: Nurse Shift Changes at Your Bedside: How You Can Get Involved.* Ask nurses and patient and family advisors about possible changes and make the changes consistent with the elements of bedside change of shift. At a minimum, it is important to insert your hospital name, logo, and tailored information into the brochure. Who will review it? What approvals are needed?

  Once adapted, determine how the brochure be distributed. How will the brochure be printed? Who will distribute? How will interpreters be involved in the distribution process, if needed? Can the brochure be integrated into current admissions materials (or with the tools distribute in *Component 2, Organizational Partnership Materials)*? If so, how? What approvals need to be sought? Who will go over the brochure with the patient and family and invite the patient and family to participate? (We recommend that this be the bedside nurse on the day of admission, but any hospital staff can do this at any time.) If applicable, how will temporary nursing staff learn about how to distribute the bedside change of shift brochure?
- ***Plan the bedside change of shift training for nurses***. Who can conduct the training for their colleagues? Training facilitators should be respected by their colleagues and model

the behaviors being asked of them. Which patient and family advisors can help to conduct or facilitate the training? How many sessions are needed to train all staff? When can the training be scheduled? Where can the training happen? How should the *Tool 3: Bedside change of shift Nurse Training* be adapted? Who needs to approve the training materials?

Recognize that individuals have different learning styles. To be most effective, use three or more different learning strategies during the training, such as giving information, modeling behavior, providing feedback, and practicing skills.

Step 3: Implement and evaluate the Nurse Bedside change of shift strategy

Inform staff of changes

If not already involved, inform unit directors and managers about what is coming and why it is important. Inform staff at staff meetings and through posters in common rooms about the changes and opportunities for training.

Train staff

The training tools for this strategy include a mix of PowerPoint slides, video, and role play. The main message to emphasize: Conducting bedside change of shift can improve quality and safety. After the training, it is important to assess:

- Did the training happen as planned? What happened during training that could challenge or facilitate implementation?
- How did staff react to training?

Conduct bedside change of shift

As defined during planning, the unit staff will distribute and go over the brochure with patients and families on the day of admission. At each shift change, nurses will conduct bedside change of shifts, using the checklist to make sure they go over the key elements.

Keep staff aware of bedside change of shift by making sure *Tool 2: Bedside change of shift Checklist and Notes Sheet* is available throughout the unit.

Assess implementation intensely during the initial first 2 weeks and periodically after that

Make sure that nurses have the support needed to do bedside change of shift. Have a nurse manager or other staff leader observe shift report and provide feedback to individual nurses. Use a standardized form to keep track of the observations, such as the checklist that is a part of *Tool 2: Bedside change of shift Checklist and Notes Sheet*. Identify a way to collect and analyze data collected, such as an Excel Spreadsheet or other database.

Continue to conduct periodic observations at (e.g., at 2 and 4 months after roll out) to ensure consistency of implementation among staff. Continual feedback and monitoring is needed to make sure behaviors become more natural.

Get feedback from nurses, patients, and families

Get informal feedback from nurses, patients, and families by asking them how bedside change of shift can be improved. What worked well? What could be improved? How could the process or tools be changed or adapted to work on other units? What was critical for success? What was not successful and what could be made better?

Incorporate formal feedback by using mechanisms already in place at your hospital, including patient and family focus groups, patient and family satisfaction surveys, and staff surveys.

Refine the process

Share feedback with the implementation team, problem solve, and adapt as necessary. Using the feedback received, refine the process and tools before implementing in other units.

Case Study on Nurse Bedside change of shift: Emory Healthcare

Emory Healthcare recently reached 100 percent implementation of bedside change of shift report across four hospitals and 73 inpatient units on every shift, including the night shift. Approximately 1800 nurses participate.

Keys to success

- **Senior leaders**, and especially the Chief Nursing Officer, provided resources and support for implementing BSR.
- **Dedicated nurse leaders** continued to pursue BSR, even when there were challenges.
- A **standardized process for BSR** made sure that everyone knew what to do.
- **Training and observation** increased buy-in because nurses immediately saw the benefits of BSR and knew that hospital leaders supported BSR.
- Committed **nurse champions** at the unit and floor levels make sure that BSR continues to happen.

In response to bedside change of shift, patients and families report feeling more knowledgeable about their care. Patient satisfaction scores reflect this change in nursing practice. In August 2010, Emory achieved a 98 percent on patient satisfaction scores, with "nurse kept you informed" as the highest rated question. In fact, this question achieved the highest score of all hospitals nationwide.

Creating this new culture of bedside report for nurses was a process, and a challenging one at that.

Bedside change of shift began with a test of change. In November 2007, a nurse champion at Wesley Woods, a 100-bed geriatric hospital, brought the idea of bedside change of shift to Emory's Unit Practice Council (UPC), a governance structure where clinical staff give input into care on the floor. Using a "*test of change*" approach, one UPC member did bedside report, followed by another. Because the process worked well, the pilot was expanded to nurses on two units. After 2 weeks, the decision was made to implement bedside change of shift across the hospital.

The first system-wide roll out did not go as planned. With the success at Wesley Woods, the idea of bedside change of shift was brought to Emory Healthcare's system council to implement bedside report system-wide, across the three existing hospitals. In February 2008, three nurse champions, one at each major hospital within the system (Wesley Woods, Emory Midtown, Emory University), began planning for system-wide implementation between May and August 2008. These three champions created teaching points for each unit. Nurses were asked to read about bedside change of shift and then do it. Unfortunately, the larger hospitals did not show much interest in bedside report. Because there was limited buy-in, bedside change of shift did not catch on.

Standardization was the key to effective system-wide roll out. In March 2009, the three nurse champions attended a Quality Academy Practical Methods course, focusing on quality improvement methods and Six Sigma. Most importantly, they learned that *standardization* was the only way to assess effectiveness. The course included a small project or test of change. The three champions got permission from the Chief Nursing Officer to work on bedside change of shift.

The three nurse champions created a standard process for bedside report, called the bedside bundle, and a process for educating staff. The bedside bundle included six components that were essential for completing bedside report. They designated a training and observation team that included the three leaders, plus one to two nurses who were not able to do clinical care.

In spring and summer of 2009, the team went to each unit in the hospital system. They spent 1 week educating nurses on the unit about bedside change of shift, both in group trainings and one-on-one. The team stayed on the unit to observe and provide feedback at every shift change for 2 more weeks, or longer if needed. The team observed individual nurses doing bedside report, checked off items in the bedside bundle, and provided real-time feedback to nurses before observing the next bedside report. After completing the initial education and observation process, the team identified two to three nurses as floor champions, who would foster an environment that supports bedside change of shift.

Support, monitoring, and education ensure continued success. Nursing Unit Directors ensure that 16 random audits are performed during different shifts. With the Director of Care Transformations and two patient and family advisors, the champions also developed a 4-hour bedside change of shift seminar. As of September 2010, they have held six seminars and have trained over 400 staff from across the four hospitals.

[1]The Guide was developed for the Agency for Healthcare Research and Quality (AHRQ), in the U.S. Department of Health and Human Services, by a collaboration of partners with experience in and commitment to patient and family engagement, hospital quality, and safety. Led by the American Institutes for Research (AIR), the team included the Institute for Patient and Family-Centered Care (IPFCC), Consumers Advancing Patient Safety (CAPS), the Joint Commission, and the Health Research and Educational Trust (HRET). Other organizations contributing to the project included Planetree, the Maryland Patient Safety Center (MPSC), and Aurora Health Care.

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What is bedside change of shift?

Nurse shift changes occur when nurses who are going off duty share information about your care with nurses coming on duty.

At [insert hospital name], this happens right by your bedside so you can be involved. This **bedside change of shift** gives you a chance to meet the nurse taking over your care, ask questions, and share information.

Bedside change of shifts happen every day between **7 and 7:30 am** and **7 and 7:30 pm**. Shift report at your bedside usually lasts 5 minutes.

Invite a family member or friend to stay during bedside change of shift, if you want them to. We will only talk about your health with others when you say it's okay.

What should I expect?

During the bedside change of shift, the nurses going off and coming on duty will:

- **Introduce** themselves to you and anyone with you. The oncoming nurse will write his or her name and phone number on the white board in your room.
- **Invite** you to take part in the bedside change of shift. It is up to you to decide who else can take part with you.
- **Talk** with you about your health, including the reason you are in the hospital and what is going on with your care. The nurses will look at your medical chart.
- **Check** the medicines you are taking. The nurses will look at your IVs, injuries, and cuts. They will also follow up on any tests or labs that were done or ordered.
- **Ask** you what could have gone better during the last shift and what you hope to do during the next shift. For example, you may want to get out of bed or just sleep. The nurse will see how they can help you meet this goal.
- **Encourage** you to ask questions and share your concerns. If needed, the oncoming nurse may come back after bedside change of shift to spend more time discussing your concerns.

