Patient and Family Engagement
Resource Guide

2014
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Introduction

The Centers for Medicare & Medicaid Services’ (CMS) Partnership for Patients (PfP) initiative calls on hospitals, from the board room to the bedside, to engage patients and families and devote staff resources to expand these partnerships. Through this Guide, which focuses on critical conversations that advance patient and family engagement, the NYS Partnership for Patients (NYSPFP) seeks to support hospitals in developing effective partnerships.

Chapter 1, *Advancing the Organizational Conversation*, distinguishes patient and family engagement from patient experience, aligns engagement with other organizational priorities, and provides guidance for establishing structures and metrics to support engagement, including developing a patient and family advisor program.

Chapter 2, *Communication Models*, describes models that hospitals may find useful for developing strategies to effectively communicate with patients and families.

Chapter 3, *Critical Conversations with Patients and Families*, highlights the various points in patient care where the communication models described in Chapter 2 can be applied to engage patients and families in preventing hospital-acquired conditions and avoidable readmissions.

Chapter 4, *Engaging Staff to Engage Patients and Families*, discusses behaviors, expectations, and strategies that organizations can use to involve their teams and build cultures that support patient and family engagement.

A series of appendices also summarize some of the key techniques and opportunities for engagement. These short appendices offer tips and resources for further reading, and are designed to be used as handouts for staff.
NYSPFP Guiding Principles on Patient and Family Engagement (PFE)

NYSPFP’s approach to achieving performance excellence is embedded in a dynamic set of Guiding Principles designed to foster a culture of safety and continuous quality improvement in hospitals across the state. The NYSPFP Guiding Principles are organized into four broad categories—innovate, engage, integrate, and hardwire best practices—to support and drive a culture of safety. The NYSPFP Guiding Principles on PFE are operationalized as follows:

### INNOVATE

Test new strategies, processes, or protocols, and organization or team approaches for effectively engaging patients and their families throughout the health care continuum.

- Consider implementing what the Picker Institute called “Always Events,” or aspects of the patient and family experience that should always occur. Read more about Always Events on page 14.
- Prioritize the importance of “Meaningful Use” or electronic health record (EHR) incentive objectives that support hospitals in sharing patients’ medical information for enhanced care coordination.
- Include patient-centered concepts in education for physicians-in-training and staff orientation curriculum.
- Implement a patient shadowing program to understand your hospital’s systems from a patient perspective and help design a patient-centered care approach.
- Implement a hotline for patients to provide positive and negative feedback.
- Seek opportunities to amplify the voice of the patient through focus groups, or by implementing a patient-activated rapid response team and patient-initiated time out.
- Work with Human Resources to establish PFE-related service standards as part of a staff management strategy for health care providers.

### ENGAGE

Promote practices for patients, families, and health care professionals to communicate effectively, understand the roles team members play, and underscore the importance of being full partners in the care process.

- Provide care that is respectful of, and responsive to, individual patient preferences, needs, and values; ensure that patient values guide all clinical decisions:
  - Share care plans with patients’ loved ones and welcome their questions.
  - Conduct bedside shift reports with the patient and family.

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• Consider the following opportunities to include patients and families as advisors at the organizational level to improve quality and safety:2
  • Serve on hospital boards of directors.
  • Help evaluate programs.
  • Participate on advisory councils or quality and safety committees.
  • Serve as co-faculty for staff education.
  • Review audiovisual and written materials.
  • Participate at conferences and working meetings.
  • Participate in focus groups.
  • Participate in special events (e.g., Hand Hygiene Week).
• Encourage patients to access their health information to make informed decisions about their care.

INTEGRATE
Establish systems that include patients and family members in the care process and allow for the integration of their voices into hospital operations.
• Establish patient engagement as a routine part of practice.
• Identify patient engagement opportunities to coordinate and integrate care by using overarching patient-centered care practices for preventing hospital-acquired conditions and readmissions:
  • Utilize whiteboards as an effective two-way communication tool.
  • Engage patients and families in discharge planning processes upon admission to reduce readmissions.3
  • Conduct bedside shift reports with patients and family members.
  • Utilize daily patient goal-setting worksheets to engage patients and staff with the same goals.
  • Involve patients and families in multidisciplinary rounds.
• Conduct leadership rounds to engage patients and family members.
• Embed PFE in the organizational culture:
  • Discuss patient engagement with the executive team so they understand it matters to staff and the organization.
  • Set aside time in meetings with leadership and staff to discuss engagement success stories.
  • Provide staff with ongoing implementation support.

HARDWIRE
Develop and implement standard organizational policies and practices that encourage including patients and family members as active members of the care team.
• Make improving PFE an organizational goal:
  • Inventory policies, processes, and training programs to determine whether PFE is appropriately included.4
  • Ensure your organization has a written mission statement for PFE.
• Implement structures to support engagement:
  • Create a dedicated functional area for PFE.
  • Invite a patient representative to serve as a member of the hospital’s governing board.
  • Establish an active PFE committee.
  • Add service standards to job descriptions, orientation, and performance appraisals.
  • Train managers on how to coach staff to effectively engage patients and family members.
• Capture data for performance improvement:
  • Use a formal patient engagement assessment to identify strengths and gaps.
  • Select measures to track process and outcome changes, and establish a process to share results.

• Track information at the micro and macro levels of care, such as intervention-specific metrics, patient satisfaction scores, and changes to the governance structure.
• Implement communication strategies for patients, families, and clinicians as a foundation for true partnerships:
  • Engage patients with TeamSTEPPS CUS words (I am Concerned; I am Uncomfortable; this is a Safety situation; or for patients, “I am Scared”).
  • Use a patient-friendly SBAR (Situation-Background-Assessment-Recommendation) technique to discuss patients’ conditions.
  • Adopt strategies to improve health literacy and support patients in learning to manage and organize their care at the level they choose.6

(Please note that the Guiding Principles are available as a handout in Appendix N.)

5 See note 3.
Chapter 1. Advancing the Organizational Conversation

The organizational conversation about PFE must begin with a shared understanding of the meaning and the goal of engagement. Although it is often discussed in the context of direct clinical care, PFE also involves partnerships in designing and improving health care services. “Family” includes anyone the patient considers important, including people who are not related, such as a close friend. “Family” is used in this broad context throughout the Guide.

Patient and family engagement has been defined by the Agency for Healthcare Research and Quality (AHRQ) as:

“A set of behaviors by patients, family members, and health professionals and a set of organizational policies and procedures that foster both the inclusion of patients and family members as active members of the health care team and collaborative partnerships with providers and provider organizations. … [T]he desired goals of patient and family engagement include improving the quality and safety of health care in the hospital setting” (emphasis added).7

As the definition suggests, patient and family engagement occurs at multiple levels. The American Hospital Association has identified and defined four levels at which PFE occurs:

- **Individual.** The aim is to increase patients’ and families’ skills, knowledge, and understanding of what to expect when receiving care.
- **Health Care Team.** The focus is to promote a shared understanding of expectations among patients and providers when seeking care.
- **Organization.** The objective is to encourage partnerships and integrate the patient and family perspective into all aspects of hospital operations.
- **Community.** The emphasis is to expand the focus beyond the hospital setting and find opportunities to improve overall community health.8

**Distinguishing Similar Terms**

Patient and family engagement is a core part of, and is sometimes used as a synonym for patient- and family-centered care, which is defined by the Institute of Medicine as “providing care that is respectful of, and responsive to, individual patient preferences, needs, and values; and ensuring that patient values guide all clinical decisions.” The Institute for Patient- and Family-Centered Care has defined the core concepts of patient- and family-centered care as, “dignity and respect, information sharing, involvement, and collaboration,” all of which promote engagement.

Patient activation is a subset of patient and family engagement that “emphasizes patients’ willingness and ability to take independent actions to manage their health and care.” Patient activation focuses on “understanding one’s role in the care process and having the knowledge, skill, and confidence to take on that role.”9

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Patient experience refers to viewing care from the patient perspective. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is one example of a patient experience survey that provides information related to aspects of engagement, such as communication. It is important to note that although patient surveys are useful tools, solely conducting patient experience surveys is not a sufficient engagement strategy.

These concepts can be visualized as concentric circles. Patient activation focuses on building patient and family skills and desire to take a more active role in health care. Patient and family engagement ensures that patients, families, and providers are partnering effectively at all levels of their care and in the design of services. Patient- and family-centered care focuses on patient and family needs, preferences, and values as the heart of care. Another concept, called Relationship-based Care,\(^\text{10}\) is an even broader circle that focuses on the relationships among patients, families, and staff, as well as the relationships among staff members.

### Understanding and Articulating the Benefits of Engagement

Although engagement is often discussed as a strategy to improve the patient experience, evidence demonstrates that PFE has broader benefits. As AHRQ highlighted in its Guide to Patient and Family Engagement in Hospital Quality and Safety, PFE can also improve:

- Quality and safety
- Financial performance
- Clinical outcomes
- Market share
- Employee experience
- Regulatory and accreditation compliance

Effective engagement has become a core leadership competency. The Institute for Healthcare Improvement (IHI) recently identified engagement as a cornerstone of high-impact leadership to achieve the Triple Aim (better care, better health, lower cost). IHI urges leaders to adopt four new “mental models,” the first of which is the patient and family partnership. IHI also identifies being “person-centered in word and deed” as one of five high-impact leadership behaviors, and puts “driven by persons and community” at the center of its leadership framework.

NYSPFP recommends that hospitals build a business case for patient and family engagement and share it with physicians, staff, and the hospital’s board. The case could include the potential return on investment as engagement strategies can support organizational priorities beyond the scope of the patient experience, and the power of patient and family partnerships can help the organization achieve all of its goals.

### Understanding the Current Level of Engagement

Many organizational assessments have been developed to assist organizations in evaluating their level of PFE. Leaders may find these tools useful in identifying where the organization excels and where the greatest opportunities for improvement exist. Assessment tools evaluate elements like: opportunities for patients and families to participate in key roles in the organization; involvement of family in direct clinical care; access to health information; and human resource activities that support a culture of patient and family engagement. It is important to involve patients, their families, and front line staff in the assessment process. While NYSPFP encourages organizations to conduct some type of engagement assessment, it does not recommend a particular assessment tool.

