Incremental Enculturation of Patient Centered Caring: Sustaining Excellence in the Patient Experience

Session Code C849

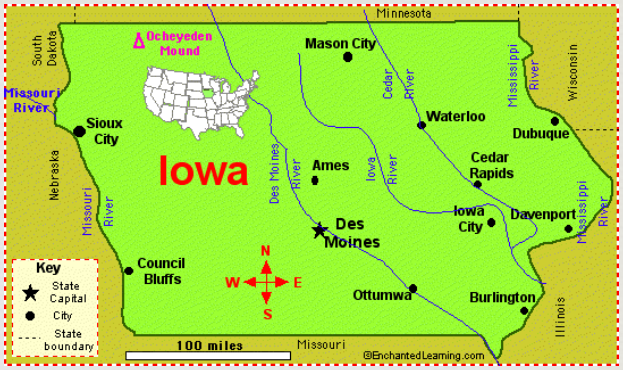
2015 ANCC National Magnet Conference

October 8, 2015 3:45 – 4:45 p.m.

Kay L. Takes, MA, RN, NEA-BC

Mercy Medical Center, Dubuque, Iowa

Mercy Medical Center Dubuque



- Founded by the Sisters of Mercy in 1879
- Member of Mercy Health Network in Iowa and of Trinity Health of Livonia, Michigan.
- Two campuses in Dubuque and Dyersville, Iowa
- Provide comprehensive services including cardiology and cardiac surgery, NICU, robotic surgery, inpatient rehab, trauma, skilled and long term care, retail pharmacy, palliative care

Mercy Nursing : Helping You Achieve Your Highest Level of Health

Through a culture of …

Pervasive leadership

Compassionate care

Collaborative relationships

Positive and forward thinking

Thriving practice environment

- Approximately 500 nurses
- Magnet-designated for the third time in May 2014

10th National Magnet Conference

Caring From the Patient's Point of View

SC314

October 6, 2006

Amy Cherne, RN, MSN
Louann Mottet, RN, MSN, OCN
Kay Takes, RN, MA, CNAA

Mercy Medical Center

Dubuque, Iowa

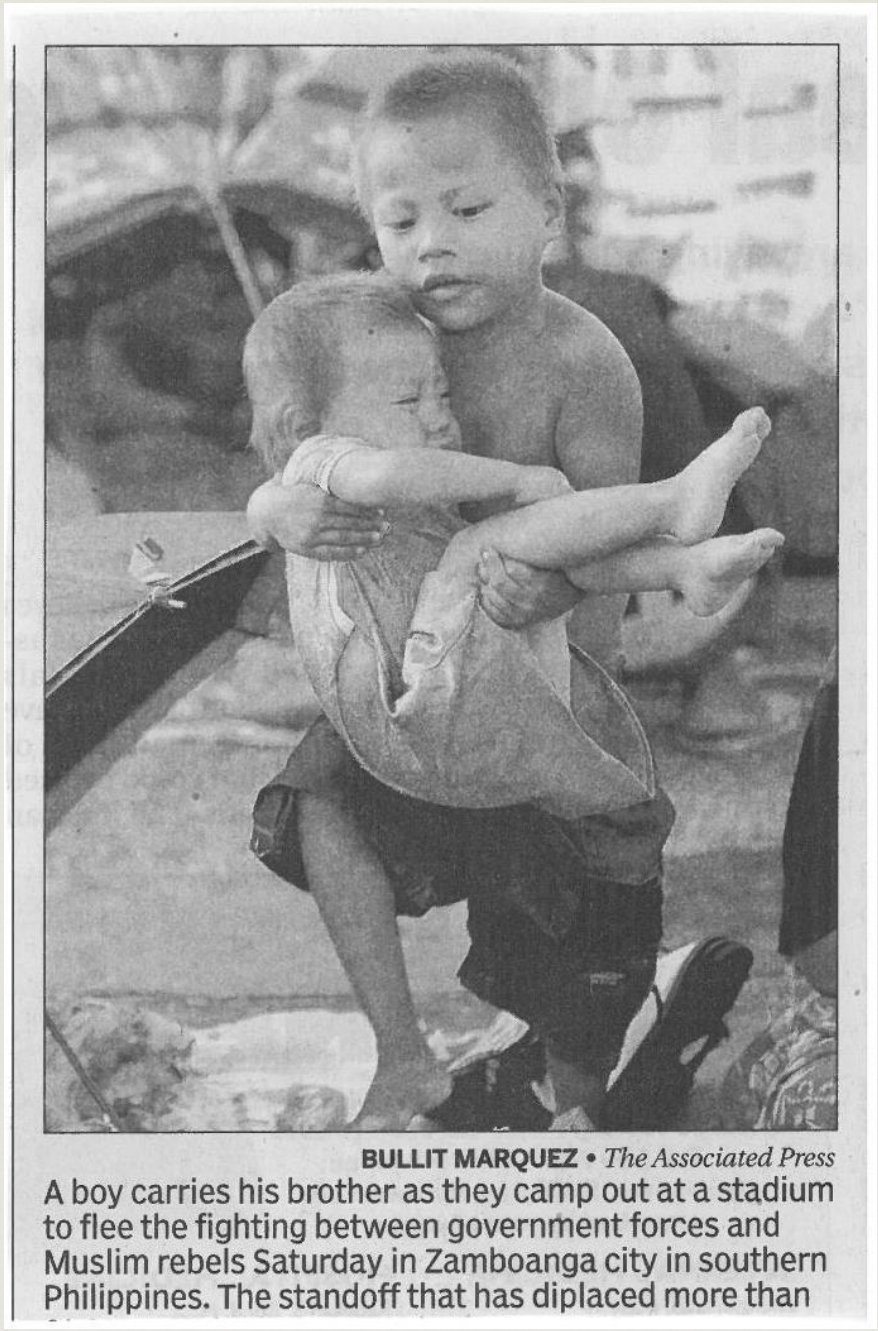
THEN
(2006)