What should I do?

- **Listen.** You are an important part of the health care team. We want to make sure you have complete and timely information about your care.
- **Speak up.** If you have questions or concerns, bedside change of shifts are the perfect times to raise them.
- **Ask if something is confusing.** If the nurses use any words or share any information you don't understand, feel free to ask them to explain it.

[Insert hospital name] wants to make sure that you get the best care possible.

If you have any concerns about the quality or safety of your care during your hospital stay, please let your nurse or doctor know.

If you are still concerned, contact our [insert Quality Coordinator name and title] at [insert phone number].

You Are Invited!

You are invited to take part in bedside shift report. You can also invite a family member or friend to take part with you.

Bedside shift reports happen every day between **7 and 7:30 am** and **7 and 7:30 pm**.

Let us know if you have any questions. You are valuable members of the health care team!

Nurse Shift Changes at Your Bedside

How You Can Get Involved

Being a partner in your care helps you to get the best care possible in the hospital. Taking part in bedside change of shift is one way you can be a partner. This brochure explains what bedside change of shift is and how you get involved.

Bedside change of shift: Checklist and Notes Sheet

- ☐ **Introduce nursing staff, the patient, and family. Invite the patient and family to take part.**

- ☐ **Open medical record to patient information / electronic work station in patient room.**

- ☐ **Conduct Verbal SBAR report with patient / family.**
  Use words that patient and family can understand.

  S=Situation (What is going on with patient? What are the current vital signs?)

  B=Background (What is the pertinent patient history?)

  A=Assessment (What is the patient's problem now?)

  R=Recommendation (What does the patient need?)

- ☐ **Do focused assessment.**
  Visually inspect all wounds, incisions, drains, IV sites, IV tubings, catheters, etc.

- ☐ **Review tasks that need to be done such as:**

  - Labs or tests needed.
  - Medications administered.
  - Forms that need to be completed– admission, patient intake, vaccination, allergy review.
  - Other tasks ____

- ☐ **Identify the patient and family's needs or concerns.**

  - Ask the patient and family:
    - *What could have gone better during the last 12 hours?*
    - *Tell us how your pain is. Tell us how much you walked today.*
    - *Are there any concerns about safety?*
    - *Any worries you would like to share? We want to work together to make certain you have what you need.*

  - Ask the patient and family what their goal is for the next shift. "*What do you want to do during the next 12 hours?*" Remember, this is the patient's goal - not our goal for the patient! Follow up to see if this was addressed at the next shift report.

Adapted from the Emory University Bedside change of shiftBedside change of shiftBedside change of shiftBedside change of shift Bundle.

Nurse Bedside Change of Shift Training

[Insert hospital name, presenter name and title, date of presentation]

Bedside Change of Shift Tool 3: Nurse Training Presentation

Today's session

- What is patient and family engagement?
- What are the components of bedside change of shift?
- What are the benefits and challenges of bedside change of shift?
- What does HIPAA say about bedside change of shift?
- Practice exercises

What is patient and family engagement?

Hospital quality

- Patients get care that is safe
- Patients get the right care for their condition
- Patients get care they need when they need it
- Patients get care that makes wise use of resources
- No differences in treatment based on race, ethnicity, income, education, or social status
- Care is patient- and family-centered

Patient- and family-centered care

- Mutually beneficial **partnerships** among clinicians, hospital staff, patients, and families
- Core concepts:
  - Dignity and respect
  - Information sharing
  - Participation
  - Collaboration

What is patient and family engagement?

- Critical component of patient- and family-centered care
- Patient and family engagement means involving patients and family members as:
  - Members of the health care team
  - Advisors working with clinicians and leaders to improve policies and procedures

Goal of patient and family engagement

- To create an environment where patients, families, clinicians, and hospital staff all work together as partners to improve the quality and safety of hospital care

Why engage patients and families?

- Research shows patient-centered communication can improve:
  - Patient safety
    (Coulter and Ellins 2007, Charmel and Frampton 2008, Joint Commission 2007)
  - Patient outcomes, including emotional health, functioning, and pain control
    (Roter 1989)
  - Patient experience
    (Iacono 2001)

What is the patient and family experience at our hospital?

What is it like being a patient?

Clinicians and hospital staff	Patients and family
• Know how the hospital works and how to get things done	• Are strangers in this environment • Don't understand the system or culture • Know about their body and life situation better than hospital staff
• Know who hospital staff are and what they do	• Don't know who different staff are and what they do • May want family or friends to support them
• Are busy and under a lot of stress	• Are often in pain or uncomfortable, vulnerable or afraid • Family members are worried and want to do what they can for the patient • Aware that hospital staff are busy and may not want to bother you
• Want to provide high quality and safe care	• Trust hospital staff to provide safe and quality care

What is it like being a patient?

- [Insert 1 to 2 experiences from real patients or family members, focus on what shift change feels like to the patient or family member:
  - Live presentation / story
  - Video
  - Vignette or quote]

Bedside change of shift

Critical elements

Benefits

Challenges

What is bedside change of shift?

- Nursing staff conducts shift change reports at the patient's bedside
- Patient can identify a family member or close friend to participate
- Report should take 3-5 minutes per patient
- Purpose is:
  - To engage the patient and family in their care
  - To share accurate and useful information between nurses, patients, and families

Critical elements of bedside change of shift

- Introduce nursing staff, patient and family. Invite patient and family to participate
- Open medical record / electronic health station in patient room
- Verbal SBAR with patient / family – use words they can understand
- Focused assessment – visually inspect all wounds, IVs, and so forth
- Review tasks needed to be done
- Identify needs and concerns from patient/family

Benefits of bedside change of shift for patients

- Demonstrates value of patient perspective as most important
- Shows the patient how much nurses know / do for their care
- Reassures the patient that everyone knows what is going on with them
- Reminds the patient and family that they can ask questions and that nurses are available and usually have answers

Benefits of bedside change of shift for patients

- Shows teamwork among nursing staff
- Builds trust in the care process
- Informs patient and family members about the patient’s care – less anxiety
- Increases patient satisfaction with their experience of care

Benefits of bedside change of shift report for nurses

- Better information about the patient’s condition
- Accountability
- Time management
- Patient safety

Video of bedside change of shift

- [To be added: Video of real example of bedside change of shift from Emory University]
- Discussion questions:
  - What are the overall impressions of the bedside change of shift?
  - What went well?
  - What could have been done differently?
  - What questions or concerns do you have about bedside change of shift?

Tips for bedside change of shift

- Invite patients and loved ones to participate using bedside change of shift brochure (Tool 1)
- Use checklist to facilitate bedside change of shift (Tool 2)
- If problem with room or situation, don't confront the outgoing nurse in front of the patient
- Don't forget to thank the outgoing nurse if everything is in good shape

Potential challenges

- Unknown visitors / family in the room
- New diagnosis / information patient is not yet aware of (e.g., waiting for doctor to discuss)
- Patient is asleep
- Patient is noncompliant and you need to share information with oncoming nurse
- Patient or family has complex question or lengthy clarification
- Semi-private rooms / HIPAA concerns

HIPAA and Bedside Change of Shift

Addressing HIPAA concerns

- Health information can be disclosed for:
  - Treatment
  - Health care operations
  - Payment
- HIPAA acknowledges incidental disclosures may occur. Not a HIPAA violation as long as...
  - Take reasonable safeguards to protect privacy
  - Only disclose or use the minimum necessary information

Addressing HIPAA concerns

- Is a covered entity required to prevent any incidental use or disclosure of protected health information?

  Answer: No. The HIPAA Privacy Rule does not require that all risk of incidental use or disclosure be eliminated to satisfy its standards. Rather, the Rule requires only that covered entities implement reasonable safeguards to limit incidental uses or disclosures. See 45 CFR 164.530(c)(2).

Addressing HIPAA Concerns

- Can physicians and nurses engage in confidential conversations with other providers or with patients, even if there is a possibility that they could be overheard?

Answer: Yes. HIPAA does not prohibit providers from talking to each other and to their patients. Providers primary consideration is the appropriate treatment of their patients.

Addressing HIPAA Concerns

- Oral communications often must occur freely and quickly. Covered entities are free to engage in communications as required for quick, effective, and high quality health care. For example:
  - Coordinate services at nursing stations
  - Discuss a patient's condition or treatment regimen in the patient's semi-private room
  - Discuss a patient's condition during training rounds in an academic or training institution

Practice exercises

Option 1: Role play vignette

- Jack, a 64 year old male with a history of chronic obstructive pulmonary disease, hypertension, and Type II diabetes, was admitted to the unit this afternoon from the ED. His symptoms were severe morning headache with occasional vomiting for 3 days, chest pain, and shortness of breath. He received a dose of Zofran for vomiting before being brought up to the unit. During the initial nursing assessment, the nurse noticed a large bruise on the elbow and hip related to a recent fall.
- It is time for evening shift change. During shift change, Jack notes he is slightly disoriented and drowsy and his headache has returned.
- Let's form groups of three for this exercise. Take about 5-8 minutes.