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\(^\text{10}\) Mary Koloroutis, Ed. Relationship-Based Care: A Model for Transforming Practice (2004). Creative Healthcare Management; Minneapolis, MN.
Structures to Support Engagement: Patient and Family Advisor Program

Partnering effectively with patients depends on more than individual interactions; processes and structures that support the partnership must be established. Rounding, focus groups, and patient surveys provide insight into some aspects of engagement, but are often limited to a specific issue. In contrast, patient and family advisor programs provide opportunities for patients and families to partner with the hospital on an ongoing basis.

NYSPFP recommends that hospitals consider developing a Patient and Family Advisor Program through which they can gain insight into advisors’ perspectives and leverage their expertise and wisdom in a wide variety of roles.

Examples of PFE Opportunities
• Participating on the Board of Trustees
• Participating on a Patient and Family Advisor Committee (PFAC)
• Evaluating programs and processes
• Evaluating patient education materials
• Participating on Safety or Quality Committee
• Acting as co-faculty for staff education
• Participating at conferences and working meetings

AHRQ has created a detailed toolkit with step-by-step guidance for developing a Patient and Family Advisor Program. The toolkit contains a number of resources described below.

• Recruiting Materials
  • Becoming a Patient and Family Advisor brochure and postcard
  • Patient and Family Advisor application form
  • Sample invitation and regret letters for Advisory Council applicants
  • Patient and Family Advisor information session presentation and handout, “Am I Ready to Become an Advisor?”

• Advisor Training Materials
  • Sharing My Story planning worksheet
  • Participation Interests form
Choosing Appropriate Tools and Metrics

As hospitals embed patient and family engagement into operations, existing quality improvement tools can be adapted to strengthen engagement. For example, some NYSPFP hospitals have applied Failure Mode and Effects Analysis (FMEA) or Root Cause Analysis (RCA) to prioritize areas where improvement is needed. Hospitals should consider using these tools to analyze and improve processes when a service-related event occurs, or to assess related trends.

The Power of Storytelling

Although quantitative and qualitative metrics are invaluable, storytelling can be an important tool for advancing PFE. Storytelling emphasizes the common humanity that connects patients, families, and staff, and has the power to influence behavior in a way that numbers may not. It also enables staff to distinguish between the disease and the person experiencing the disease. Each person is unique, even if their clinical condition is the same. Organizations working to advance PFE can use storytelling in a variety of ways. In its High Impact Leadership Guide, IHI encourages leaders to use patient and family stories, noting that “by beginning meetings with a patient’s story of their health care experience, leaders reinforce the understanding that staff in the organization are impacting lives, not numbers.” Using patient and staff stories together can also be powerful, as evidenced by a Cleveland Clinic video\(^\text{11}\) that many organizations use for staff training.

Shadowing, which involves staff members following patients and families through an organizational process and recording their observations, can provide valuable insight into patient and family perspectives. Anthony M. DiGioia, M.D., of the University of Pittsburgh Medical Center (UPMC), has developed a Patient- and Family-Centered Care Methodology that depends on shadowing to understand the current experience and create ideal stories of care.\(^\text{12}\) Many excellent improvement ideas came from patient stories gathered through shadowing. For example, the UPMC Guardian Angels Program, which supports transplant patients, was inspired by a patient comment during shadowing.

Identifying Metrics

Selecting appropriate metrics will help organizations evaluate their progress in advancing patient and family engagement. NYSPFP encourages hospitals to consider identifying measures to evaluate patient and family engagement efforts, as appropriate. As the hospital implements specific processes designed to foster patient and family engagement, such as bedside shift reporting, metrics also may be identified for these processes.

CMS, through its national PfP initiative, has worked to develop metrics for measuring the success of each hospital’s PFE efforts. These metrics reflect an expectation of effort at every level of the organization.

### CMS PfP Patient and Family Metrics

- Prior to admission, hospital staff provides and discusses with every patient who has a scheduled admission—allowing for questions or comments from the patient or family—a planning check list that is similar to CMS’ Discharge Planning Checklist.
- Hospitals conduct shift change huddles and do bedside reporting with patients and family members in all feasible cases.
- Hospital has a dedicated person or functional area that is proactively responsible for PFE and systematically evaluates PFE activities.
- Hospital has an active PFE Committee, or at least one former patient who serves on a patient safety or quality improvement committee or team.
- Hospital has one or more patients who serve on a Governing or Leadership Board, and serves as a patient representative.

### Resources: Metrics and Tools


The PFCC Innovation Center of UPMC’s Shadowing Resources [http://www.pfcc.org/go-shadow/](http://www.pfcc.org/go-shadow/).


CMS’ “Your Discharge Planning Checklist: For Patients and Their Caregivers Preparing to Leave a Hospital, Nursing Home, or Other Care Setting,” Publication ID 11376. Available at [http://www.medicare.gov/publications](http://www.medicare.gov/publications).
Chapter 2. Communication Models

Effectively engaging patients and families depends in part on tailoring communication to the patient’s health literacy level, and understanding cultural considerations that influence care and communication. Hospitals should consider offering staff training focused on how to communicate more effectively with a diverse population of patients and families. This chapter highlights some common techniques used to promote effective communication.

Patients and family members can be integral partners in building the cultural competence of staff. Some hospitals choose to have patients and family members serve as faculty and educate staff about cultural issues affecting health care. Hospitals may consider selecting advisors with diverse perspectives and backgrounds reflecting the hospital’s patient population who can assist with designing services to meet patients’ needs. Hospitals may also consider involving patient and family advisors in co-designing any supporting written materials.

TeamSTEPPS
TeamSTEPPS is a Department of Defense (DOD)/AHRQ program originally designed to improve safety through enhanced teamwork and communication among health care professionals. Many of the program tools can be adapted to engage patients and families (Appendix A).

Hospitals may integrate TeamSTEPPS principles into the admission process by providing patients and families with the DOD’s “Team Up” brochure, which asks patients to be active members of the care team. Hospitals may also encourage patients and families to assess their own understanding using SBAR (Situation-Background-Assessment-Request). It is particularly important for them to participate in the “S” and “R” steps:

- **Situation.** What are the symptoms or concerns that brought you to the hospital emergency department (ED) or that you want to speak with your health care team about today?
- **Background.** What does the care team need to know about your medical history that is related to this visit (ED)?
- **Assessment.** Is there anything related to the current situation that you want to make sure the health care team is aware of (have you experienced this symptom, condition, or side effect before and how did you manage it)?
- **Request.** What can the staff do for you right now (pain management)?

Teach patients to make a time out symbol with their hands to alert staff whenever they are concerned, uncomfortable, or scared and need more information. Ask patients to demonstrate how to do it. This is an adaptation of the TeamSTEPPS CUS model (I am Concerned, I am Uncomfortable, this is a Safety issue, or for patients and families “I am Scared”).

Organizations implementing TeamSTEPPS may consider including patient and family advisors in the formal TeamSTEPPS master training program. Involving patients and families on the TeamSTEPPS implementation team engages them and leads to greater insights into how to adapt these tools for broader use.

Resources: TeamSTEPPS

For more information about TeamSTEPPS, visit, [http://teamstepps.ahrq.gov/](http://teamstepps.ahrq.gov/).
Teach Back

Teach Back, referenced frequently throughout this Guide, is a method of communication that engages patients and families by creating opportunities for meaningful, health literacy–appropriate dialogue and demonstrations.

With the Teach Back method, staff members share information and then verify whether patients and families understand what was taught by asking them to explain it in their own words or demonstrate the care or treatment (Appendix B).

Take care to ensure that the language used invites dialogue, and does not make the patient and family feel ashamed for not understanding. Use open-ended, non-judgmental questions that focus on the provider's communication skills:

- “To be sure I was clear, can you repeat back to me the signs and symptoms of high and low blood sugar? Tell me how you will feel if your blood sugar goes too low.”
- “What will you tell your family about the changes we made to your medications today?”

Focus on the most important information first, and use plain, non-clinical language (e.g., refer to "high blood pressure," not "hypertension" and "the best way," instead of "optimal"). Break complex information into distinct parts, and use Teach Back to verify understanding of each topic before moving on.

If the patient or family does not understand the information, try explaining it in a different way. Invite them to stop you as soon as you say something that needs clarification. Provide the patient and family with written information that reinforces the information given verbally.

Consider recording Teach Back so other staff are aware of what the patient understood and what topics need to be reinforced. Remind staff to use Teach Back by adding it to your clinical competencies, standards of care, and order sets.

Resources: Teach Back

IHI’s “Always Use Teach Back!” Training Toolkit includes:
- Elements of Competence for Using Teach Back Effectively
- Coaching Tips
- Observation Tool


The tools are part of a comprehensive online training toolkit http://www.teachbacktraining.org/, including an online learning module and videos, developed by UnityPoint Health (formerly the Iowa Health System) in partnership with Health Literacy Iowa, Des Moines University, and the Picker Institute.


Active Listening Techniques

Caring for patients requires understanding not only their clinical condition, but developing an understanding of the individual patient. Although many of the techniques described in this Guide focus on engaging patients and families as partners by sharing information, the core of patient and family engagement is rooted in the ability to create authentic two-way communication, which depends on effective listening. The patient and family story, unique preferences, and individual needs are vital threads for promoting continuity across the plan of care. Each care team member has a responsibility to steward that story across the organization in a usable and compelling way.

Active listening is an essential skill that guides staff in building effective relationships and communi-
cating effectively with patients and families. Active listening and other effective engagement skills can be taught. Organizations may consider implementing training programs that help staff to build these communication skills.

**Resources: Listening Techniques**


**Engaging Patients Through Cultural Competence**

Part of engaging patients and families includes recognizing the unique needs of diverse groups. Respecting and meeting those needs can help improve quality of care and patients’ and families’ satisfaction of the care provided.