NOW
(2015)

Caring

- At the center of our Mission and Vision is a deep commitment to caring.

- Consistent with our Catholic identity, we believe:
  - Every person is a treasure
  - Every life a sacred gift
  - Every human being a unity of body, mind, and spirit



BULLIT MARQUEZ • *The Associated Press*

A boy carries his brother as they camp out at a stadium to flee the fighting between government forces and Muslim rebels Saturday in Zamboanga city in southern Philippines. The standoff that has diplaced more than

The ultimate in caring

Evolution of Our Model of Caring

2002 - Opportunity Discovered

2003 – Caring Model Phase I

2005 – Caring Model Phase II

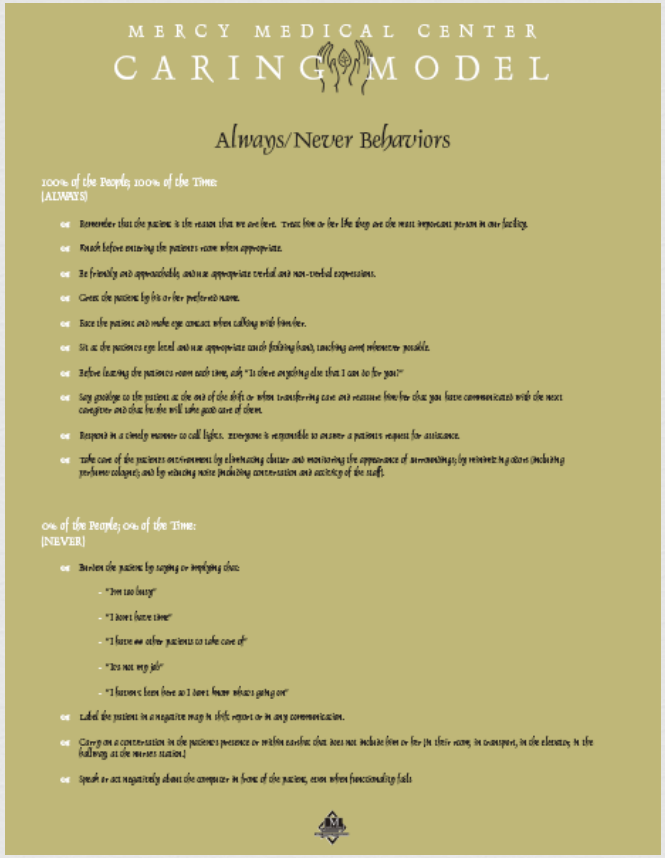
2007 – Caring Model Phase III

2010 – Caring Model Phase IV

2013/Ongoing

– Caring Model Phase V

First Step:
Caring Model Phase I



MERCY MEDICAL CENTER

CARING MODEL

Always/Never Behaviors

100% of the People; 100% of the Time:
(ALWAYS)

- Remember that the patient is the reason that we are here. Treat him or her like they are the most important person in our facility.
- Knock before entering the patient's room when appropriate.
- Be friendly and approachable, and use appropriate verbal and non-verbal expressions.
- Greet the patient by his or her preferred name.
- Face the patient and make eye contact when talking with him/her.
- Sit at the patient's eye level and use appropriate touch (holding hand), touching most whenever possible.
- Before leaving the patient's room each time, ask "Is there anything else that I can do for you?"
- Say goodbye to the patient at the end of the shift or when transferring care and examine how/to what you have communicated with the next caregiver and that he/she will take good care of them.
- Respond in a timely manner to call lights. Everyone is responsible to answer a patient's request for assistance.
- Take care of the patient's environment by eliminating clutter and maintaining the appearance of surroundings; by removing items (including psychomotor catalysts) and by reducing noise (including conversation and activity of the staff).