Option 1: Role play vignette

- Debrief :
  - How did you each feel during this interaction?
  - What really went well?
  - What could have been done differently?
  - Anything else?

Option 2: Small group discussion

- Break into groups of X with one patient / family advisor in each group
- Each person should discuss experience with bedside change of shift – what went well, what did not go well
- Report back to large group

Final thoughts

- Our hospital is committed to patient and family engagement – everyone plays a critical part
- Patients and families won’t engage if they believe that you don’t want them to – it is simply too risky for them
- Your job is to make it safe for them to be involved, not just as patients, but as partners in their care

Thank you!

- For questions or more information
  [Insert name, phone number, and email]

Draft Treatment for Bedside change of shift Nurse Training Video

The video will be included in the nurse training PowerPoint materials for Component 1- Working with patients and families at the bedside, Nurse Bedside change of shift.

The goal of the Bedside change of shift strategy is to help ensure the safe handoff of care between nurses by involving the patient and family and to involve patients and families in the change of shift report for nurses. Hospitals will train nurses on how to conduct change of shift report at the patient's bedside. The primary focus of the training is to prepare nurses to do shift report at the bedside, and to help them understand how to engage patients and family members in the process. The training will include a video that shows the process of a bedside change of shift report.

This treatment describes the video, what will happen and when. It describes why certain actions will take place, i.e., the intended effect on the audience. Because we plan to video an actual bedside change of shift at Emory University Hospital, this treatment does not contain the full narration or dialogue. The video would be approximately 5 minutes in length.

Treatment of bedside change of shift video

[SETTING: Interior of hospital room. Patient is lying in hospital bed with family member seated in chair next to the bed. Two nurses walk into the room and stand at the side of the patient's bed.]

- Nurse 1 greets the patient by name and introduces the patient and family member to Nurse 2.
- Nurse 1 verbally reviews the patient's diagnosis and symptoms and also reviews medications, treatments, procedures to date [used to illustrate what information will be exchanged at the bedside change of shift].
- During this process, Nurse 2 asks one or two questions (of Nurse 1 and the patient) and clarifies as needed [used to illustrate how the patient can be involved].
- Nurse 1 asks the patient and family member if they have anything to add to the review of the patient's history, asks patient what their goal is for the day, and writes it on the white board in the patient room [used to illustrate how the family member can be involved].
- Nurse 1 asks Nurse 2 if she has any questions.
- Nurse 2 tells the patient that she will be back later, provides instructions for if the patient needs her in the meantime.
- Get patient/family reactions to bedside change of shift

[Nurses exit]

Component 1

Strategy 3:

Discharge Plan -

IDEAL Discharge Planning

Strategy 3

IDEAL Discharge Planning

Implementation Handbook

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Implementation Handbook: IDEAL Discharge Planning

The *Guide to Patient and Family Engagement in Hospital Quality and Safety* (the *Guide*) is a resource to help hospitals develop effective partnerships with patients and family members, with the ultimate goal of improving hospital quality and safety.[1]

Discharge from hospital to home requires the successful transfer of information from clinicians to the patient and family to reduce adverse events and prevent readmissions. Engaging patients and families in the discharge planning process helps make sure this transition in care is safe and effective.

This handbook gives you an overview of and rationale for the IDEAL discharge planning strategy. It also provides step by step guidance to help you put this strategy into place at your hospital.

Overview of the IDEAL Discharge Planning Strategy

The goal of the *IDEAL Discharge Planning* strategy is to engage patients and family members in the transition from hospital to home, with the goal of reducing adverse events and preventable readmissions.

The IDEAL discharge strategy highlights the key elements of engaging the patient and family in discharge planning:

Include the patient and family as full partners in the discharge planning process.

Discuss with the patient and family five key areas to prevent problems at home: describe what life at home will be like, review medications, highlight warning signs and problems, give test results, and make followup appointments.

Educate the patient and family in plain language about the patient’s condition, the discharge process, and next steps at every opportunity throughout the hospital stay.

Assess how well the patient and family understand the diagnosis, condition, and next steps in the patient’s care – Use Teach Back.

Listen to the patient and family’s goals, preferences, observations, and concerns.

Each part of IDEAL discharge planning has multiple components:

Include the patient and family as full partners in the discharge planning process.

- Always include the patient and family in team meetings about discharge. Remember that discharge is not a one-time event, but a process that takes place throughout the hospital stay.
- Identify which family or friends will provide care at home and include them in conversations.

Discuss with the patient and family five key areas to prevent problems at home.

1. *Describe what life at home will be like*: Include home environment, support needed, what the patient can or cannot eat, and activities to do or avoid.
2. *Review medications*: Use a reconciled medication list to discuss the purpose of each medication, what and how to take it, and potential side effects.
3. *Highlight warning signs and problems*: Identify warning signs or potential problems. Write down the name and contact information of someone to call if there is a problem.
4. *Explain test results*: Explain test results to the patient and family. If test results are not available at discharge, let the patient and family know when they should hear about results and identify who they should call if they have not heard the results.
5. *Make followup appointments*: Offer to make followup appointments for the patient. Make sure that the patient and family know what followup is needed.

Educate the patient and family in plain language about their condition, the discharge process, and next steps at every opportunity throughout the hospital stay.

Getting all the information on the day of discharge can be overwhelming. Discharge planning should be an ongoing process throughout the stay– not a onetime event. You can:

- Elicit patient and family goals at admission and note how progress is being made each day during the hospital stay.
- Involve the patient and family in nurse change of shift report or bedside rounds.
- Share a written list of medications every morning during the hospital stay.
- Go over medicines at each administration – what it is for, how to take it, and side effects.
- Encourage the patient and family to take part in care practices to support their competence and confidence in care giving at home.

Assess how the patient and family understand the diagnosis, condition, and next steps in their care: Use Teach Back.

- Provide information in small chunks and repeat key pieces of information throughout the hospital stay.
- Ask the patient and family to repeat back what you said back to you in their own words to be sure that you explained things well.

Listen to the patient and family's goals, preferences, observations, and concerns.

- Invite the patient and family to use the white board in their room to write questions or concerns throughout their stay.
- Ask open-ended questions to elicit questions and concerns
- Use *Tool 2: Be Prepared to Go Home Checklist*, to make sure the patient and family feel prepared to go home.
- Schedule at least one meeting specific to discharge planning with the patient and family caregivers.

What are the IDEAL Discharge Planning tools?

This section provides an overview of the tools included in this strategy. The set of tools included in this *Guide* are for discharges to home only, with or without home- and community-based services, such as home health care.

Tool	Use this tool to…	Description and formatting
Tool 1 **IDEAL Discharge Planning Overview, Process, and Checklist**	Inform clinicians about the new discharge planning process and keep track of when tasks are accomplished.	• Used by clinicians, this handout gives an overview of the IDEAL discharge planning process and includes a checklist that could be completed for each patient. • Format: 2-page overview, 2-page process steps, 2-page checklist
Tool 2 **Be Prepared to Go Home Checklist**	Identify and discuss the patient and family's questions and concerns about going home.	• Given to patients soon after admission, this checklist highlights what the patient and family need to know before leaving the hospital, gives example questions they can ask, and gives space for writing information as needed. • Format: Booklet
Tool 3 **Improving Discharge Outcomes With Patients and Families**	Inform physicians of the IDEAL discharge planning process.	• Given to physicians, this handout describes the new discharge planning process. A verbal description should also accompany the distribution of the handout – either at a staff meeting or other venue. • Format: 1-page handout
Tool 4 **IDEAL Discharge Planning Training**	Prepare clinicians and hospital staff to support the efforts of patient and family engagement related to discharge planning.	• A training for any staff involved in the discharge process – physicians, nurses, discharge planners, social workers, pharmacists, or physicians. • Format: PowerPoint presentation and talking points

What is the IDEAL Discharge Planning process?

You can incorporate elements of the IDEAL discharge planning process into your current discharge process. This process incorporates the IDEAL elements from admission to discharge and includes at least one meeting between the patient, family and discharge planner to specifically address the patient and family's questions and concerns.