**Resources: Cultural Competence**

The Health Resources and Services Administration’s “Cultural, Language, and Health Literacy” site has a number of resources dedicated to diverse communities, as well as toolkits to help create materials to improve health literacy. These resources are available at [http://www.hrsa.gov/culturalcompetence/index.html](http://www.hrsa.gov/culturalcompetence/index.html).
Communication is at the center of patient and family engagement, and there are many opportunities—from care delivery to patient safety—to engage patients and families through effective communication. During routine processes, such as bedside shift reporting and purposeful rounding, staff can strengthen partnerships with patients, every time, every day, by having important conversations. This is especially true in regard to engaging patients and families in reducing hospital-acquired conditions identified by CMS through its PfP initiatives. This chapter examines approaches and strategies for improving engagement through effective communication with patients and families, and suggests various points of care where conversations may be started.

Setting the Stage for Effective Conversations: Always Events

Health care providers should change their mindset from being driven by negative, risk avoidance (Never Events), to the positive, emphasizing what should always occur to ensure a positive patient encounter. This concept, called “Always Events” by the Picker Institute, can be applied to help shape an effective health care experience. The IHI’s Always Events program helps health care organizations define those "aspects of the patient experience that are so important to patients and families that health care providers must perform them consistently for every patient, every time." For example, Dartmouth-Hitchcock Medical Center uses this concept to define always expectations for communication, specifically:

- Address and refer to patients by the name they choose, not their disease.
- Let patients and families know who you are and your role in the patient’s care.
- Welcome and respect those defined by the patient as “family.”
- Advocate for patient and family involvement in decision-making to the extent they choose.
- Ensure patients can read your name badge.
- Show patients and families the same respect you would expect from them.13

Other organizations have used the Always Events concept to identify specific topics that will always be discussed with the patient. For example, Anne Arundel Medical Center’s SMART (Signs, Medications, Appointments, Results, and Talk with me) Discharge protocol ensures that all providers discuss Symptoms, Medications, Appointments, and Results with the patient and address their questions or concerns.

Every interaction between a patient or family member and a staff member is a form of human currency—an investment in building relationships that can either be shared or squandered. Providers should choose their words carefully and with sensitivity. Although the interaction may be routine for staff, it is often monumental for the patient and family. As one parent involved in an Always Events program said, "Do clinicians realize that we will never forget their names, their faces, and what they said to us about our dying child?"14

NYSPFP encourages hospitals to define their own Always Events for patient-centered communication.

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Critical Conversations at Specific Points of Care

Admission and Initial Assessment

The admission and initial assessment process provides a critical opportunity to begin engaging patients and families and set expectations for partnering throughout the hospitalization. Consider taking this opportunity to remind patients that they are important members of the care team. Demonstrate respect for patients’ expertise with statements like, “You are the expert about you,” and emphasize that patients’ knowledge is indispensable. Written reinforcement in admission materials and hospital guides, or other targeted materials (e.g., AHRQ’s “Be a Partner in Your Care” materials) can serve as reminders throughout a patient’s stay. Ask the patient who else they would like to include in their care by asking questions such as, “You may want family or friends to take part in conversations about your health or health care. Who would you like to be involved?”

Obtain and record information from the patient and family about the patient’s story, preferences, fears, and desires so all staff members can have access to the information. This will enhance understanding and more effective communication by the care team (Appendix C).

The University of Minnesota Amplatz Children’s Hospital’s “My Story” templates, for example, are age-specific questionnaires that are used at admission. At the other end of the lifespan, the University of California San Francisco’s “Partner with Me” program assists family caregivers in preparing for the hospitalization of loved ones with dementia. The program includes tools that staff can use to gather detailed information from family about how to best care for the patient.

Explain in concrete terms how patients and families can partner with staff. Describe communication opportunities, including operational processes like bedside shift reporting and tools, such as a bedside notepad, or space on the whiteboard where questions can be listed. Encourage patients and families to share information, to speak up about any concerns, and to ask questions.

Examples of “Always Events”
- Wear and display identification.
- Check for the “3Ps” (pain, potty, and position) before leaving a patient’s bedside.
- “Thank you.”
- “I am sorry that…”
- “How can I help?”
- “I am delighted (or happy, or it is my pleasure) to help you with…”

Examples of “Never Events”
- Saying, “That’s not my job. You will have to check with…”
- Saying, “I’m too busy right now.”
- Talking about other staff members or personal issues in front of patient.
- Failing to address pain in a timely manner.
- Excusing lapses in care due to staffing, or saying, “We don’t have enough staff.”

Resources: Always Events Toolkit and Examples


Teach Back can be an effective tool. Show patients how it works during admission and initial assessment by teaching back to the patient the information they are sharing with you. For example, “You just gave me a lot of information and I want to make sure I understood it all correctly. I am going to repeat it back to you. Please correct me if I misunderstood anything or if there is anything else I should know.”

Explain that staff will be asking patients to Teach Back during their stay to ensure that they explained things effectively. Emphasize that the patient should ask about anything he or she doesn’t fully understand, even if it needs to be explained multiple times or several different ways (Appendix B).

Bedside Shift Report

Bedside shift report is a practice in which nurses share information about patients at the bedside during change of shift. This provides an opportunity to routinely engage patients (and family members, as desired by the patient) as partners by inviting and encouraging them to participate in the discussion. Evidence shows that a bedside shift report can improve quality, safety, patient and staff satisfaction, and reduce overtime. AHRQ has developed a detailed toolkit to support hospitals in implementing bedside shift report as an engagement strategy, with several tools for patient and staff education (Appendix D).

Physically moving the end-of-shift reports to the patient’s bedside is not enough; nurses should take the next step of inviting patients and families to participate in the report. Invitations can include:

- Verbally informing patients and families about the bedside shift report process upon admission, including the approximate time the process will occur. Also consider providing a written description of the process and an invitation to participate.
- Reminding patients on rounds that a bedside shift report will be taking place and inviting them to ask questions and raise concerns at that time.
- Consider allowing families to listen or participate over the telephone.

Effective bedside shift reports may be facilitated by providing staff with a bedside shift report checklist reminding them to:

- Begin the report by inviting patients and families to participate.
- Ask patients and families about their needs and concerns. For example, ask “Do you have any worries you would like to share? What could have gone better in the last 12 hours?”
- End the report by asking the patient and family about the patient’s goals for the next shift. For example, “What do you expect in terms of care over the next 12 hours?”

Resources: Admission and Initial Assessment

“Be a Partner in Your Care” materials:
- “Tips for Being a Partner” brochure
- “Talk to Us” handout
- “We Are Partners in Your Care” sign


University of California San Francisco “Partner with Me” Program, available at http://memory.ucsf.edu/caregiving/hospitalization.
Using Purposeful Rounding as an Opportunity for Engagement

Many hospitals conduct a variety of types of rounding, including frequent nurse rounding, care team rounding, and leadership rounding. Each staff member who enters the room should engage patients and any family members who may be present, and communicate in a way that continues to build meaningful partnerships.

AHRQ has created educational materials to train staff on how to communicate in a way that engages patients and promotes quality care. AHRQ encourages staff to engage in behaviors such as making eye contact and smiling, if appropriate, introducing themselves, and having conversations at eye level. Rounding is also an opportunity to distribute or reinforce the AHRQ Be a Partner in Your Care materials described in the Admissions section on page 15.

As desired by the patient, staff may encourage family members to participate in care discussions by informing them when care team rounding will take place and reminding patients and family members to note any questions or concerns they would like to raise with the care team. Giving patients and families advance notice and an opportunity to think about their questions may help encourage participation. These rounds are also ideal opportunities to set and clarify ongoing goals and expectations.

During leadership rounds, ask patients and family members about their experiences with questions such as, “What is working well, and how can care be improved?” In any interaction it is important to respond positively, listen carefully, and follow-up on any questions asked or issues raised.

Effective Use of Whiteboards

Whiteboards can be powerful engagement tools that reinforce the patient’s and family’s important roles on the care team. Although whiteboards are often used to communicate information to the patient, such as names of staff members, they also can be an effective vehicle for the patient and family to share information with staff. With approval, consider adding patient’s key family and discharge planning contact numbers to involve them in education and rounds.

Orient the patient and family to the whiteboard and encourage them to write on it. Ensure that whiteboard pens are attached to the board and restocking supplies are readily available—one study found that a lack of pens was the biggest barrier to staff using the whiteboard.\textsuperscript{15}

Review the elements included on the whiteboard with patient and family advisors to determine if there are additional fields that should be included. Common whiteboard elements used to engage

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patients and families include patient milestones; pain scales; patient and family goals for discharge; the patient's daily goal; patient and family notes, questions, or concerns; and what is most important to the patient today (Appendix E).

Staff may also use the whiteboard as a trigger tool to orient the patient and family to any applicable heightened safety risks and how they can help prevent them. They can also serve as a visual reminder of safety precautions (e.g., patients who are at risk for falls). Instructions for the patient and family can also be written on the whiteboard (e.g., it is important for the patient to get out of bed and walk a certain number of times today).

Hospitals that are not already using whiteboards can consider designing unit-specific whiteboards. Collaborate with teams on each unit to determine what information is most valuable to patients and families. Be sure to consider including patients and families on the teams designing the whiteboards.

Discharge Planning
Discharge is a particularly challenging time for patients, families, and staff. The most effective discharge plans are those that have been developed in conjunction with the patient and family and reflect the reality of the patient’s life outside the hospital. Hospitals help patients and families prepare for this transition by sharing a discharge planning checklist at the time of admission, or before the admission for scheduled patients. Many organizations, including AHRQ and CMS, offer discharge planning checklists to assist with this process. Prior to admission and throughout the hospitalization staff should gather and document information about the patient’s preferences and goals and make it available to other care team members. Doing so better informs the discharge planning process.