0% of the People; 0% of the Time:
(NEVER)

- Burden the patient by saying or implying that:
  - "I'm too busy"
  - "I don't have time"
  - "I have so many patients to take care of"
  - "It's not my job"
  - "I haven't been here so I don't know what's going on"
- Label the patient in a negative way in shift report or in any communication.
- Carry on a conversation in the patient's presence or within earshot that does not include him or her (in their room, in transport, in the elevator, in the hallway, at the nurses' station).
- Speak or act negatively about the caregiver in front of the patient, even when functionality fails.

- Set out to create a framework for caring
- Focus groups: "What's Good About Caring?"
- Clinicians only
- 'Make vs Buy' options
- Selected Kristen Swanson's Mid-Level Caring Theory; Along with the creation of 'AWAYS/NEVER' behaviors

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

Kristen Swanson's Middle Range Theory of Caring

- Principle #1

- **Maintaining Belief and Hope in the Patient**
  - Having a hope-filled attitude that offers optimism

Principle #2

- **Knowing the Patient**
  - Seeing the world through the patient's eyes by avoiding assumptions based on our own reality in relation to physical, cultural, spiritual, and emotional responses to illness and wellness

Principle #3

- **Being With the Patient**
  - Clearly conveying a message that the patient's experience matters to us

Principle #4

- **Doing For/Assisting the Patient**
  - Doing for others what they would do for themselves if they could

Principle #5

- **Facilitating Care for the Patient**
  - Promoting shared problem solving, teaching and self-care; coaching, guiding, informing, explaining, giving feedback

Always

- Knock before entering the patient's room
- Be friendly and approachable
- Greet the patient by his/her preferred name
- Face the patient and make eye contact when talking with him/her
- Sit at the patient's eye level and use appropriate touch
- Ask the patient, 'Is there anything else I can do for you?'
- Tell the patient that you are leaving at the end of your shift or when transferring care
- Respond in a timely manner to call lights
- Take care of the patient's environment

Never

- Burden the patient by saying you're too busy
- Label the patient in a negative way
- Carry on a conversation in the patient's presence that does not include him/her

Caring Model Phase II (2005)

The Goal:

Know the patient by actively involving them in communication during shift report and unit-to-unit transfers in care.

Opportunity…Challenge

How do you really get to know a patient?

Ask Questions!

Patient Involvement in Shift Report

- Ask the patient for input in preparation for hand-offs in care (we called it the "PR")
- Pass it on in report and document it for future reference (Caring Model Flowsheet)
- New nurse closes the loop with the patient at the start of the shift and asks if there is anything else important for him/her to know.

"I'm preparing my report for the next person who will be caring for you. Is there anything specific that you would like me to pass along?"

Caring Model Phase III (2007)

The Goal: Patient Centered Care & the Electronic Medical Record

(Incorporated:

- Being with the patient; knowing the patient; doing for the patient; facilitating care for the patient)

Clinician Observations of Care Delivery with the EMR

- Nurse points out & shares information on the screen with patient
- Patients frustrated with pauses and time it takes to enter information
- Location of the computer in relation to the patient is **important**
- Functionality limitations are frustrating
- High variation in where computerized charting is occurring
- Troubleshooting seems to be 'ok' with patients
- Still a lot of handwritten notes; charting on old forms with batch entry of data

Clinician Observations of Care Delivery with the EMR

- Aside from assessments, a lot of **charting is being done away from the bedside**
- **Space** is a problem
- Computer charting often **not practical with quick cares**
- **MD utilization** is problematic
- Computer charting may impair development of relationships with the patient if the **focus is on the computer**
- **Less likely to get up from computer** to help/greet customers & peers
- **Lack trust** in computer reliability

Additional Comments…

- People who took a long time to chart in the paper world are often the same people who take a long time to chart in the EMR.
- People leaving late are often batch charting. In addition, they seem to have higher stress levels. People charting as they go are more likely to get out on time.
- Coaching staff members on how to 'chart-as-you-go' has proven to be helpful.
- The Mercy Homecare experience with the EMR valuable.