What to do?	Who does it?
When: At initial nursing assessment	
• Identify the family or others who will be at home with patient.	Bedside nurse
• Let the patient and family know that they can use the white board in the room to write questions or concerns.	Bedside nurse
• Elicit the patient and family goals for hospital stay.	Bedside nurse
• Inform the patient and family about steps toward discharge.	Bedside nurse
When: Daily activities	
• Educate the patient and family about the patient's condition at every opportunity.	All clinical staff
• Explain medications to the patient and family.	All clinical staff
• Discuss progress toward goals.	All clinical staff
• Involve the patient and family in care practices.	All clinical staff
When: Prior to discharge planning meeting (1 to 2 days before discharge planning meeting; for short stays, may happen on admission)	
• Give *Tool 2: Be Prepared to Go Home Checklist* to the patient and family.	TBD by hospital: Nurse, physician, volunteer, patient advocate, discharge planner
• Schedule discharge planning meeting with the patient, family, and hospital staff.	
When: Discharge planning meeting (1 to 2 days before discharge, earlier for more extended stays in the hospital)	
• Use *Tool 2: Be Prepared to Go Home Checklist* as a starting point for dialogue questions, needs and concerns going home.	TBD by hospital: Nurse, physician, volunteer, patient advocate, discharge planner, or combination
• Offer to make followup appointment. Ask if patient has preferred day / time and if they can get to appointment.	TBD by hospital: Nurse, physician, volunteer, patient advocate, discharge planner
When: Day of discharge	
• Review a reconciled medication list with the patient and family.	TBD by hospital: Nurse, physician, or pharmacist
• Write followup appointment times on checklist.	Staff who scheduled appointment
• Write name, position, and phone number of a person to contact if there is a problem after discharge.	TBD by hospital: Nurse, physician, volunteer, patient advocate, discharge planner

Rationale for the IDEAL Discharge Planning Strategy

The goal of patient and family engagement is to create an environment where patients, families, clinicians, and hospital staff all work together as partners to improve the quality and safety of hospital care. Patient and family engagement encompasses **behaviors** by patients, family members, clinicians, and hospital staff, as well as the **organizational policies and procedures** that support these behaviors.

Discharge from a hospital can be a complex process: It is not a one-time event, and no single act will make it work better. For discharge to be most effective, communication among clinicians and between clinicians, the patient, and family needs to happen throughout the hospital stay.

Education and learning is a two-way path. The patient and family need to learn from clinicians about their condition and next steps, and clinicians need to learn from the patient and family about their home situation (both what help and support they can count on and the barriers they may face in taking care of themselves) and their questions about their health after they get home. Clinicians also need to make sure that patients and family members *really* understand the next steps in their care.

Why is the discharge process important?

Nearly 20 percent of patients experience an adverse event within three weeks of discharge. Of these adverse events, three-quarters could have been prevented or ameliorated. Common complications post-discharge include adverse drug events, hospital acquired infections, and procedural complications.(1) Further, rehospitalization is becoming a focus of attention for hospitals, purchasers, hospital quality organizations, and others. In a recent study using Medicare data, Jencks and colleagues (2) concluded that "rehospitalizations among Medicare beneficiaries are prevalent and costly." Nearly 20 percent of Medicare patients were rehospitalized within 30 days after discharge. Half the medical patients who were rehospitalized had no claim filed for a visit with a physician during the period following the discharge. About 70 percent of surgical patients were rehospitalized for a medical condition. The authors estimate that the cost of these unplanned hospitalizations in 2004 was $17.4 billion.(2)

What are the key issues related to discharge?

Several important challenges have been identified in providing high quality care as patients leave the hospital:(3-5)

- **Discontinuity between inpatient and outpatient providers**. Studies have shown that hospital discharge summaries fail to reach outpatient providers, and when they do, often fail to provide important administrative and medical information. Also, patients go to multiple providers, making continuity of care more difficult between inpatient and outpatient settings.

- **Changes or discrepancies in medication lists before and after hospital stay**. To ensure an accurate medication list at hospital discharge, hospital providers need to take a complete and accurate medication history at the time of admission, keep track of changes to medications administered throughout the hospital stay, and reconcile medication lists upon discharge. Patients prescribed high risk medications or complex medication regimens may be at higher risk of adverse drug events.

Key areas to address prior to discharge

- Medication reconciliation
- Structured communication to patients, families, and outpatient physicians
- Patient and family education and involvement

- **Inadequate preparation for discharge**. Quality of discharge teaching is the strongest predictor of discharge readiness. Patients may not been properly informed about food choices, medication side effects, danger signs, and when to resume activities. Also, studies have shown that there is a disconnect between the information that patients and families believe they need to know and what providers think patients need to know.

- **Disconnect between provider information-giving and patient understanding**. Studies have demonstrated that providers may not relay information to patients in a way they can understand. Key instructions at discharge should be given in plain language, use both verbal and audiovisual instruction, be repeated by multiple providers (e.g., physician, nurse, pharmacist), and be confirmed using a "teach-back" method, where patients are asked to repeat back what they understood about discharge instructions in their own words.

- **Burden of care assumed by patients and families after discharge**. Patients are responsible for administering new medications, tracking symptoms, participating in physical therapy, and following up with their outpatient physician. For many patients, sufficient social and family support is not available to help perform these activities effectively. Also, patients may feel overwhelmed and unprepared to take on an active role in their health care without adequate information, and in some cases, coaching.

Many of these challenges can be attributed to problems in discharge planning. **Discharge planning** is the process of identifying and preparing for a patient's anticipated health care needs

after they leave the hospital.(6) Hospital staff cannot do discharge planning in isolation from the patient and family.

Comprehensive discharge planning involving the patient and family contributes to positive patient outcomes, such as reductions in unplanned readmissions and increases in patient and caregiver satisfaction with the health care experience.(7, 8) However, it is often difficult for hospitals to do comprehensive discharge planning given the shortened length of stays for most hospital admissions. That is why it is critical to involve and educate the patient and family throughout the hospital stay.

How to prevent adverse events after discharge

Ensuring safe transitions from hospital to home requires a systematic approach that includes the patient and family in the discharge process. At this time, no consensus exists on the single best method to prevent adverse events after discharge.

Although more research is needed to verify these findings, various medication reconciliation approaches have shown promise in improving clinical outcomes. Promising interventions include discharge "checklists" to standardize the discharge process, and structured post-discharge phone calls to patients. Similarly, evidence is mounting for structured discharge communication approaches. One approach uses specially trained staff to meet with patients before (and sometimes after) discharge to reconcile medications, instruct patients and caregivers in self-care methods, prepare patient-centered discharge instructions, and facilitate communication with outpatient physicians.

Coleman's *Care Transitions Program*, Naylor's transitional care intervention with advanced practice nurses, and the *Project RED (Re-Engineered Discharge) study* use variations of this method, and all successfully reduced readmissions and emergency department visits after discharge.(9-11) Other interventions aimed at transitions from hospital to home show similar promise. The *BOOSTing (Better Outcomes for Older adults through Safe Transitions) Care Transitions* project uses a combination of assessment and communication strategies for improving discharge outcomes for older adults. Also, Transforming Care at the Bedside (TCAB), a national program from the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement, developed the *How-to Guide: Creating an Ideal Transition Home for Patients with Heart Failure*. This guide integrates what TCAB hospitals have learned as they strive to improve the quality of care for patients discharged from the hospital to home or to another health care facility.

The IDEAL discharge planning materials in the *Guide* build on these important initiatives, focusing on those elements intended to engage the patient and family in their care. **The IDEAL discharge strategy and tools can stand on their own or be used *with* these successful initiatives, rather than instead of them.** [Note: Could include example here from Task 7]

How does the IDEAL discharge planning strategy improve the discharge process?

The *IDEAL Discharge Planning* strategy focuses on engaging the patient and family in the discharge process. This approach involves working *with* patients and families rather than only doing something *to or for* patients and families. The tools in this strategy support discharge planning among the patient, family, clinicians, and hospital staff in several ways. They:

- Help clinicians and hospital staff include the patient and family as full partners in the discharge planning process.
- Provide an opportunity for the patient and family to think about the discharge throughout the hospital stay.
- Identify opportunities for educating the patient and family throughout the hospital stay.
- Train clinicians and hospital staff on ways to conduct patient and family education and confirm understanding.
- Provide a structured setting in which patients and families can discuss their concerns and get their questions answered, prior to the often chaotic day on which the discharge actually occurs.
- Ensure that patients have a followup appointment prior to leaving the hospital.
- Ensure that patients know who to call if they are having problems.

Also, the Joint Commission suggests that hospitals meet the following four goals in a discharge process. The *IDEAL Discharge Planning* strategy helps to meet these goals:

1. Address patient communication needs during discharge and transfer.
2. Engage patients and families in discharge and transfer planning and instruction.
3. Provide discharge instruction that meets patient needs.
4. Identify followup providers that can meet unique patient needs.

(Placeholder for examples from Task 7, Implementation and Evaluation in this section in the form of patient/family/staff quotes or a case study.)

Implementing the IDEAL Discharge Planning Process

(Note: This is a section where we will want to incorporate information from the Task 7 Implementation and Evaluation. We will also be able to provide more specific guidance about what worked and what did not work.)