As part of the discharge planning process, identify which family members the patient would like to be involved in their care and who will be providing the actual care when the patient returns home. Encourage the patient to invite these family members to participate in hospital processes, including bedside shift report and discharge planning discussions. Schedule discussions to facilitate family participation and make it possible for family members to participate by phone if they are not able to be at the hospital during key discussions. Encourage family members to share any questions and concerns they have either in a designated space on the whiteboard, discharge planning guide, or other appropriate location.

Consider adopting AHRQ’s IDEAL discharge model, or a similar approach that outlines several ways to engage patients and families in discharge:

- **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
  - Explain test results
  - Make follow-up appointments
- **Educate** the patient and family in plain language about the patient’s condition, the discharge process, and next steps throughout the hospital stay (emphasis added).
- **Assess** how well doctors and nurses explain the diagnosis, condition, and next steps in the patient’s care to the patient and family, and use Teach Back.
- **Listen** to and honor the patient’s and family’s goals, preferences, observations, and concerns.16

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Involve the patient and family in designing the post-hospital care plan. Ask the patient and family if there is anything in the discharge plan that is going to be difficult to achieve. For example, "Is there anything that we have discussed that is going to be difficult for you to do? We want to help you continue to improve. If this plan isn’t practical, we can work with you to come up with one that will work for you."

Ensure that patients and families know who the appropriate contact is for post-discharge questions or concerns in case unexpected difficulties arise.

The United Hospital Fund’s (UHF) Next Step in Care, available at www.nextstepincare.org, provides many resources to support meaningful engagement of family caregivers during the discharge process and at care transitions. UHF’s guides are designed to help health care providers and family caregivers collaborate to achieve safe transitions between health care settings, including discharges from hospital to home, long-term care, or other health care settings, and reduce preventable hospital readmissions. Hospitals may consider utilizing these tools, which emphasize planning, communication, and ongoing care coordination, to support their partnerships with patients and family caregivers. The family caregiver guides are available in English, Spanish, Russian, and Chinese.

Consider implementing a discharge follow-up phone call process to check in with patients shortly after discharge to clarify any instructions and address any concerns or unanticipated challenges. Use the information gathered during these calls not only to address concerns raised by specific patients, but to also identify patterns that can help the hospital improve its discharge process. Ask the staff members making the discharge phone calls, "What are the most common sources of confusion for recently discharged patients?"

Informed Waiting

In inpatient and outpatient settings, patients and families may spend a portion of their time waiting to see the physician, hear about test results, undergo a procedure, or receive pain medication. Often, they may not know how long they can expect to wait, or may not understand the reason for the delay. Keeping them informed is one way to demonstrate respect for their time and build trusting partnerships.

**Resources: Discharge Planning**


CMS Discharge Planning Checklist is available at http://www.medicare.gov/ Publications/Pubs/pdf/11376.pdf.


UHF’s Next Step in Care: Hospital Discharge Planning-First Steps with Family Caregivers is available at: http://www.nextstepincare.org/provider_home/hospital_to_home/.

Project RED Tool 7: Understanding and Enhancing the Role of Family Caregivers in the Re-Engineered Discharge is available at http://www.nextstepincare.org/provider_home/project_red/.
It is important to inform patients about why they are waiting, the next steps in the process, and update them regularly. Over a period of time, patients may feel neglected, or not know that you are waiting on a process that is outside of your immediate control, such as waiting for an x-ray to be read. When family members are separated from the patient, such as during a surgical procedure, update them regularly about the patient's status. This is particularly important if there is a delay before a procedure begins, or if the procedure is taking longer than expected. Consider partnering with the patient and family by encouraging them to ring the call button at a specified interval if you haven’t returned to give them an update. For example, one NYSPFP hospital shared that emergency department staff tell patients who are waiting for test results, “I’ll be back to give you an update in one hour or less. If you haven’t seen me in an hour, please press the call button.”

**Critical Conversations for Patient Safety**

Patient and family engagement is both simple and profound. It requires hospitals to recognize patients and family members as partners with skills and expertise to offer to improve their care, without abdicating their responsibility to provide excellent clinical care while keeping patients safe.

This section highlights ways hospitals can partner with patients and families to promote patient safety and improve certain focus areas. Each subsection focuses on engaging patients in safety at the direct care level, but patients and families also may be engaged as advisors in patient safety and quality improvement initiatives related to each of the hospital-acquired conditions. It is important to note that engagement is only one aspect of harm prevention, and there are many actions that providers take unilaterally to promote safety that are not discussed in this Guide.

**Adverse Drug Events**

Patients and families have key roles to play in reducing adverse drug events (ADEs), both in the hospital and after hospitalization. NYSPFP’s ADE initiative focuses on promoting safe medication management and reducing ADEs from high-alert medications, and provides a variety of recommendations related to patient and family engagement in the NYSPFP Nursing-Centered Initiatives Action Planning Guide, which is available at [https://www.nyspfp.org](https://www.nyspfp.org). In direct clinical care, patients and families should be engaged before and at the time of admission, during hospitalization, and at discharge. Patients and families may also be used as advisors in reducing adverse events and involved in co-designing medication information materials and discharge instructions for families.

Patients’ and families’ expertise are indispensable for the medication reconciliation process. Prior to or at admission, ask patients and family to bring all of their prescription medications, vitamins, and over-the-counter medications to the hospital to help accurately reconcile medications. During the admission process, ask the patient questions designed to elicit their actual medication usage practices.

In its “Medications at Transitions and Clinical Handoffs (MATCH) Toolkit,” AHRQ provides hospitals guidance for conducting an effective patient interview, including a list of “probing questions.” AHRQ recommends that medication history be discussed at admission, and then again during the hospitalization to verify the information.17

Many patients have significant experience with managing their medications, and understanding how patients manage their medication will help to shape care and post-discharge care plans. Ask patients what strategies they use to manage their medications at home, and assess how well those strategies have been working. For example, staff might ask, “Do you have a system you use to keep track of when to take your medications and to verify whether you have taken them each day? How well does that system work for you?” Consider asking the reverse: “What do you feel is the most difficult part of taking your medications?” Attentiveness to the patient can

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provide insight and reveal other important aspects of the patient’s life related to planning effective care and identifying education needs.

Throughout the hospitalization, review medications and reinforce medication education in preparation for discharge. Based on their interest and ability, engage patients and families in creating the medication administration record and tracking medications throughout the hospital stay. Explain the process the hospital uses to verify the patient’s identity prior to administering medication and encourage the patient to speak up if their identity has not been verified or they don’t understand the medication they are about to receive. This is also the ideal time to reinforce the relationships between the patient’s medication, signs and symptoms, and alternative management approaches. IHI encourages hospitals to consider involving appropriate patients in self-administering some medications. For example, if their clinical condition permits, diabetic patients may be allowed, at their request, to continue managing their insulin administration under the nurse’s supervision.

Educate the patient about new medications using both verbal and written materials. Discuss the purpose of each new medication, use Teach Back, and invite and answer patient and family questions. Develop the post-hospital care plan in conjunction with the patient, including the medication plan.

At discharge, provide the patient with a reconciled list of medications. Review any changes to the patient’s pre-admission medication regimen. Consider providing visual and text-based information, like AHRQ’s Pill Card, and other relevant materials to track changes to their medications at home. Use Teach Back to verify that the patient understands the reason for each medication, when and how to take it (including the next dose due on the day of discharge), drug-food interactions, and potential side effects.

Consider asking questions designed to assess whether the patient has any concerns about managing the medication regimen or about the medications themselves. For example, “I want to make sure that you think this plan will work for you and that we discuss any problems you think might arise. Do you have any concerns about taking these medications? What system will you use to track your medications at home? Is there someone who helps you at home with your medications and, if so, how will you explain this new schedule to them?”

Many patients find using pill boxes very helpful. A number of specialty clinics provide a different color (i.e., red) pill box for anticoagulant medications. Provide the patient with a contact phone number to use if they have any questions about their medications after they leave the hospital.

Resources: Preventing ADEs


Catheter-Associated Urinary Tract Infections (CAUTI)

CAUTI are the most common hospital-acquired infections, due in part to the widespread use of catheters. Effective partnerships with patients and families can help reduce unnecessary catheterizations and assist in maintenance and expedited removal of catheters.

If a patient or family member is requesting a catheter that staff believe is not medically necessary, staff should talk to the family to understand the reason for the request. Common reasons include concerns about the frequency of toileting, the effort required to get to the bathroom, and fear of falling. Discussing the risks of CAUTI and reassuring the patient and family that staff will assist the patient to the bathroom or promptly address incontinence may make the patient less likely to want a catheter.

Patients with catheters should be encouraged to ask staff daily whether the catheter can be removed. They should also be educated about how to minimize their risk of CAUTI by:

- Notifying staff if the urine drainage bag is too high (it should be below the bladder).
- Avoiding disconnecting, twisting, or kinking the catheter.
- Asking providers to wash their hands if the patient or family do not observe them doing so.
- Cleaning their own hands before touching the catheter and keeping the catheter clean.

Staff should ask all patients and family members to immediately report any signs of a urinary tract infection, including burning, lower abdominal pain, or increase in frequency of urination (Appendix F).

Central Line–Associated Bloodstream Infections (CLABSI)

Patients and families can be key allies in preventing CLABSI, right from the start. Even before the central line is inserted, patients and families can be educated about the risk of CLABSI, strategies to prevent it, and the need for partnership. For example, staff might say, “We will be taking several actions to help reduce your risk of infection,
including cleaning your skin thoroughly before we insert the catheter, and we need your help to keep it clean."

Discuss how to care for the central line with the patient and family, including the importance of not touching the catheter or tubing. Encourage the patient and family to ask questions. Consider using Teach Back to ask the patient to explain what they understand about their central line care.

Ask patients and families to notify staff immediately if they develop any discomfort, redness, or itching around the catheter site. Explain that these could be warning signs of infection. If the patient is going home with the catheter, provide him or her with verbal and written information describing proper catheter care while providing opportunities for Teach Back and show back. When assessing CLABSI prevention strategies and developing action plans, consider patient and family education as a key component of the plan (Appendix G).