Patient Perspective of Care Delivery with the EMR

- 19 Patients discharged during the seven day period from March 1 – March 7, 2007
- Four age categories
- Male and female
- Seven nursing areas included
  - CMU (2)
  - 3 West (5)
  - 4 West (6)
  - Birth Center (1)
  - RSU (2)
  - Pediatrics (1)
  - Ambulatory (2)

Questions Used in Interviews

- While you were in the hospital, did you notice that the caregivers were using a computer to do their documentation?
- Can you describe a positive experience in regards to the clinician's use of the computer in documenting about your care?
- Can you describe a negative experience in regards to the clinician's use of the computer in documenting about your care
- If you have been a patient at Mercy before, did you notice anything different in your care because of the computer
- Is there anything that we can improve on regarding use of the computer in your care?

Sampling of Responses

- "I noticed that they were keeping track of all pharmaceuticals that they were giving me through the electronic device. They would check to make sure that my wristband matched what they were giving me. I know they were keeping records on computer."
- "They came up and scanned my name from my bracelet into the computer, and they had to do it again every time they gave me medicine,… I don't know what it's called – the little Palm Pilot thingy."
- "I've seen the carts out in the hallway with the laptops when I took a walk, but I don't recall that they brought one into my room."

Sampling of Responses

- "At admission, they had computers when I was answering their admission questions. That was in my room. They were asking me questions, and they were inputting the answers into the computer. It was on a stand, like a PC on a stand. That's the only one I can recall."
- I remember seeing the actual laptop in there for a little while, and then otherwise, I saw almost like a PDA-type thing that was scanning my bracelet all the time."
- I didn't see anything wrong or odd about what they were doing. I have confidence in it. I thought I received wonderful care, and everybody took time with me."

Sampling of Responses

- I can't really point to any specific advantage that the computers gave me, but the admission, my allergy history, my medication history – that was all caught at the beginning, and the continuity was there. I never had the feeling that the nurses were paying more attention to the computer than to me."
- "I think that the nurses were more easily able to compare the changes in my blood pressure when the nurses changed shifts. That seemed fairly easy for them to do. There were a few times when they wrote things down instead of entering it on the computer right there in my room."
- I think that computers don't detract from patient care. They're a good thing."

Sampling of Responses

- "I don't know how secure computers are anymore, you know, hacking et cetera, but I think that a lot of health information is shared anyway, so,.."
- "They try to keep it as quiet and easy as they can. But I noticed that there wasn't a lot of room. I was in a double bed, and it was a little difficult for them to get around with those computers – kind of a hindrance."
- "Yes, I noticed those computers. I'm a retired RN, so I've done admissions and hospital patient care. So the first thing I noticed was that this is all computerized now, and I thought it was very efficient. And the continuity was very good also,…"

Sampling of Responses

- "I use a computer all the time at work, very familiar with them. I was asking the nurses how they liked them. It was my impression that 80-90% of the nurses I asked like them, and the others were still getting familiar with them,.. I think they're a good thing, and they'll make care a lot more efficient."
- "… I also heard a doctor who said that he wasn't particularly happy with it. He suggested that I go to Finley for that one procedure instead of Mercy because of the computer reports. It was too much scrolling when the reports were coming back to the doctors. Honestly, I just assume that people don't like changes but they'll get used to it and eventually it'll work out okay."

Caring Model III: Key Deliverables

1. Positive First Impressions
2. Attitude
3. Clinical Documentation
4. The Physical Environment
5. Computer Functionality & Enhancements
6. Clinician Competency

1. Positive First Impressions

Making sure that the patient's first impressions are positive by providing him or her with an opportunity to be introduced to Mercy and to 'settle in' prior to being bombarded by well-intended clinicians who now have immediate access to patient information in Cerner/Healthquest.

Caring Model Welcome

- Opportunity for the patient to 'settle in' before others arrive
- Should not delay necessary care, but rather allow the RN to control chaos
- Takes priority over other activities and interventions, which should be deferred until the **Caring Model Welcome** is completed.

2. Attitude

Addressing how the employee should act when the computer doesn't do what it is supposed to do (when functionality is problematic/fails)

Introducing,…a new "NEVER" behavior:

"Never speak or act negatively about the computer in front of the patient, even when functionality fails." All of the ALWAYS/NEVER behaviors will be reinforced with roll-out.

3. Clinical Documentation

Supporting the Caring Model Principle 'Facilitating Care for the Patient' by making pertinent information available in a timely manner to all clinicians caring for the patient.