The *IDEAL Discharge Planning* strategy is designed to be flexible and adaptable to each hospital's environment and culture. As such, this guidance provides choices and questions for hospital leaders about how to implement this strategy. It may be helpful to implement this

strategy initially on a small scale (e.g., a single unit). Identify lessons learned from the single-unit pilot implementation, refine your approach, and then spread to more units. In this way, you can build on your successes as a pathway to broader dissemination and wider-scale change.

Step 1: Form a multi-disciplinary team to identify areas of improvement

As with any new activity or quality improvement effort, planning and identifying areas of improvement are important parts of the process. Below are some key considerations as you get started implementing the *IDEAL Discharge Planning* strategy.

Engage patients and families and unit staff in the process: Establish a multi-disciplinary team

This team should include hospital leaders, physicians, nurses, other key clinical and management staff, and patient and family representatives.

Guide **Resource**	For more information about working with patient and family advisors, see *Component 2, Organizational Partnership Materials*

Throughout the process of implementing the IDEAL discharge planning strategy, patient and family advisors can:

- Give feedback on what the current discharge process feels like as a patient or family member.
- Contribute to adapting the IDEAL strategy and tools for your hospital (both the overall process and the individual tools).
- Take part in training clinicians about the IDEAL discharge process by participating in role plays or other small group exercises or by describing how the discharge process feels to the patient or family.
- Observe clinicians throughout hospital stay and give feedback about how they meet the key elements of the IDEAL discharge process.

Assess family visitation policies

The family cannot be part of the health care team if they are not present. It is important that the patient can define who is included their family and that these members of the health care team are encouraged and supported.

***Guide* Resource**	For more information about family presence policies, see *Supporting Patient and Family Engagement: Best Practices for Hospital Leaders* in *Component 3.*

Assess the current discharge process, including how and the extent to which patients and family members are engaged

Use the multi-disciplinary team to review what is known, from formal survey measures, readmission rates, and people's sense of how things are going with respect to discharge planning from the clinician, patient, and family perspectives. Who from the hospital staff are involved in the process? How do they coordinate their interactions with the patient? How satisfied are the clinicians and hospital staff involved in the process?

The team can identify strengths related to discharge planning – what is done well in terms of engaging the patient and family in this discharge planning process and making sure the patient and family understands all of the next steps in their care. Also, the team can identify areas for improvement – what can be done better?

Improving the discharge planning process may require new behaviors from each member of the health care team – the patient, family, clinicians, and hospital staff. Each team member brings a different perspective to the discharge process, and understanding those perspectives is important for effective discharge planning.

Keep in mind that taking on new behaviors will be challenging. The multi-disciplinary team can identify challenges and facilitators for engaging patients and families in discharge planning at your hospital or unit. What factors seem to support patient and family engagement in discharge planning? How can we replicate them? What are the challenges that need to be addressed from the patient, family, clinician, and hospital staff perspectives?

Some examples of challenges related to engaging patients and families in discharge planning and ways to overcome those challenges are:

- ***Clinicians and hospital staff may feel that they already engage the patient and family in discharge planning or may not know how to incorporate new communication approaches into their care.*** Some clinicians or hospital staff may feel that they already engage the patient and family in discharge planning, even when decisions are made about discharge without the patient and family present. Although many clinicians recognize the importance of communication, they tend to be overly positive in their perceptions of how effectively they communicate.(12) Even when providers see the need for better communication, such as with the use of teach back, it may be difficult to operationalize those skills in practice.(13)

- ***Inadequate time to prepare the patient and family for discharge.*** Occasionally, the physician's discharge orders may come as a surprise to discharge planning staff or bedside nurses. Similarly, hospital staff may feel pressure to rapidly make a bed available for another patient. Because of limited time, hospital staff may not feel able to engage the patient and family in the discharge planning process, reducing the effectiveness of some discharges. Recognize that discharge planning is not a one-time event, but a process throughout the hospital stay.
- ***Negotiating interactions with family members*.** Families are complicated, and it may be difficult for clinicians and hospital staff to know which family members should be involved in discharge planning and how to interact with those family members. As part of the initial nursing assessment, it is important for nurses to ask patients which family or friends would they like to participate and who will be involved in their care at home.
- ***Fearing change*.** Some clinicians or hospital staff may fear losing control of the discharge planning process or may not feel confident in engaging the patient and family in discharge planning. Often, if consistent use of the IDEAL discharge planning is not monitored, clinicians or hospital staff may revert back to the "old way." It is important to let clinicians and hospital staff know that the IDEAL discharge planning is not optional. Acknowledge that change is hard, but stress the importance of engaging the patient and family in the discharge planning process.

Identify ways to overcome these challenges at your hospital or unit. Are there particular units where it might be wise to "pilot" this new approach, either because of staff attitudes or because there is a pressing need to improve discharge for a group of patients?

Set aims to improve discharge planning

Once you have a strong understanding of the existing family presence policies, discharge planning challenges, and facilitators, you can identify what needs to be improved and ways to measure that improvement.

Any quality improvement initiative requires setting aims. The aim should be time-specific, measurable, and define who will be affected.

For example, hospitals may want to improve patients' experience of care as measured by the CAHPS Hospital Survey®. CAHPS Hospital Survey® questions related to discharge include:

- Q19: 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?

> For more information on setting aims and identifying measures, see the Institute of Healthcare Improvement's Web site on improvement methods. Available at: http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/.

- Q20: During the hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?

If a hospital wants to improve their CAHPS Hospital Survey® scores related to discharge, an aim might be "to improve scores on CAHPS Hospital Survey® Questions 19 and 20 by 5 percent within 1 year."

Step 2: Decide on how to implement the IDEAL discharge planning strategy

Once the team has set specific aims for improvement, it may be helpful to identify a single point person as the primary person staff would go through with any kind of question. This person may not have the answers to all questions, but would know who would have them. This way, people are clear about whom to go to, and that person will hear all the questions and concerns.

Decide on how to adapt the IDEAL discharge planning process for your hospital

As described above, the IDEAL discharge planning strategy includes four tools.

Guide **Resources**	*Tool 1: IDEAL Discharge Planning Overview, Process, and Checklist* informs clinicians about the new discharge planning process and keeps track of when tasks are accomplished. *Tool 2: Be Prepared to Go Home Checklist* identifies the patient and family's questions and concerns about going home. *Tool 3: Improving Discharge Outcomes With Patients and Families* informs physicians of the IDEAL discharge planning process. *Tool 4: IDEAL Discharge Planning Training* prepares clinicians and hospital staff to support the efforts of patient and family engagement related to discharge planning.

Answer the following questions to decide how to use and adapt the tools in this strategy at your hospital:

- ***Decide on how to use and adapt the IDEAL discharge planning process.*** First, decide on which elements of the IDEAL discharge planning process need to be incorporated at your hospital. Ask clinicians, hospital staff, and patient and family advisors about possible changes. Adapt *Tool 1: IDEAL Discharge Planning Overview, Process, and Checklist* to fit your hospital environment. How can these processes be incorporated into

electronic health records? Once this tool is adapted, who will review it? What approvals are needed?

- ***Decide how to use and adapt the checklist for the patient and family.*** Next, adapt the patient and family checklist, *Tool 2: Be Prepared to Go Home Checklist.* Ask clinicians, hospital staff, and patient and family advisors about possible changes. At a minimum, it would be important to insert hospital name, logo, and tailored information into the brochure. Who will review it? What approvals are needed?

  Once adapted, determine how the checklist be distributed. How will the checklist be printed? Who will distribute? How will interpreters be involved in the distribution process, if needed? Can the checklist be integrated into the current admission or discharge materials? If so, how? What approvals need to be sought? Who will go over the checklist with the patient and family and invite the patient and family to participate? (The hospital can determine which staff should be involved in meeting to go over the checklist; this could include the nurse, doctor, volunteer/patient advocate, discharge planner, or a combination. The patient should determine if family or friends should be involved and if so, who.) If applicable, how will temporary staff learn about how to engage patients and families in the discharge planning process?

  Once ready, how will the checklist be printed? Will they be distributed in a folder, online, or another way? How can the messages from the tools be incorporated or distributed via different communication methods such as video, social media such as Facebook, or cell phone text messages?

- ***Plan the IDEAL discharge process training for clinicians***. Who can conduct the training for their colleagues? The facilitators should be respected by their colleagues and model the behaviors being asked of them. Which patient and family advisors can help to conduct or facilitate the training? How many sessions are needed to train all staff? When can the training be scheduled? Where can the training happen? How should the *Tool 4: IDEAL Discharge Planning Training* be adapted? Who needs to approve the training materials?

  Recognize that individuals have different learning styles. To be most effective, use three or more different learning strategies during the training, such as giving information, modeling behavior, providing feedback, and practicing skills.