Early Elective Deliveries (EEDs)
Pregnant women and their families are critically important partners in minimizing EEDs before 39 weeks. Women who are aware of the risks of early elective deliveries may be less likely to request them, and more comfortable raising concerns if their providers or others suggest an early delivery (Appendix H).

Provide information to expectant mothers and families about the risks of elective deliveries before 39 weeks, ideally throughout the prenatal period. In addition to conversations, information can be made available through:

- Posters displayed in areas of the hospital that expectant mothers will visit on a hospital tour.
- Childbirth education classes offered by the hospital.
- Hospital communications, such as a community newsletter and the hospital Web site.

Resources: Reducing EEDs
CMS’ “Strong Start Toolkit” is available at http://www.cms.gov/outreach-and-education/outreach/partnerships/strongstarttoolkit.html and includes:

- Pre-Term Brain Development brochure
- “Don’t Rush Me” poster
- “Worth the Wait” poster

Falls
Staff are advised to engage patients (and family as desired by the patient) throughout the hospital stay in assessing the fall risk and taking appropriate action to prevent falls.

During the admission fall risk assessment, explain why there are questions about prior falls and related issues. Ask the patient and family what they do at home to prevent falls.

If the patient has been assessed as a fall risk, inform and educate the patient and family about why they are at risk and what precautions to take. Ensure
they understand the reason for the risk signage or other identification (e.g., colored socks or wristbands) and strategies to mitigate the risk (e.g., belts and floor pads). Add patient and family communication and education to the staff fall checklist. Update the patient and family when the patient's fall risk changes (e.g., a medication change), and educate about any additional precautions.

Using Teach Back and show back can help verify that patients and families understand what they can do to help prevent falls. Ask, “Can you please tell me in your own words what are the techniques you can use to help prevent falls?” Ask patients to show you how to use the call light.

Reinforce fall prevention strategies during routine processes, including rounding and bedside shift reports. Involve the patient and family in ongoing prevention activities such as environment (everything within reach), medication (completing toileting prior to any sedating), and strengthening (exercise and ambulation as appropriate). Engage patients and families in proactive physical or occupational therapies to prevent hospital-acquired deconditioning.

If a fall occurs, interview patients and family members to find out what contributed to the fall and identify opportunities for improvement (Appendix I).

Pressure Ulcers

Patients and caregivers can be important allies in preventing pressure ulcers. During the initial skin assessment conducted upon admission, explain why
the patient’s skin is being examined and ask the patient and family if they are aware of any discolored or tender areas. Explore the patients’ and families’ ability to assist with bed mobility and positioning, and, if appropriate, explain the goals of hourly rounding related to pressure ulcer prevention. Encourage the patient and family to let staff know immediately if they notice any skin changes, including red, purple, or sore areas (Appendix J).

If the patient is identified as at risk for pressure ulcers, inform and educate the patient and family about ways to help prevent pressure ulcers. The following are sample statements staff can use to discuss prevention:

- **Positioning and movement.** “Shifting your position frequently helps to reduce the risk of pressure ulcers, but certain movements increase the risk of pressure ulcers. Please do not drag yourself across the bed or chair, or push or pull with your heels or elbows. If you are having difficulty adjusting your position yourself, please ask for help. Please don’t rub your skin against anything repeatedly, such as using the sheets to scratch an itch.”
- **Skin care.** “One thing you can do to help prevent pressure ulcers is to keep your skin clean. Please notify us immediately if any part of your skin is wet or soiled. Dry skin is also vulnerable to pressure ulcers, so please use the lotion we have provided.”
- **Other risk factors.** “Pressure ulcers are also more likely if you are not eating well or drinking enough fluids. We will offer you a choice of foods and beverages, but you may not always feel like eating at typical meal times, so please let us know anytime you are hungry or thirsty.”

**Resources: Preventing Pressure Ulcers**


- Brochure Example: “You and Your Family Can Help Prevent Pressure Ulcers”
- Action Plan Example: Assessing Patient and Family Education Program


For more information on pressure ulcer prevention, the NYSPFP Nursing-Centered Initiatives Action Planning Resource Guide summarizes pressure ulcer prevention strategies and includes links to several toolkits and resources, [https://www.nyspfp.org/materials/nursing_resource_guide.pdf](https://www.nyspfp.org/materials/nursing_resource_guide.pdf).

**Readmissions**

Although PFE is an important part of reducing any hospital-acquired condition, the goal of reducing preventable readmissions is especially dependent on the expertise of patients and families. Patients and families should be engaged at every step of readmissions reduction efforts, including identifying causes of readmissions. NYSPFP has developed a Preventable Readmissions Initiation Action Planning Resource Guide that recommends several engagement strategies, including:

- Conducting patient and family caregiver interviews to understand their view of the reasons for a readmission.
- Providing education tailored to the patient’s needs, lifestyle, and health literacy level.
- Engaging patients as partners in their care through processes including updating the whiteboard and participating in change of shift reports.
- Using Teach Back methods.
- Involving patients and families in developing the post-hospital care plan.
- Implementing post-discharge phone calls and a post-hospital care hotline.
Discharge can be thought of as a “hand-off” to the patient and families. It is essential that staff understand the scope of what patients and their families understand, and can provide and manage. Patient and family involvement is most critical in structuring a post-hospital care plan to meet the patient’s needs, abilities, and lifestyles.

**Surgical Site Infections (SSIs)**

Patients and families can do many things to help prevent SSIs before and after surgery. Staff should begin educating patients about prevention strategies prior to surgery, including modifying risk factors. Staff should also encourage patients and families to immediately report any signs of infection, and ensure that they understand how to care for their surgical site after discharge.

Prior to the surgery, explain to patients why it is important that staff have a complete list of medications, and how to take certain medications pre-admission and on the morning of surgery. Inform patients and families about what they can do prior to surgery to help prevent surgical site infections, including not shaving the surgical site and washing with chlorhexidine as instructed. Use Teach Back to ensure patients appropriately prepare prior to the procedure, and to help reduce patients’ anxiety, ensure they understand the reasons for various procedures, such as warming, glucose control, fluids, and oxygen use.

During hospitalization, educate the patient and family about signs of an SSI. Encourage them to notify the staff immediately if they notice redness at the surgical site, increased pain, drainage, or other signs. Inform patients and families about the importance of proper hand hygiene and discourage them from unnecessarily touching the surgical site or dressings.

Teach patients and families how to care for the surgical site after discharge and include information about resuming activities of daily life. Have the patient and family Teach Back the signs and symptoms of infection to watch out for, and what to do if they occur. If dressings are being changed prior to discharge, involve the patient and family so they can demonstrate what they have learned about wound care (Appendix K).

**Ventilator-Associated Events (VAE)**

VAE, like ventilator-associated pneumonia (VAP), are life-threatening and, in many cases, preventable. Patients with scheduled surgeries can take ac-
tion to minimize their risk prior to admission. Family members also can partner with staff to help ensure that the ventilator bundle is consistently followed.

For patients with scheduled surgeries who are likely to remain on a ventilator following their procedures, discuss what a ventilator is and why it might be necessary; the risk of VAP; and what the patient can do to reduce that risk. For example, staff might say, “If you are on a ventilator after surgery, we will be doing several things to help reduce your risk of getting an infection. One step you can take before your surgery to reduce that risk is to stop smoking. We have programs that can help you do that.”

Invite questions and discussion, and address any patient concerns about being on a ventilator. Understanding patients’ fears and preparing them for the experience may lessen their need for sedation.

For ventilated patients with family members involved in their care, explain what staff is doing to prevent infection, including placing the head of the bed between 30 and 45 degrees, unless contraindicated. Encourage family members to partner with staff by:

- Asking if the head of the bed should be repositioned (if the family notices it is not in the 30–45 degree range).
- Asking when the patient will be allowed to try breathing without a ventilator.
- Reminding providers to clean their hands if they do not observe that being done.

Involve family members in prevention techniques like bed mobility, appropriate stimulation and rest, calming or relaxation techniques to minimize sedation, and participation with the rounding teams. Understanding what calms the patient, such as music, lighting, or certain approaches, will be essential in optimizing the care delivered (Appendix L).

**Venous Thromboembolism (VTE)**

VTE is a common and life-threatening complication of hospitalization. Preventing VTE provides a critical opportunity for staff to partner with patients and families in assessing risk, preventing, identifying, and managing this complication.

Hospitals can promote effective risk assessment by informing patients why staff is asking about a personal or family history of blood clots and other risk factors. For example, a staff member might say, “I’m going to ask you some questions that may not seem important to you right now since they are not the reason for your hospital visit. However, it is very important that you answer these questions accurately because they help us to better understand whether you are at higher risk for certain complications while you are here, and to develop a plan to prevent them.” If the patient is on anticoagulants, explore how the patient managed his or her care prior to admission and their level of understanding.

Inform patients and families about the risk of VTE, early warning signs, and potential complications of prophylaxis. Ask them to notify staff immediately if any of the signs or complications are present. Educate and partner with patients and families in prevention strategies by emphasizing the importance of regular ambulation and other physical activities in the hospital, as their condition permits. Involve families in ambulation.

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**Resources: Reducing VAEs**

CDC’s FAQs on Ventilator-Associated Pneumonia is available at [http://www.cdc.gov/HAI/vap/vap.html](http://www.cdc.gov/HAI/vap/vap.html).


If medication is being used to mitigate the risk of deep vein thrombosis (DVT), use Teach Back to educate patients and families about medication management. Ensure that they are aware of the signs and symptoms of adverse anticoagulation reactions, including drug-to-drug interactions and drug-to-food interactions. Make patients and families aware of titration principles and the associated laboratory work that is required. If pneumatic compression devices are being used to reduce the risk of VTE, explain why (Appendix M).

**Resources: Preventing VTE**


Patients and family can only be engaged if staff are engaged first. Each and every hospital staff member and clinician has a role to play in engaging patients and families. Ensuring that staff are engaged is a critical step toward engaging patients and families. This chapter shares strategies that organizations can use to recruit and develop teams to build cultures that support patient and family engagement.