Introduced,... A **'Chart-As-You-Go'** expectation. If this is not possible, then computerized **charting should occur within 60 minutes of completing the patient care activity.**

4. The Physical Environment

Identifying opportunities to more effectively 'Be With' the patient by adjusting the physical environment to better accommodate patient-centered care with the computer.

Addressed issues around **placement of the computer in relation to the patient; and the actual set up of the space** where the patient resides.

Clinicians should ‘chart-as-you-go’, **with the computer at the patient’s bedside.** If this is not possible, then computerized charting should occur within 60 minutes of completing the patient care activity.

The Physical Environment Cont'd

Consistent with our 'Always' behaviors, *clinicians should position themselves (with the patient and the computer) in a way that allows them to sit at the patient's eye level, face the patient, and make eye contact.*

Along with the above, *the clinician should invite the patient to observe and ask questions about what is being documented in the computer at the bedside.*

5. Computer Functionality & Enhancements

Key features included processes to ensure **computers are accessible/working;** improvements to the electronic **'Caring Model Flow sheet'**; and implementation of **Patient Interactive Systems**.

6. Clinician Competency

The sixth and last deliverable dealt with our ability to 'Do For' the patient and to 'Be With' the patient by addressing clinician competency in using the computer in patient care. If the caregiver is preoccupied with the computer, she may not be effectively focusing on the patient/family; and she may not take full advantage of functionality in optimizing care.

Key features promoted **proficiency related to keyboarding and knowledge and use of the Cerner system**.

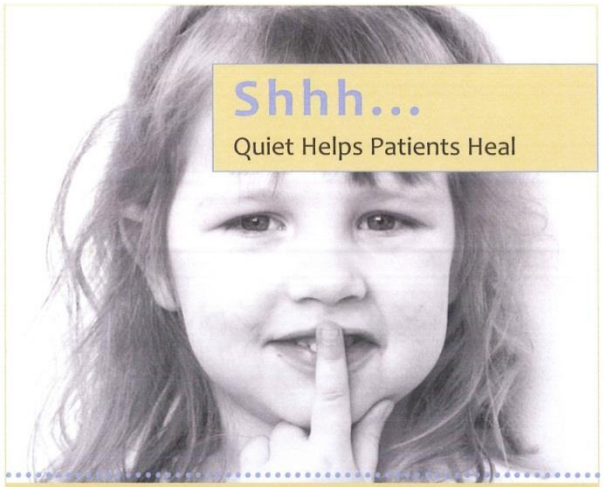
Caring Model Phase IV (2010)

The Goal:

Excellence in the Patient Experience by Making Patient/Client Centered Care Everyone's Job; and Incorporating Guiding Behaviors as a Standard for all Colleagues

Primary Deliverables

- 35 Projects implemented at the department level, intended to 'move the needle' on patient satisfaction.
- Examples:
  - Take home meals for OB patients
  - Shhhh… Program



Primary Deliverables

- Decommissioned our 'Citizenship Standards' and adopted the Trinity Health Guiding Behaviors
- Transitioned from a Caring Model with 5 Caring Principles to a more comprehensive Model of Caring

Caring Model Phase V (2013…)

The Goal:

Use our Model of Caring Framework to Enhance the Patient Experience as Evidenced by Improvement in Our Results on the Patient Experience Domain Measures to Top Decile

Model of Caring Oversight Committee

Committee Purpose:

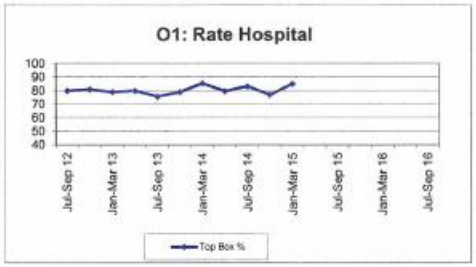
The purpose of the Mercy Medical Center Model of Caring Oversight Committee is to **continuously improve the patient/family/customer experience** with Mercy and to **achieve top quartile/top decile scores on patient experience measures of performance**. The Model of Caring Committee will conduct and provide direction/oversight of activities **aimed at advancing our Model of Caring,** including those related to how we care for our patients/customers and how we care for each other.