Step 3: Implement and evaluate the IDEAL Discharge Planning Strategy

Inform staff of changes

If not already involved, inform unit directors and managers so they know what is coming and why it is important. Inform staff at staff meetings and through posters in common rooms about

the changes in the discharge planning process and opportunities for training. Specifically, inform physicians of upcoming changes using *Tool 3: Improving Discharge Outcomes With Patients and Families.*

Train staff

Staff training will include those chosen by the hospital to implement the tools. Training includes a mix of PowerPoint slides and role play, and should take about an hour, but can be tailored to the needs of your hospital. Main messages to emphasize: (1) To improve safety and quality of care at home, the patient and family needs to be included as a member of the team for all of discharge planning, and (2) Discharge planning is not a one-time event with a single fix; it needs to occur throughout the hospital stay.

After the training, it is important to assess:

- Did the training happen as planned? What happened during training that could challenge or facilitate implementation?
- How did staff react to training?

Distribute tools and incorporate key principles into practice

As defined during Step 2, identified staff will distribute and go over materials with the patient and family. The main message to emphasize with the patient and family is: The patient and family are full partners in discharge planning and need to be prepared little by little throughout the hospital stay to ensure that they know what to do and have what they need to succeed at home. This will result in higher quality discharges with more positive outcomes.

Keep staff aware of the IDEAL discharge planning by making sure *Tool 1: IDEAL Discharge Planning Overview, Process, and Checklist* is available throughout the unit.

Assess implementation intensely during the initial first month and periodically after that

Make sure that all clinicians and hospital staff have the support needed to implement the new discharge planning process and to effectively communicate with the patient and family. Have the nurse manager or other staff leader observe interactions with the patient and family and provide feedback to individual clinicians and hospital staff. Use a standardized form to keep track of the observations, such as the checklist that is a part of *Tool 1: IDEAL Discharge Planning Overview, Process, and Checklist.* Identify a way to collect and analyze data collected, such as an Excel Spreadsheet or other database.

Continue to conduct periodic observations at 2 and 4 months after roll-out to ensure consistency of implementation among staff. Continual feedback and monitoring is needed to make sure behaviors become more natural.

Get feedback from clinicians, hospital staff, patients and families

Get informal feedback from clinicians, hospital staff, patients, and family members by asking them about how communication and the tools can be improved. If applicable, it may be helpful to get feedback from community physicians, especially for those patients who need strong discharge planning support. What worked well? What could be improved? How could tools be changed or adapted for use on another unit? What was critical for success? What was not successful and what could have been made better?

Incorporate formal feedback in mechanisms already in place at hospital such as patient and family focus groups, patient and family satisfaction surveys, and staff surveys.

Refine process

Share feedback with implementation team, problem solve, and adapt, as necessary. Using the feedback received, refine the process and tools before implementing in other units.

[1]The Guide was developed for the Agency for Healthcare Research and Quality, in the U.S. Department of Health and Human Services, by a collaboration of partners with experience in and commitment to patient and family engagement, hospital quality, and safety. Led by the American Institutes for Research (AIR), the team included the Institute for Patient and Family-Centered Care (IPFCC), Consumers Advancing Patient Safety (CAPS), the Joint Commission, and the Health Research and Educational Trust (HRET). Other organizations contributing to the project included Planetree, the Maryland Patient Safety Center (MPSC), and Aurora Health Care.

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IDEAL Discharge Planning: Overview, Process, and Checklist

Overview of IDEAL Discharge Planning

What is IDEAL discharge planning?

Discharge and transition planning from the hospital to home cannot be done successfully in isolation from the patient and family. IDEAL discharge planning emphasizes the key elements of engaging patients and families:

- ✓ **I**nclude the patient and family as full partners in the discharge planning process.
- ✓ **D**iscuss with the patient and family five key areas to prevent problems at home: (1) what life at home will be like, (2) medications, (3) warning signs and problems, (4) test results, and (5) followup appointments.
- ✓ **E**ducate the patient and family in plain language about their condition, the discharge process, and next steps at every opportunity throughout the hospital stay.
- ✓ **A**ssess how the patient and family understand the diagnosis, condition, and next steps in their care – Use Teach Back.
- ✓ **L**isten to the patient and family's goals, preferences, observations, and concerns.

How can you do IDEAL discharge planning?

Each element of IDEAL discharge planning has multiple components:

Include the patient and family as full partners in the discharge planning process.

- Always include the patient and family in team meetings about discharge. Remember discharge is not a one-time event, but a process throughout the hospital stay.
- Identify which family or friends will provide care at home and include them in conversations.

Discuss with the patient and family five key areas to prevent problems at home.

1. *Describe what life at home will be like*: Include home environment, support needed, what the patient can or cannot eat, and activities to do or avoid.
2. *Review medications*: Use a reconciled medication list to discuss the purpose of each medication, what and how to take it, and potential side effects.
3. *Highlight warning signs and problems*: Identify warning signs or potential problems. Give the name and contact information of someone to call if there is a problem.

4. *Explain test results*: Explain test results to the patient and family. If test results are not available at discharge, let the patient and family know when they should hear about results and identify who they should call if they have not heard the results by that date.
5. *Make followup appointments*: Offer to make followup appointments for the patient. Make sure that the patient and family know what followup is needed.

Educate the patient and family in plain language about condition, discharge process, and next steps at every opportunity throughout the hospital stay.

Getting all the information on the day of discharge can be overwhelming. That's why discharge planning should be an ongoing process throughout the stay – not a onetime event. You can:

- Elicit the patient and family goals at admission and note how progress is being made toward these goals each day during the hospital stay.
- Involve the patient and family in nurse change of shift report or bedside rounds.
- Share a written list of medications every morning during the hospital stay.
- Go over medicines at each administration – what it is for, how to take it, and potential side effects.
- Encourage the patient and family to take over care practices to support their competence and confidence in care giving at home.

Assess how the patient and family understand the diagnosis, condition, and next steps in their care: Use Teach Back.

- Provide information in small chunks and repeat key pieces of information throughout the hospital stay.
- Ask the patient and family to repeat back what you said in their own words to be sure that you explained things well.

Listen to the patient and family's goals, preferences, observations, and concerns.

- Invite the patient and family to use the white board in the room to write questions or concerns throughout their stay.
- Ask open-ended questions to elicit the patient's and family's questions and concerns.
- Use *Tool 2: Be Prepared to Go Home Checklist* to make sure the patient and family feel prepared to go home.
- Schedule at least one meeting specific to discharge planning with the patient and family caregivers.

IDEAL Discharge Planning Process

The elements of the IDEAL discharge planning process can be incorporated into your current discharge. The information below describes key elements of the IDEAL discharge from admission to discharge to home. Note that this process includes at least one meeting between the patient, family, and discharge planner to help the patient and family feel prepared to go home.

Initial nursing assessment

☐ **Identify who the caregiver will be at home along with potential back-ups** – these are the "learners" who need to understand instructions for care at home. Do not assume that family in the hospital will be caregivers at home.

☐ **Let the patient and family know that they can use the white board in the room to write questions or concerns**.

☐ **Elicit the patient and family's goals for when and how they leave the hospital**, as appropriate. With input from their doctor, work with the patient and family to set feasible and realistic goals.

☐ **Inform the patient and family about steps in progress toward discharge**. For common procedures, create a patient handout, white board or poster that identifies the "road map" to get home. This "road map" may include things like "I can feed myself" or "I can walk 20 steps."

Daily

☐ **Educate the patient and family about their condition at every opportunity:** Shift report, rounds, vital status check, nurse calls, and other opportunities that present themselves.
Who: All clinical staff

☐ **Explain medications to the patient and family daily (for example, print out a list every morning) and at any time medication is administered.** Explain what each medicine is for, describe potential side effects, and make sure the patient knows about any changes in the medicines they are taking.
Who: All clinical staff

☐ **Discuss the patient, family, and clinician goals and progress toward discharge.** Once goals are set at admission, revisit these goals on a daily basis to make sure the patient and family understand how they are progressing toward discharge.
Who: All clinical staff

☐ **Involve the patient and family in practices to improve confidence in caretaking after discharge.** Examples of care practices could include changing the wound dressing, helping the patient with feeding or going to the bathroom, or assisting with rehabilitation exercises.
Who: All clinical staff

Prior to discharge planning meeting

When: 1 to 2 days before discharge planning meeting; for short stays, may happen on admission

☐ **Give the patient and family the *Tool 2: Be Prepared to Go Home Checklist*.**
Who: Hospital identifies person to distribute; this could be a nurse, doctor, volunteer/patient advocate, or discharge planner.

☐ **Schedule discharge planning meeting with the patient, family, and hospital staff.**
Who: Hospital identifies person to schedule; this could be a nurse, doctor, volunteer/patient advocate, or discharge planner.

Discharge planning meeting

When: 1 to 2 days before discharge, earlier for more extended stays in the hospital.