Staff Management Ideas in the Context of PFE

To establish and advance a patient-centric environment through a workforce of empowered health care professionals who are committed to providing quality care that is aligned with a set of service standards, hospitals may consider using the following processes:

Set the Bar18

- Create and establish your organization’s own “Top 10” Service Standards for providing patient care in partnership with the patient and family.
- Assign behaviors to explain how to achieve each service standard.19
  - Engage the staff and managers in this exercise. Study the top health care providers and note the behaviors they exhibit. Create a master list. Carve out a one- to two-hour session and break team into small groups to discuss the top attributes, and then report back to the larger group. Narrow down to the top behaviors.

With this buy-in, move forward to enhance the culture in ways such as:

- Create clusters of competencies that align with PFE standards and have front line managers manage and train staff according to the competencies.20
- Train front line managers to coach behaviors (consider using the one-minute praisings and one-minute reprimands discussed in Ken Blanchard’s book, *One Minute Manager*).21
- Add service standards to job descriptions and performance appraisals.22
- Establish the team scorecard and post progress weekly in a visible location. Discuss shortcomings and gather team input to improve the scorecard.
- Make posters and hang in visible locations.
- Create wallet cards or add to badges so the list is always at hand for staff.
- Establish recognition boards, e-mails, prizes, etc., to promote top performers.
- Use case studies to train staff—weekly or monthly—in group staff meetings to dissect what worked well and what could have been improved.
- Have staff create role play videos—use humor—and use the videos to train the service standards.
- Share positive and constructive patient and family feedback, and use that as an opportunity to discuss with staff one-on-one and in small groups.

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21 K. Blanchard and Johnson, S. *The One Minute Manager*. William Morrow (October 7, 2003).
• Select staff who are strong in certain service standards and give them opportunities to train others in that area to encourage peer-based learning. Reward the peer trainers with a gift card or small token of appreciation.
• Assign a PFE-related book or article as required reading for staff, and have brown bag discussions.
• Always keep the lines of communication open with staff.
• Address problems as they arise and keep staff informed. People who are in the communication loop are more engaged and committed to successful outcomes.
• Include Top 10 service standard training in orientation programs.

Building a culture of commitment to PFE can begin as early as the recruitment process by hiring staff who share the organization’s values and goals.
• Use your organization’s Top 10 service standards to create behavioral-based interview questions.
  - Provide the service standards in the interview process to get the candidates talking about the standards.
  - Ask candidates how they define PFE, and see if it aligns with the institution’s philosophy.
• Adopt an “Always Recruiting” philosophy and a “Recruiting is Everyone’s Job” approach. Encourage and reward successful employee referrals.
• Adopt a “Hire the Smile” philosophy by seeking candidates (and future candidates) who naturally exhibit the service-oriented skills and competencies. Consider relaxing education and experience requirements for the candidates who have the soft skills, and put them on a training plan to learn the “hard skills.”
• Cultivate the future workforce:
  - Offer internships and job shadow days.
  - Host programs on topics relevant to students and use attendee list to follow up with participants.
• Develop student relationships by partnering students with top employees for mentoring meetings at the hospital.
• Provide students with the opportunity to perform community service at the hospital for college credit.

Resources: Engaging Staff


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33 Appendix B. Teach Back Communication Model
35 Appendix C. Critical Conversations: Admission/Initial Assessment
36 Appendix D. Critical Conversations: Bedside Shift Report
37 Appendix E. Effective Use of Whiteboards
39 Appendix F. Critical Conversations for Patient Safety: CAUTI
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44 Appendix K. Critical Conversations for Patient Safety: SSI
45 Appendix L. Critical Conversations for Patient Safety: VAE/VAP
46 Appendix M. Critical Conversations for Patient Safety: VTE
47 Appendix N. Guiding Principles
TeamSTEPPS Communication Model

TeamSTEPPS is a program that was originally designed to improve safety by enhancing teamwork among health care staff members, but many of the program tools can be adapted to engage patients and families.

Key Engagement Opportunities

- Integrate TeamSTEPPS principles into the admission process, such as providing patients and families with the Department of Defense Team Up brochure that asks patients to be active members of the care team.
- Encourage patients and families to assess their own understanding and to communicate using SBAR. Do they understand the situation with their health? Do they need additional background information to help them understand? It is particularly important for them to provide input in the “S” and “R” steps. Here are examples of SBAR adapted for a patient or caregiver to use:
  - Situation: What are the symptoms or concerns that brought you to the hospital emergency department (ED), or that you want to speak with your health care team about today?
  - Background: What does the care team need to know about your medical history that is related to this visit (ED)?
  - Assessment: Is there anything related to the current situation that you want to make sure the health care team is aware of (such as whether you had this symptom, condition, or side effect before and how you managed it)?
  - Request: What can the staff do for you right now (such as managing pain)?
- Teach patients to make a time out symbol with their hands (for example, the T symbol used in sporting events) to alert staff whenever the patient is concerned, uncomfortable or scared, or needs more information. Ask patients to demonstrate how to do it. This is an adaptation of the TeamSTEPPS CUS model (“I am Concerned, I am Uncomfortable, this is a Safety issue, or for patients and families, “I am Scared”).
- Organizations implementing TeamSTEPPS for staff should consider including patient and family advisors in the formal TeamSTEPPS master training program. Putting patients and families on the TeamSTEPPS implementation team not only engages them, but it may also lead to greater insights for adapting these tools for broader use by patients and families.

AHRQ has a number of resources for the TeamSTEPPS program, available at http://teamstepps.ahrq.gov/.

Teach Back Communication Model

Teach Back is a method of communication that engages patients and families by creating opportunities for meaningful, health-literate, and appropriate dialogue. After sharing information with the patient and family, staff members should verify whether they understand what was taught by asking them to explain in their own words what they understood.

Key Engagement Opportunities

- It is not enough to ask the patient or family a yes or no question such as, "Do you understand?" or "Any questions?" These questions do not invite dialogue and may make the patient or family feel ashamed for not understanding.
- Ask the patients and families open-ended, non-judgmental questions that focus on the provider’s skill in communicating, such as, "What will you tell your family about the changes we made to your medications today?"
- Focus on the most important information first and use plain, non-clinical language (for example, refer to "high blood pressure" not "hypertension" and "the best way" instead of "optimal").
- If the patient or family does not understand the information, don’t simply repeat it; try explaining it in a different way. Invite them to stop you as soon as you say something that needs clarification.
- Provide the patient and family with written information that reinforces the information that was given verbally.
- Record the use of Teach Back so other staff are aware of what the patient understood and what needs to be reinforced.
- Add Teach Back to your clinical competencies, standards of care, and order sets.

Schillinger’s 10 Elements for Effectively Using Teach Back*

1. Use a caring tone of voice and attitude.
2. Display comfortable body language and make eye contact.
3. Use plain language.
4. Ask the patient to explain back, using their own words.
5. Use non-shaming, open-ended questions.
6. Avoid asking questions that can be answered with a simple yes or no.
7. Emphasize that the responsibility to explain clearly is on you, the provider.
8. If the patient is not able to Teach Back correctly, explain again and re-check.


Iowa Health System, in partnership with Health Literacy Iowa, Des Moines University, and the Picker Institute, has created the Always Use Teach Back! Training Toolkit, available at http://www.teachbacktraining.org. It includes elements of competence for effectively using teach back, coaching tips, and an observation tool.

UHF’s Next Step in Care Toolkit for Working with Family Caregivers includes information on how to use Teach Back to review discharge instructions with the family caregivers and is available at http://www.nextstepincare.org/provider_home#toolkit.
Critical Conversations: Admission/Initial Assessment

The admission and initial assessment process is an important opportunity to immediately engage patients and families and set expectations for partnership throughout the hospitalization.

Key Engagement Opportunities

• Remind patients that they are important members of the care team. Demonstrate respect for patients' expertise with statements such as, “You are the expert about you,” and emphasize that patients' knowledge is indispensable.
  • Provide written reinforcement in admission materials and hospital guides, or with targeted materials, such as the AHRQ's Be a Partner in Your Care brochure, flyer, and sign.

• Ask the patient who else they would like to include in his or her care, using language such as, "You may want family or friends to take part in conversations about your health or health care. Who would you like to be involved?"

• Explain in concrete terms how patients and families can partner with staff.
  • Describe opportunities for patients and families to communicate with staff. These include bedside shift reporting, providing notepads for patients and families to write down and share questions, and using space on the whiteboard.
  • Encourage patients to share information, to speak up about any concerns, and to ask questions.

• Practice Teach Back by showing patients how it works during admission and initial assessment. “Teach Back” to the patient the information they are sharing with you. Explain that staff will ask patients to Teach Back during their stay to ensure that they explained things effectively. Emphasize that the patient should ask about anything he or she doesn’t fully understand,

even if it needs to be explained multiple times or several different ways.

The “Be A Partner in Your Care” brochure, tips for being a partner, “Talk To Us” handout, and “We Are Partners In Your Care Sign” are from the AHRQ Guide to Patient and Family Engagement in Hospital Quality and Safety, Strategy 2: Communicating to Improve Quality, available at http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/strategy2/index.html.
Critical Conversations: Bedside Shift Report

Bedside shift report is a practice in which nurses share information about patients at the bedside during change of shift. Bedside shift report is an opportunity to routinely engage patients (and family members, as desired by the patient) as partners by inviting and encouraging them to participate in the discussion. Evidence shows that the bedside shift report can improve quality, safety, and patient and staff satisfaction, as well as reduce overtime.* **

Key Engagement Opportunities

- It is not enough to move reports to the bedside; staff needs to invite patients and families to participate.
- Invitations can include:
  - Verbally informing patients and families about the bedside shift report process upon admission, including the approximate time the process will occur. This should be accompanied by a written description of the bedside shift report process.
  - Reminding patients on rounds prior to the bedside shift report that it will be taking place and inviting them to ask questions or raise concerns at that time.
- Provide staff with a bedside shift report checklist reminding them to:
  - Begin the report by inviting patients and families to participate.
  - Ask patients and families about their needs and concerns.
    - For example: “Do you have any worries you would like to share? What could have gone better in the last 12 hours?”
  - End report by asking the patient and family about the patient’s goal for the next shift.
    - For example: “What do you want to happen in the next 12 hours?”