Model of Caring Trending Reports

Mercy Medical Center-Dubuque
Nursing Unit Trended Patient Satisfaction Survey Results
Mercy Medical Center-Dubuque Most Recent Quarter: Jan-Mar 2015
Prepared by Art Roche, Mercy Planning Department, July 13, 2015

Dubuque HCAHPS

Time Period	Top Box %	N
Jul-Sep 12	80	170
Oct-Dec 12	81	177
Jan-Mar 13	79	194
Apr-Jun 13	80	171
Jul-Sep 13	76	138
Oct-Dec 13	79	147
Jan-Mar 14	85	153
Apr-Jun 14	80	165
Jul-Sep 14	83	260
Oct-Dec 14	77	218
Jan-Mar 15	85	232
Apr-Jun 15		
Jul-Sep 15		
Oct-Dec 15		
Jan-Mar 16		
Apr-Jun 16		
Jul-Sep 16		
Oct-Dec 16		



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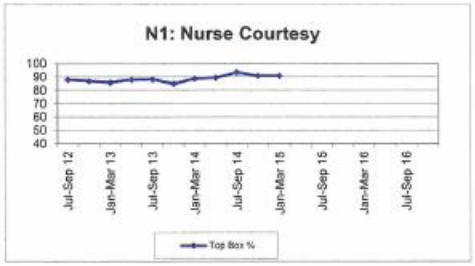


Discharge Dates			Communication with Nurses				Pain Management			Communication with Doctors				Responsiveness of Hospital Staff		
	HCAHPS: Rate Hospital 0-10	HCAHPS: Would definitely recommend this hospital	HCAHPS: Nurses treat with courtesy/ respect	HCAHPS: Nurses listen carefully to you	HCAHPS: Nurses explain in a way you understand	Comm w/Nurses	HCAHPS: Pain well controlled	HCAHPS: Staff do everything to help with pain	Pain	HCAHPS: Doctors treat with courtesy/ respect	HCAHPS: Doctors listen carefully to you	HCAHPS: Doctors explain in a way you understand	Comm w/doctors	HCAHPS: Help toileting soon as you wanted	HCAHPS: Call button help soon as wanted it	Response of Hospital Staff
April - June 2012	74.4	78.2	85.8	82.7	72.9	80.5	62.2	74.9	68.5	91.6	85.4	76.6	84.5	66.7	57.1	61.9
July - September 2012	80.1	78.2	88.1	79.1	70.4	79.2	61.7	81.7	71.7	88.9	83.0	76.5	82.8	68.4	62.0	65.2
October - December 2012	80.8	79.9	86.6	77.7	76.3	80.2	64.4	81.6	73.0	83.8	80.1	76.2	80.7	75.9	58.9	67.4
January - March 2013	78.6	78.3	85.6	76.5	73.6	78.6	59.9	77.5	68.7	89.2	80.2	73.2	81.5	76.3	63.1	69.7
April - June 2013	79.7	81.6	88.0	81.5	74.9	81.5	66.9	83.3	75.1	92.8	85.8	77.5	85.4	70.3	58.2	64.3
July - September 2013	77.8	80.7	88.1	82.0	76.4	82.2	64.2	81.2	72.7	91.6	84.5	75.2	83.8	75.4	60.6	68.0
October - December 2013	79.5	79.5	85.4	80.2	69.9	78.5	67.5	83.4	75.4	87.5	79.0	71.7	79.4	74.7	59.7	67.2
January - March 2014	85.4	85.7	88.9	82.7	72.6	81.4	66.0	84.1	75.0	91.7	85.4	82.0	86.4	81.6	63.1	72.3
April - June 2014	79.6	79.7	89.6	79.3	74.6	81.2	66.6	84.9	75.7	91.7	85.2	81.1	86.0	76.1	61.5	68.8
July- September 2014***	83.1	81.1	93.5	85.2	81.8	86.9	71.6	85.1	78.4	89.4	81.3	76.2	82.3	75.0	69.6	72.3
October- December 2014	77.1	79.9	90.9	77.7	76.3	81.6	64.2	86.5	75.3	89.5	80.7	70.9	80.4	78.0	66.5	72.2
January- March 2015	84.6	83.5	90.9	81.9	79.0	84.0	64.5	83.6	74.0	92.1	84.2	80.7	85.7	81.6	71.1	76.4
Jan-March 2015 Top Decile	≥84	≥84.3	≥91.8	≥88.1	≥82.2	≥88.1	≥71.8	≥86.9	≥78.2	≥92.9	≥88.9	≥83.6	≥88.8	≥77.6	≥76	≥79.8
Jan-March 2015 Top Quartile	78≤x< 84	78.8≤x< 84.3	88≤x< 91.8	79.6≤x< 88.1	78.8≤x< 82.2	82.1≤x< 88.1	67.8≤x< 71.8	82.4≤x< 86.9	76≤x< 78.2	88.9≤x< 92.9	83.2≤x< 88.9	79.8≤x< 83.6	84.1≤x< 88.8	71.7≤x< 77.6	68.4≤x< 76	70.2≤x< 79.8