☐ **Use the *Tool 2: Be Prepared to Go Home Checklist* as a starting point for dialogue about questions, needs and concerns going home.**

- If the patient or family did not read or fill out the checklist, review it verbally. Make sure to ask if they have questions or concerns other than those listed. You can start the dialogue by asking, "*What does being back home look like for you?*"
- Repeat the patient's concerns in your own words to make sure you understand.
- Use Teach Back to check if the patient understands the information given.
- If another clinician is needed to address concerns (e.g., pharmacist, doctor, or nurse), arrange for this conversation.

Who: Hospital determines which staff should be involved in meeting; this could include the nurse, doctor, volunteer/patient advocate, discharge planner, or a combination. Patient determines if family or friends should be involved and if so, who.

☐ **Offer to make followup appointment. Ask if the patient has a preferred day / time and if they can get to the appointment.**
Who: Hospital identifies person to schedule followup appointments; this could be a nurse, doctor, volunteer/patient advocate, or discharge planner.

Day of discharge

☐ **Review a reconciled medication list with the patient and family. Go over the list of current medications. Ask them to repeat what, when, and how to take each medicine.** Make sure that patients have an easy-to-read, printed medication list to take home.
Who: Hospital identifies person to review this list with patient and family. Because this involves medications, we assume it would be a clinician – nurse, doctor, or pharmacist.

☐ **Write down followup appointment times on the *Tool 2: Be Prepared to Go Home Checklist*.**
Who: Staff who scheduled appointment.

☐ **Write the name, position, and phone number of a person to contact if there is a problem after discharge on the *Tool 2: Be Prepared to Go Home Checklist*.** Make sure the contact person is aware of the patient's condition and situation (e.g., if the primary care physician is the contact person, make sure the primary care physician has a copy of the discharge summary on the day of discharge to be able to answer questions).
Who: Hospital identifies person to write contact information; this could be a nurse, doctor, volunteer/patient advocate, or discharge planner.

IDEAL Discharge Planning Checklist

Fill-in, initial, and date next to each task as completed.

Patient Name: ____

Initial Nursing Assessment	Prior to Discharge Planning Meeting	During Discharge Planning Meeting	Day of Discharge
_____Identified family caregiver and back-ups at home _____Told patient and family about white board _____Elicited patient and family goals for discharge _____Informed patient and family about steps to discharge	_____Distributed checklist to patient and family with explanation _____Scheduled discharge planning meeting Scheduled for __ / ___ / _____ at ___________[time]	_____Discussed patient questions _____Discussed family questions _____Reviewed discharge instructions as needed _____Offered to schedule followup appointments with providers. Preferred dates / times for: PCP: Other:	Medication _____Reconciled medication list _____Reviewed medication list with patient and family Appointments and contact information _____Scheduled followup appointments: 1. With ______________________________ at ___ / ___ / ____at _________[time] 2. With ______________________________ at ___ / ___ / ____at _________[time] _____Arranged any home care needed _____Confirmed appointments with patient / family _____Confirmed contact information for followup person after discharge
Notes:			

IDEAL Discharge Planning Daily Checklist

Fill-in, initial and date next to each task as completed.

Patient Name: ____

Day 1	Day 2	Day 3	Day 4
______Educated patient and family about condition ______Discussed progress toward patient, family, and clinician goals ______Explained medication to patient and family AM__________ NOON_______ PM__________ BED_________ OTHER_______ ______Involved patient and family in care practices, such as:	______Educated patient and family about condition ______Discussed progress toward patient, family, and clinician goals ______Explained medication to patient and family AM__________ NOON_______ PM__________ BED_________ OTHER_______ ______Involved patient and family in care practices, such as:	______Educated patient and family about condition ______Discussed progress toward patient, family, and clinician goals ______Explained medication to patient and family AM__________ NOON_______ PM__________ BED_________ OTHER_______ ______Involved patient and family in care practices, such as:	______Educated patient and family about condition ______Discussed progress toward patient, family, and clinician goals ______Explained medication to patient and family AM__________ NOON_______ PM__________ BED_________ OTHER_______ ______Involved patient and family in care practices, such as:
Notes:			

Be Prepared to Go Home Checklist

Before you leave the hospital, we want to make sure you feel ready to be at home. During your hospital stay, your doctors and nurses will talk with you about the things on this checklist. It is our responsibility to make sure you have the information you need and that we address your questions and concerns.

Use this checklist to see what information you still need from us as you or your family member prepare to go home. Make sure you can check all of the boxes. If you cannot check a box, talk to your doctor or nurse. Use the questions below to help you get the information you need.

☐ My family or someone close to me knows I am coming home. They also know about the next steps in my care.

Family or someone close to you can help keep track of and understand information about your health. It is up to you to say who you want to be involved.

Ask: Do I need help from my family or someone close to me when I get home?

If so, who will help me? What do they need to do to get ready?

How do I make sure my family or someone close knows what I need when I get home?

What should I do if there is no one at home who can help me?

☐ I know what problems to look for and who to call if I have problems at home.

Some symptoms such as pain or swelling may be normal when you get home. Sometimes, these symptoms are signs of bigger problems. Be sure you understand when you need to call for help and who you should call.

Ask: What problems do I need to watch for when I get home? When do I need to call if there are problems?

Who do I call if I have questions or problems after I leave the hospital?

☐ I know when my followup appointments are and how to get there.

You will need followup appointments after you leave the hospital. At these appointments, your doctor will check on how well you are recovering. Your doctor may also ask you to get some tests or give you test results that you are waiting for.

Be sure to keep these appointments.

Ask: What followup appointments do I need to have after I leave the hospital? Can the hospital help me make these appointments?

Am I waiting on results of any tests? When should I get the results?

Are there tests I need after I leave the hospital?

☐ I know what my medicines are and how to take them.

Before you leave the hospital, go over the medicines you need to take when you get back home (your medication list) with your doctor or nurse. The medicines you need to take may be different from what you took before you went into the hospital.

Tell your doctor and nurse about all the medicines you usually take at home, including over-the-counter medicines, vitamins, and herbal supplements.

Ask: What is the name of this medicine? Is this the generic or brand name?

Why do I take this medicine? What does this medicine look like?

How much do I take? When and how do I take this medicine?

What are potential side effects of this medicine? What problems do I need to look out for?

Will this medicine interfere with other medicines I am taking?

Will this medicine interfere with vitamins or other herbal supplements I am taking?

Where and how do I get this medicine?

What medicines can I take for pain? Upset stomach? Headaches? Allergies?

☐ I feel confident that I or someone close to me can take care of me when I leave the hospital.

Before leaving the hospital, you will get written instructions about your care.

Make sure you understand these instructions. Repeat these instructions back to the doctor or nurse in your own words. That way, you can check your understanding. If needed, ask your doctor or nurse to explain things more clearly.

Ask: How do I take care of any wounds, cuts, or incisions? Can you show me how to do this?

What foods or drinks should I avoid? For how long?

Are there any activities I should avoid (for example, driving, sex, heavy lifting, climbing stairs)? For how long?

What exercises are good for me? When can I start doing them? How often should I do them?

What do I need to do to make my home safer?

☐ I know about other help I need at home.

You may need other help at home. Or, you may do fine on your own.

We will set up nursing care, therapy, or other help if you need it. Family or friends can also help. Ask your doctor or nurse how others can help you recover.

Ask: When I get home, what kind of help or care will I need? Should someone be with me all the time? Will I need…

- Nursing care (for taking my medicines or taking care of cuts or wounds)? For how long? Who pays for it?
- Physical or occupational therapy (for help doing exercises or relearning how to do things)? For how long? Who pays for it?
- Help with eating, bathing, or going to the bathroom? For how long? Who pays for it?

Will I need any equipment such as crutches or oxygen? Where do I get it? Who pays for it? How do I use it?

How can friends or family members help me at home?

☐ My doctors or nurses answered questions that are important to me and my family.

You may have other questions or concerns that are not in this checklist. Write them down here, and make sure you have the answers you need before you leave the hospital.

____

____

____

____

____

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____

Tips for Going Home

Patients and families at [insert hospital name] wrote these tips to help you get ready to go home: [Use patient and family advisors to tailor this list to your hospital.]

- Write down what your doctors and nurses say.
- Ask questions again until you get the answers you need.
- Make lists – what has to be done, who can do it, and who can help.
- Talk with someone else who has been in the same situation to help you prepare and know what to expect.
- Talk to other people in the hospital, such as social workers, chaplains, and other patients about your care or other support you may need.

Going Home Too Soon?

If you feel that you are going home before you are ready, call [insert name] at [phone number].

Use this space to write any information you need.

Notes

Improving Discharge Outcomes With Patients and Families

Nearly 20 percent of patients experience an adverse event within three weeks of discharge. Of these adverse events, three-quarters could have been prevented or ameliorated. Common complications post-discharge include adverse drug events, hospital acquired infections, and procedural complications.[1] Many of these complications can be attributed to problems in discharge planning. For this reason, [insert hospital name] is pioneering the use of the IDEAL discharge planning tools to engage patients and families in preparing for discharge to home.