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Effective Use of Whiteboards

Whiteboards can be powerful patient and family engagement tools. Although whiteboards are typically used to communicate information to the patient, such as names of staff members, they also can be an effective vehicle for the patient and family to share information and reinforce the patient’s and family’s important roles on the care team.

Key Engagement Opportunities

• If you are already using whiteboards, clearly express their purpose as an engagement tool and review the elements to determine if there are additional opportunities to engage:
  • Orient the patient and family to the whiteboard and encourage them to write on it. Ensure that whiteboard pens are attached to the board, and restocking supplies are readily available. A study found that a lack of pens was the biggest barrier to staff using the whiteboard.*
  • Use the whiteboard as a trigger tool to orient the patient and family to the applicable heightened safety risks, such as if a patient is a fall risk, and what they can do to help prevent them. This also serves as a visual reminder of safety precautions.
  • Consider adding space on the whiteboard for patients and families to communicate with the care team, including:
    • Family contact information
    • Daily goal as defined by the patient
    • Patient and family questions
• If you are not already using whiteboards, consider designing unit-specific whiteboards by working with teams on each unit to determine what information is most valuable to patients and families. Be sure to include patients and families on the teams that design the whiteboards.


Information Often Included on Whiteboards

• Day and date
• Patient name or initials
• Family’s day and evening contact numbers
• Care team
  • Names of physicians
  • Names of shift care team (primary nurse and nursing assistant)
  • Names of therapists (PT, OT, RT, etc.)
• Safety considerations
  • Patient-specific risk factors (falls, pressure ulcers, foley catheter, etc.)
  • Mobility status
  • Safety precautions and alerts

• Patient status
  • Pain scale
  • Wonk-Baker (visual) Pain Scale
  • Next dose pain meds due

• Clinical goals
  • For hospital stay
    • Care plan and patient milestones
    • Patient goals for discharge
    • Family goals for discharge
    • Probable discharge date
    • Scheduled discharge appointment
  • For day
    • Daily clinical targets or orders that promote patient safety:
      • Examples from Studer**—orders that promote patient safety:
        • “Cough, turn, and deep breath every 2 hours”
        • “Walk with assistance 3 times today”
        • “Keep the head of the bed at 45 degrees”
        • “Most Important Thing for Today”
      • Scheduled testing and procedure appointments
      • Last hourly rounding visit
  • Communication
    • Patient and family questions
    • Family and visitor observations
    • Staff team member to staff team member communication

Catheter-associated urinary tract infections (CAUTI) are common healthcare-associated infections. Effective partnerships with patients and families can help reduce unnecessary catheterizations. Patients and families can also assist with maintaining catheters and having them removed more quickly.

Key Engagement Opportunities

- If a patient or family member requests a catheter that staff believe is not medically necessary, staff should talk to the patient and family to understand the reason for the request. Common reasons include concerns about the frequency of toileting, the effort required to get to the bathroom, and the fear of falling. Discussing the risks of CAUTIs, as well as reassuring the patient and family that staff will assist the patient to the bathroom or promptly address incontinence, may make the patient less likely to want a catheter.
- Patients with catheters should be encouraged to ask staff daily about whether the catheter can be removed.
- Patients and families should be educated about how to minimize a patient’s risk for CAUTI. This includes:
  - Notifying staff if the urine drainage bag is too high (it should be below the bladder).
  - Avoiding disconnecting, twisting, or kinking the catheter.
  - Asking providers to wash their hands if the patient or family does not observe them doing so.
  - Cleaning their own hands before touching the catheter and keeping the catheter clean.
- As appropriate, staff should involve patients and families in the ambulation, transferring, and toileting processes.
- Staff should ask all patients and family members to immediately report any signs of infection, including burning, lower abdominal pain, or increase in frequency of urination.

A brochure, “What Patients and Family Members Need to Know About the Risks Associated with Urinary Catheters,” and a script for when patients or family requests a non-medically indicated in-dwelling urinary catheter are available at http://catheterout.org/drupal/bladder%20bundle/?q=patient-family-ed.

The Centers for Disease Control and Prevention (CDC) also has a page dedicated to preventing CAUTIs that includes a number of resources: http://www.cdc.gov/hai/ca_uti/uti.html.

NYSPFP has a page of resources for its CAUTI prevention clinical focus area, https://www.nyspfp.org/members/initiatives/infectionprevention/cauti/overview.aspx.
Patients and families can be key allies in preventing central line–associated bloodstream infections (CLABSI).

Key Engagement Opportunities

- Prior to inserting a central line, educate patients and families about the risk of CLABSI and strategies to prevent it.
- Emphasize the need for partnership, by saying, for example, “We will be taking several actions to help reduce your risk of infection, including cleaning your skin thoroughly before we insert the central line, and we need your help to keep it clean.”
- Discuss with the patient and family how to care for the central line, including the importance of not allowing family members to touch the catheter or tubing. Remember to give the patient and family meaningful opportunities to ask questions. Don’t simply ask, “Are there any questions?” Use Teach Back to ask patients to explain what they understand about their central line care.
- Ask patients and families to notify staff immediately if they develop any discomfort, redness, or itching around the catheter site. Explain that these could be warning signs of infection.
- If the patient is going home with the catheter, provide the patient with information verbally and in writing about how to properly care for the catheter at home. Provide opportunities for Teach Back and “show back” demonstrations.
- When assessing CLABSI prevention strategies and developing action plans, include patient and family education as a key component of the plan.

The CDC has a page on CLABSI prevention with resources for patients, families, and providers, [http://www.cdc.gov/hai/bsi/bsi.html](http://www.cdc.gov/hai/bsi/bsi.html).

NYSPFP has resources on its page dedicated to the CLABSI prevention clinical focus area, [https://www.nyspfp.org/members/initiatives/infectionprevention/clabsi/overview.aspx](https://www.nyspfp.org/members/initiatives/infectionprevention/clabsi/overview.aspx).
Critical Conversations for Patient Safety: EED

Pregnant women and their families are critically important partners in minimizing early elective deliveries (EEDs) before 39 weeks without medical indication. Women who are aware of the risks of EEDs may be less likely to request them, and be more comfortable with raising concerns if their providers or others suggest an early delivery.

Key Engagement Opportunities

Provide information to expectant mothers and families about the risks of elective deliveries before 39 weeks in ways such as:

- Displaying posters in areas of the hospital where expectant mothers will visit on a hospital tour.
- Incorporating information about the risks of EEDs in childbirth education classes offered by the hospital.
- Including information in hospital communications, such as a community newsletter.


A teaching tool that illustrates the difference in a baby’s brain development at 35 versus 40 weeks is available for purchase from the March of Dimes at https://www.marchofdimes.com/catalog/product.aspx?productid=4984&categoryid=&productcode=37-2229-07.

The Association of Women’s Health, Obstetric, and Neonatal Nurses has a “Go the Full 40” campaign with fact sheets and other resources at http://www.health4mom.org/a/go_the_full_40_campaign_resources_847.

NYSPFP has a page on its maternal safety clinical focus area, which includes resources for reducing early elective deliveries: https://www.nyspfp.org/members/initiatives/obstetrical/overview.aspx.

Appendix H
Patients play an essential role in preventing falls. Staff should engage patients (and family, as desired by the patient) throughout the entire hospital stay to assess their fall risk and take appropriate action to prevent falls.

Key Engagement Opportunities

- During the fall risk assessment at admission, explain why you are asking questions about prior falls and related issues. Ask the patient and family what they do at home to prevent falls.
- Include the patient and family in ongoing prevention activities that involve the physical environment (everything within reach), medication (toileting prior to any sedating), and strengthening (exercise and ambulation as appropriate).
- If the patient has been assessed as a fall risk, inform the patient and family and educate them about why the patient is at risk and what precautions to take. Ensure they understand the risk signage, colored socks or wristbands, use of belts, floor pads, and other techniques.
  - Add patient and family communication and education to the staff fall checklist to ensure that they occur.
  - Use Teach Back and “show back” demonstrations to verify that patients and families understand what they can do to help prevent falls, such as asking, “Can you please tell me in your own words what are the prevention techniques you will use to prevent falls?” Ask patients to show you how to use the call light.
  - Reinforce fall prevention strategies in routine processes, such as rounding and bedside shift reports. Prevent hospital-acquired deconditioning with proactive physical or occupational therapies and programs.
  - If a fall occurs, interview patients and family members to find out what contributed to the fall and identify opportunities for improvement.


The Joint Commission has a Speak Up™ brochure to help patients and families learn about fall prevention, available at [http://www.jointcommission.org/topics/speakup_brochures.aspx](http://www.jointcommission.org/topics/speakup_brochures.aspx).

IHI has tips and tools for using Teach Back to help teach patients about preventing falls at [http://www.ihi.org/resources/pages/tools/alwaysuseteachback!.aspx](http://www.ihi.org/resources/pages/tools/alwaysuseteachback!.aspx).
Critical Conversations for Patient Safety: Pressure Ulcers

From the initial admission assessment to ongoing care and monitoring of skin, patients and caregivers can help prevent pressure ulcers.