Discharge Dates	Communication about Medication			Hospital Environment			Discharge Information			Trinity Questions		Care Transitions			
	HCAHPS: Tell you what new medicine was for	HCAHPS: Staff describe medicine side effect	Comm regarding medication	HCAHPS: Room and bathroom kept clean	HCAHPS: Area around room quiet at night	Hospital Environ-ment	HCAHPS: Info regarding symptoms/ problems to look for	HCAHPS: Staff talk about help when you left	Discharge	IP: Sat w/spiritual care by chaplain	IP: Often nurses checked on you	Hospital Staff took preference into account	Good understand managing health	Understood purpose of taking meds	Care Transitions
April - June 2012	73.1	44.1	58.6	72.8	57.6	65.2	91.1	88.9	90.0	57.9	53.6				
July - September 2012	77.5	51.5	64.5	69.2	59.8	64.5	90.7	91.8	91.3	63.0	47.3				
October - December 2012	75.4	56.1	65.8	76.3	62.2	69.3	93.9	93.8	93.9	61.4	37.6	51.1	61.0	72.6	61.6
January - March 2013	83.6	59.8	71.7	74.9	59.7	67.3	86.7	89.6	88.2	53.1	32.1	52.8	59.8	62.0	58.2
April - June 2013	77.1	44.2	60.7	72.3	59.8	66.1	91.0	89.1	90.1	60.0	37.2	48.2	55.0	59.7	54.3
July-September 2013	76.6	48.0	62.3	73.7	60.9	67.3	93.1	89.0	91.1	58.0	37.4	48.9	59.4	61.8	56.7
October - December 2013	76.4	41.7	59.0	71.9	57.3	64.6	91.7	89.6	90.7	62.1	61.4	51.7	60.1	69.4	60.4
January - March 2014	87.4	63.6	75.5	75.0	61.4	68.2	94.6	93.2	93.9	67.4	30.0	58.3	63.2	80.2	67.2
April - June 2014	77.4	53.4	65.4	76.3	68.3	72.3	90.4	91.7	91.1	55.0	54.0	50.9	61.4	64.7	59.0
July- September 2014***	79.5	54.1	66.8	79.5	62.9	71.2	92.1	86.1	89.1	**44.8	30.8	48.7	52.5	59.9	53.7
October- December 2014	79.7	52.2	65.9	79.0	60.3	69.6	92.5	87.6	90.0	45.5	43.9	51.6	58.2	64.3	58.1
January- March 2015	76.4	54.5	65.5	80.9	61.1	71.0	90.0	87.6	88.8	45.5	46.6	52.7	59.6	61.0	57.8
Jan-March 2015 Top Decile	≥83.8	≥69.4	≥72.8	≥83.8	≥71.9	≥78.1	≥90.9	≥89.9	≥90.4	≥67.5	≥62	≥64.7	≥61.4	≥68.7	≥61
Jan-March 2015 Top Quartile	80.6≤x< 83.8	64.4≤x< 69.4	67.5≤x< 72.8	78.3≤x< 83.8	66≤x< 71.9	70.8≤x< 78.1	91.8≤x< 90.9	88.7≤x< 89.9	88.7≤x< 90.4	63.4≤x< 67.5	58.4≤x< 62	49.8≤x< 64.7	58.9≤x< 61.4	64.9≤x< 68.7	58.7≤x< 61

** Question has changed to: *Staff addressed spiritual needs*
*** *Using Mailed Survey*

Current Focus

- Four subcommittees:
  - **Responsiveness:** 2 minute target; ensuring patients assigned in patient communication system/future assignment functionality; texting; 'no pass zone'
  - **Communication about medications:** Medication side effects tool; discharge folder
  - **Communication with nurses:** Purposeful hourly rounds; anatomy drawings
  - **Hospital Environment:** Environmental Services (ES) note cards; education on reducing clutter; ES orientation; noise monitoring and mitigation algorithm