Changes to the discharge planning process at [insert hospital name]

Discharge planning cannot be done successfully in isolation from the patient and family. Families are the constants in a patient's life and are instrumental for ensuring the patient continues to get high quality and safe care at home. [insert hospital name] will incorporate the following in our discharge planning process:

Include the patient and family as full partners in the discharge planning process. Always include the patient and family in team meetings about discharge.

Discuss with the patient and family five key areas to prevent problems at home: Describe what life at home will be like, review medications, highlight warning signs and problems, give test results, and make followup appointments.

Educate the patient and family in plain language about their condition, the discharge process, and next steps at every opportunity throughout the hospital stay.

Assess how the patient and family understand the diagnosis, condition, and next steps in their care – Use Teach Back.

Listen to the patient and family's goals, preferences, observations, and concerns.

For patients transitioning home, there will be at least one discharge planning meeting to discuss the patient and family's concerns and questions. This meeting will include the patient, family of their choice, and a [nurse, discharge planner, other].

What does this mean for you?

We expect you to incorporate the IDEAL discharge elements throughout the hospital stay and make yourself available to the [nurse, discharge planner, other HCP] who is working with the patient and family in case they have questions.

This process ensures that your patients will be better equipped to support the best possible recovery when they go home, which will lead to better patient outcomes. Copies of the IDEAL discharge process overview and checklist for clinicians and a checklist for patients and family members are available at the nurses' station.

[1] Forster AJ, Murff HJ, Peterson JF, Gandhi TK, Bates DW. The incidence and severity of adverse events affecting patients after discharge from the hospital. Ann Intern Med. 2003;138:161-167

IDEAL Discharge Planning: Clinician Training

[Insert hospital name, presenter name and title, date of presentation]

Discharge Tool 4: Clinician Training Presentation

Today's session

- What is patient and family engagement?
- What is the patient and family experience of discharge?
- IDEAL discharge planning:
  - What are we asking patients and families to do?
  - What are we asking you to do?
- Practice exercises

What is patient and family engagement?

Hospital quality

- Patients get care that is safe
- Patients get the right care for their condition
- Patients get care they need when they need it
- Patients get care that makes wise use of resources
- No differences in treatment based on race, ethnicity, income, education, or social status
- Care is patient- and family-centered

Patient- and family-centered care

- Mutually beneficial **partnerships** among clinicians, hospital staff, patients, and families
- Core concepts:
  - Dignity and respect
  - Information sharing
  - Participation
  - Collaboration

What is patient and family engagement?

- Critical component of patient- and family-centered care
- Patient and family engagement means involving patients and family members as:
  - Members of the health care team
  - Advisors working with clinicians and leaders to improve policies and procedures

Goal of patient and family engagement

- To create an environment where clinicians, hospital staff, patients, and families all work together as partners to improve the quality and safety of hospital care.

Why is the discharge process important?

- Nearly 20 percent of patients experience an adverse event within 3 weeks of discharge, of which ¾ could be prevented
- Common complications post-discharge are:
  - Adverse drug events
  - Hospital acquired infections
  - Procedural complications
- Growing concern about re-admissions to the hospital, especially those that are preventable
  - 20 percent Medicare patients rehospitalized within 30 days of discharge

What is the patient and family experience of discharge at our hospital?

What is it like being a patient?

- How do patients and families feel at discharge?
  - Relieved and excited to go home
  - Scared or nervous about home situation or lack of support
  - Worried about their ability to take care of themselves or the patient
  - Hesitant to ask questions or raise concerns, especially about home life, with hospital staff

What is it like being a patient?

Clinicians and hospital staff	Patients and family members
• Are taught that discharge starts at admission, but may not do this often	• Can feel as if they are being forced out of the hospital when you raise the idea of discharge starting at admission • May not start to think about discharge until later in stay
• May prioritize clinical care at home (e.g., wound care)	• May prioritize functioning and quality of life (e.g., activities, diet) • May not know all the questions they should ask or what they need to know when they are home
• Have limited time for discharge planning	• May not understand all written information related to discharge • Feel rushed on the day of discharge
• Want patient to succeed at home	• Want to know one person to call if they have problems

What is it like being a patient?

- [Insert1 to 2 experiences from real patients or family members on what the discharge process feels like from the patient/family perspective, using:
  - Live presentation / story
  - Video
  - Vignette or quote
- Preferably include at least one positive and one negative story (what worked well, what did not work well)]

What will we do to improve the discharge planning process?

IDEAL discharge planning materials and process

What is the IDEAL discharge?

- **I**nclude the patient and family as full partners
- **D**iscuss with the patient and family 5 key areas to prevent problems at home
- **E**ducate the patient and family throughout the hospital stay
- **A**ssess how the patient and family understand the diagnosis, condition, and next steps in their care – Use Teach Back
- **L**isten to the patient and family's goals, preferences, observations, and concerns

What is the IDEAL discharge process?

1. At initial nursing assessment
    - Identify who will be at home with patient
    - Let the patient and family know that they can use the white board in the room to write questions or concerns
    - Elicit the patient and family goals for hospital stay
    - Inform the patient and family about steps toward discharge

What is the IDEAL discharge process?

2. Daily
   - Educate the patient and family about condition at every opportunity
   - Explain medications to the patient and family
   - Discuss progress toward goals
   - Involve the patient and family in care practices

What is the IDEAL discharge process?

3. Prior to discharge planning meeting
   - [Identify who] will give the *Be Prepared to Go Home Checklist* to the patient and family
   - [Identify who] will schedule the discharge planning meeting with patient and family of their choice
     - When depends on patient condition: at least 1 to 2 days before discharge, earlier if needed

What is the IDEAL discharge process?

4. At discharge planning meeting
   - [Identify who] to discuss and address patient and family questions
   - Use Teach Back to check your understanding of concerns and patient's understanding of information you give
   - Follow up on any questions you cannot address right at the meeting
   - Offer to schedule followup appointments with all providers as needed (primary care, specialists, therapy)

What is the IDEAL discharge process?

5. Day of discharge
   - [Bedside nurse] will review reconciled medication list with patient and family
     - Hand patient list of medications they need to take after they get home
     - Go over list with patient and family
     - Ask them to repeat back what, when and how to take each medicine
   - [Insert who] will write down followup appointments and give name and contact information of someone to call with problems

Benefits of discharge process for clinicians

- Improves information about the patient's condition and discharge situation
- Reduces risk and liability
- May take some more time at first, but can eventually save time

Benefits of discharge process for patients

- Demonstrates that hospital staff view patient perspective as important
- Reassures patients and families that they know how and what to do – less anxiety
- Shows teamwork among hospital staff
- Patient and family have a better experience of care
- Prevent post-discharge complications and avoidable readmissions

Potential challenges

- Difficult to identify family members who will be caregivers
  - Patient has no family or other support
  - Family caregiver has not been at the hospital
- Discharge plans change immediately before discharge
- Patient unable to read, write, or articulate questions or concerns

Practice exercises

Vignette 1: An easy discharge

- Emily, a 50 year old woman, came in for a gall bladder removal. She is married, has a college education, and is generally quite healthy, as is her husband. She is not in the med/surg unit for long.
- You are doing the discharge planning meeting with Emily and her husband Jack the day before she expects to be discharged.
- Let's form groups of three for this exercise. Take about 5-8 minutes.

Vignette 1 debrief

- Debrief each role:
  - How did you each feel during this interaction?
  - What really went well?
  - What could have been done differently?
  - Anything else?

Tips for effective engagement

- Slow down
- Use plain language
- Reassure patient and family by giving information
- Thank patient or family for calling attention to any issue they raise; don't act annoyed
- Invite them to continue asking questions
- Remember non-verbal communication says just as much as verbal communication

Vignette 2: A tougher discharge

- Arnold, 84 with serious exacerbation of congestive heart failure. He lives alone. His children live in another city. His long-time neighbor has visited him in the hospital. This is Arnold's 3rd hospitalization in the last year. Mobility is okay, but he has shortness of breath. He is fine cognitively, but is getting depressed and worried about his circumstances.
- Arnold will go home in 2 days, with home health care to help him with new portable oxygen. He is worried about using the oxygen, getting it, moving it around.
- You are doing the discharge planning meeting with Arnold alone. Form pairs for this exercise. Take 8-10 minutes.

Vignette 2 debrief

- Debrief each role:
  - How did you each feel during this interaction?
  - How was this different from the first vignette?
  - What really went well?
  - What could have been done differently?
  - Anything else?

Final thoughts

- Our hospital is committed to patient and family engagement – everyone plays a critical part
- Patients and families won’t engage if they believe that you don’t want them to – it is simply too risky for them
- Your job is to make it safe for them to be here, not just as patients, but as partners in their care

Thank you!

- For questions or more information

  [Insert name, phone number, and email]