Key Engagement Opportunities

• During the initial skin assessment conducted upon admission, explain why the patient’s skin is being examined and ask the patient and family if they are aware of any discolored or tender areas.
• Explore both the patients’ and families’ ability to assist with bed mobility and positioning.
• If appropriate, explain goals of hourly rounding.
• Encourage the patient and family to let staff know immediately if they notice any skin changes, including red, purple, or sore areas.
• If the patient is identified as at risk for pressure ulcers, inform the patient and family and educate them about ways to help prevent pressure ulcers. Use sample statements like those below.
  • Positioning and movement. “Shifting your position often helps reduce the risk of pressure ulcers, but certain movements increase the risk of pressure ulcers. Please do not drag yourself across the bed or chair, or push or pull with your heels or elbows. If you are having difficulty adjusting your position by yourself, please ask for help. Please do not rub your skin against anything repeatedly, such as using the sheets to scratch an itch.”
  • Skin care. “One thing you can do to help prevent pressure ulcers is keep your skin clean. Please notify us immediately if any part of your skin is wet or soiled. Dry skin is also vulnerable to pressure ulcers, so please use the lotion we have provided.”
  • Other risk factors. “Pressure ulcers are also more likely if you are not eating well or not drinking enough fluids. We will offer you a choice of foods and beverages, but you may not always feel like eating at typical meal times, so please let us know anytime you are hungry or thirsty.”


Critical Conversations for Patient Safety: SSI

There are many things that patients and families can do to help prevent surgical site infections (SSIs), both before and after surgery. Staff should begin educating patients about prevention strategies prior to surgery, such as modifying risk factors like smoking.

Key Engagement Opportunities

• Prior to the surgery, explain to patients why it is important that staff have a complete list of medications, and how and why they need to take certain medications pre-admission and on the morning of surgery.
• Inform patients and families about what they can do prior to surgery to help prevent surgical site infections, including not shaving the surgical site and washing with chlorhexidine as instructed. Use Teach Back and other approaches to ensure patients appropriately prepare (for example, mechanical bowel preps) prior to their procedure.
• Reduce anxiety and enhance compliance by ensuring that patients and families understand the reasons for various procedures such as warming, glucose control, fluids, and oxygen use.
• During the hospitalization, educate the patient and family about signs of an SSI. Encourage them to notify the staff immediately if they notice redness at the surgical site, increased pain, drainage, or other signs of infection.
• Inform patients and families about the importance of proper hand hygiene, and discourage them from unnecessarily touching the surgical site or dressings.
• Teach patients and families how to care for the surgical site after discharge, including information about resuming activities of daily life, such as showering.

• If dressings are being changed before discharge, involve the patient and family so they can “show back” what they have learned about wound care.

The CDC has a page of resources for preventing SSIs that includes a PDF of frequently asked questions at http://www.cdc.gov/hai/ssi/ssi.html.

IHI has a customizable flyer that hospitals can use to encourage patients to bathe or shower with chlorhexidine soap to reduce the risk of SSIs, http://www.ihi.org/resources/pages/tools/chgbathingflyerpreventingssis.aspx.

NYSPFP has a page of resources for its SSI reduction clinical focus area at https://www.nyspfp.org/members/initiatives/infectionprevention/ssi/overview.aspx.
Critical Conversations for Patient Safety: VAE/VAP

Ventilator-associated events (VAE), such as ventilator-associated pneumonia (VAP), are life-threatening and in many cases preventable. Patients with scheduled surgeries can take action to minimize their risk prior to admission. Family members can also partner with staff to help ensure that the ventilator bundle is consistently followed.

Key Engagement Opportunities

• For patients with scheduled surgeries who are likely to remain on a ventilator following surgery, discuss the following: what a ventilator is, why it might be necessary, the risk of VAP, and smoking cessation as one step the patient can take to reduce that risk.
  • For example: “If you are on a ventilator after surgery, we will be doing several things to help reduce your risk of getting an infection. One thing that you can do before your surgery to reduce that risk is to stop smoking; we have programs that can help you do that.”

• For ventilated patients with family members involved in their care, explain what staff are doing to prevent infection, including the placement of the head of the bed to 30–45 degrees, unless contraindicated. Encourage family members to partner with staff by:
  • Asking if the head of the bed should be repositioned (if the family notices it is not in the 30–45 degree range).
  • Asking when the patient will be allowed to try breathing without a ventilator.
  • Reminding providers to clean their hands if family members do not observe that it is being done.

• Involve families with prevention techniques such as bed mobility, appropriate stimulation and rest, calming or relaxation techniques to minimize sedation, and participation with the rounding teams.

The American College of Surgeons has a handout for patients to help them quit smoking before surgery. Copies are available through http://www.facs.org/patienteducation/quitsmoking.html.

The CDC has a site on VAP that includes fact sheets and other resources at http://www.cdc.gov/hai/vap/vap.html.

The Web site for New York State Smokers’ Quitline has a number of fact sheets and posters available for download at http://www.nysmokefree.com/.

NYSPFP has a VAE clinical focus area and a page of resources: https://www.nyspfp.org/members/initiatives/infectionprevention/vap/overview.aspx.
Critical Conversations for Patient Safety: VTE

Venous thromboembolism (VTE) is a common and life-threatening complication of hospitalization. It presents staff with an important opportunity to partner with patients and families in assessing VTE risk, along with preventing, identifying, and managing VTE.

Key Engagement Opportunities

- Promote effective risk assessment by informing patients why you are asking about a personal or family history of blood clots and other risk factors. For example: “I’m going to ask you some questions that may not seem important to you right now. It’s very important that you answer these questions accurately, because they help us to better understand whether you are at higher risk for some complications while you are here and to develop a plan to prevent them.”
- If a patient is on anticoagulants, explore how he or she managed prior to admission, and his or her level of understanding.
- Inform patients and families about the risk of VTE and the early warning signs, as well as potential complications of prophylaxis. Ask the patient and family to notify staff immediately if any of the signs or complications are present.
- Educate patients and families about prevention strategies, including the importance of regular ambulation and other physical activities in the hospital as their condition permits.
- If medication is being used to mitigate the risk of deep vein thrombosis (DVT), use Teach Back to educate patients and families about medication management.
- Ensure that patients and families are aware of the signs and symptoms of adverse anticoagulation reactions, including drug and food interactions.
- Ensure that patients and families understand titration principles and associated laboratory work.

- If you are using pneumatic compression devices to reduce the risk of VTE, explain why the devices are being used and why it is important to keep them on. If patients don’t understand why the devices are important, they may not continue to use them.

NYSPFP has a clinical focus area on VTE, along with a number of resources, at https://www.nyspfp.org/members/initiatives/nursing/vt/overview.aspx.

The University of North Carolina at Chapel Hill’s Hemophilia and Thrombosis Center has developed a Web site to raise awareness of VTE and pulmonary embolism (PE) called Clot Connect, http://www.clotconnect.org/. This site has a number of resources, including patient handouts for newly diagnosed patients, as well as “DVT and PE: The Basics,” and “Hospitalized? Preventing Blood Clots Is as Easy as 1-2-3.”
Test new strategies, processes, or protocols, and organization or team approaches for effectively engaging patients and their families throughout the health care continuum.

- Consider implementing what the Picker Institute called “Always Events,” or aspects of the patient and family experience that should always occur.
- Prioritize the importance of “Meaningful Use” or electronic health record (EHR) incentive objectives that support hospitals in sharing patients’ medical information for enhanced care coordination.
- Include patient-centered concepts in education for physicians-in-training and staff orientation curriculum.
- Implement a patient shadowing program to understand your hospital’s systems from a patient perspective and help design a patient-centered care approach.
- Implement a hotline for patients to provide positive and negative feedback.
- Seek opportunities to amplify the voice of the patient through focus groups, or by implementing a patient-activated rapid response team and patient-initiated time out.
- Work with Human Resources to establish PFE-related service standards as part of a staff management strategy for health care providers.

Promote practices for patients, families, and health care professionals to communicate effectively, understand the roles team members play, and underscore the importance of being full partners in the care process.

- Provide care that is respectful of, and responsive to, individual patient preferences, needs, and values; ensure that patient values guide all clinical decisions.\(^1\)
  - Share care plans with patients’ loved ones and welcome their questions.
  - Conduct bedside shift reports with the patient and family.
- Consider the following opportunities to include patients and families as advisors at the organizational level to improve quality and safety.\(^2\)
  - Serve on Hospital Boards of Directors.
  - Help evaluate programs.
  - Participate on advisory councils or quality and safety committees.
  - Serve as co-faculty for staff education.
  - Review audiovisual and written materials.
  - Participate at conferences and working meetings.
  - Participate in focus groups.
  - Participate in special events (e.g., Hand Hygiene Week).
- Encourage patients to access their health information to make informed decisions about their care.

Establish systems that include patients and family members in the care process and allow for the integration of their voices into hospital operations.

- Establish patient engagement as a routine part of practice.
- Identify patient engagement opportunities to coordinate and integrate care by using overarching patient-centered care practices for preventing hospital-acquired conditions and readmissions.
  - Utilize whiteboards as an effective two-way communication tool.
  - Engage patients and families in discharge planning processes upon admission to reduce readmissions.\(^3\)
  - Conduct bedside shift reports with patients and family members.

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Develop and implement standard organizational policies and practices that encourage including patients and family members as active members of the care team.

- Make improving PFE an organizational goal:
  - Inventory policies, processes, and training programs to determine whether PFE is appropriately included.4
  - Ensure your organization has a written mission statement for PFE.
- Implement structures to support engagement:
  - Create a dedicated functional area for PFE.
  - Invite a patient representative to serve as a member of the hospital’s governing board.
  - Establish an active PFE committee.
  - Add service standards to job descriptions, orientation, and performance appraisals.
  - Train managers on how to coach staff to effectively engage patients and family members.
- Capture data for performance improvement:
  - Use a formal patient engagement assessment to identify strengths and gaps.
  - Select measures to track process and outcome changes, and establish a process to share results.
  - Track information at the micro and macro levels of care, such as intervention-specific metrics, patient satisfaction scores, and changes to the governance structure.
- Implement communication strategies for patients, families, and clinicians as a foundation for true partnerships:5
  - Engage patients with TeamSTEPPS CUS words (I am Concerned; I am Uncomfortable; this is a Safety situation; or for patients, “I am Scared”).
  - Use a patient-friendly SBAR (Situation-Background-Assessment-Recommendation) technique to discuss patients’ conditions.
  - Adopt strategies to improve health literacy and support patients in learning to manage and organize their care at the level they choose.6


5 See note 3.