Orientation for New Colleagues

2015 Mercy Model of Caring (MMOC) Agenda

Topic	Presenter	Speaker Time Frames	Media/Materials Needed
• Introductions/Welcome • MMOC Overview (Caring Model Principles/Guiding Behaviors) • Maintaining Hope and Belief in patient/customer	Kay Takes	8:00 – 8:30	-MMOC Handout -Wordle Activity - Yellow Post It Notes to write down name and key words from MMOC principles as they familiarize themselves with the handout.
• Knowing the Patient/Customer	Marie Duster	8:30 – 8:45	-Herman Grid Activity -Knowing the patient/customer/ask questions/by knowing patient/customer you can"do" for the patient/customer, "be" with the patient/customer and "facilitate care" for the Patient/customer. -Cleveland Clinic Video
• Being with the Patient/Customer • Doing for the Patient/Customer • Facilitating Care for the Patient Customer	Art Roche	8:45 – 9:30	-Moment of Truth -Healthcare ToolKit video – case scenario's
Break		9:30 – 9:45	
• We support each other in serving our patients/customers and communities • We trust and assume the goodness and intentions	Marie Duster	9:45 – 10:10	-Bear/Fox Empathy video -Healthcare ToolKit Video – has a section on team building -Lean scenario -Employee Recognition Awards Overview
• We communicate openly/honestly, respectfully and directly • We are fully present • We are all acc • We are contir	Gail Gates	10:10 – 10:40	-Communication Presentation -Always/Never Behaviors -First Impression Activities
• Overview of i Model of Cari • Thank you's			

MEDICATION SIDE EFFECTS FACT SHEET

CARDIAC MEDICATIONS

The chart below contains information about the most common side effects of medications you may be taking at home or during your hospital stay.

REASON FOR MEDICATION	NAME OF MEDICATION Generic - *Brand*		POSSIBLE SIDE EFFECTS
ANTI-PLATELET *(stops clots from forming)*	· Aspirin · Clopidogrel - *Plavix* · Prasugrel - *Effient*		· Bruising · Risk of Bleeding · Upset Stomach
BLOOD THINNER *(prevents or breaks up clots)*	· Dabigatran - *Pradaxa* · Enoxaparin - *Lovenox* · Fondaparinux - *Arixtra* · Heparin	· Rivaroxaban - *Xarelto* · Warfarin - *Coumadin, Jantoven*	· Bleeding *Risk of bleeding is increased* · Bruising
EDEMA *(extra fluid/ swelling)*	· Bumetidine - *Bumex* · Furosemide - *Lasix* · Hydrochlorothiazide - *Hydrodiuril*	· Triamterene/ Hydrochlorothiazide - *Maxide, Dyazide*	· Dizziness · Increased Urine Output
HEART RHYTHM	· Amiodarone - *Pacerone, Cordarone* · Digoxin - *Digitek, Lanoxin*	· Flecainide - *Tambocor* · Propafenone - *Rythmol*	· Dizziness · Headache · Nausea · Sensitive to light
HIGH CHOLESTEROL	· Atorvastatin - *Lipitor* · Fenofibrate - *Tricor, Lofibra, Triglide* · Lovastatin - *Mevacor*	· Pravastatin - *Pravachol* · Rosuvastatin - *Crestor* · Simvastatin - *Zocor*	· Headache · Muscle Aches · Muscle Pain · Upset Stomach

Medication Side Effects Teaching Tool

MERCY MEDICAL CENTER

Waiting Room Care Card - **Emergency Dept.**

Mercy MEDICAL CENTER

SPRING IS HERE!

Along with spring comes the desire to be outside… enjoying the sunshine and fresh air and participating in sports and other outdoor activities. Whether it's biking and skating or softball and baseball, protect your child by making sure he or she is wearing the appropriate helmet and that it fits well.

Thank you for choosing Mercy Medical Center for your emergency care needs! Our staff is highly trained and ready to provide you with the quality and compassion you've come to expect from Mercy.

Who you will be seeing in the Emergency Department:

As a patient in Mercy's Emergency Department you will be seen by a board certified Emergency Medicine Physician. Your physician is residency trained in Emergency Medicine. An Emergency Medicine Physician is not a Family Medicine Physician and is not a substitute for your primary care provider or a specialist. When a diagnosis is not arrived at in the Emergency Department, the Physician will do his or her best to manage your symptoms and recommend appropriate after care and follow-up.

Dr. Anna Lorence, Dr. Kelly Brown, Dr. Mark McKeon, Dr. Clark Williams, Dr. Tami Gudenkauf, Dr. Amy Engelman

While You Wait

- Read the Frequently Asked Questions on the back of this sheet
- Guest wi-fi is available
- Vending machines are located in the hallway leading into the hospital, on the right hand side
- Please avoid using your cell phone during patient care
- The **Chapel, Cafeteria, Pharmacy and Gift Shop** are all located on the 1st floor. You may use the elevators or stairs at the end of the hallway leading into the hospital (near Ambulatory Services Unit).

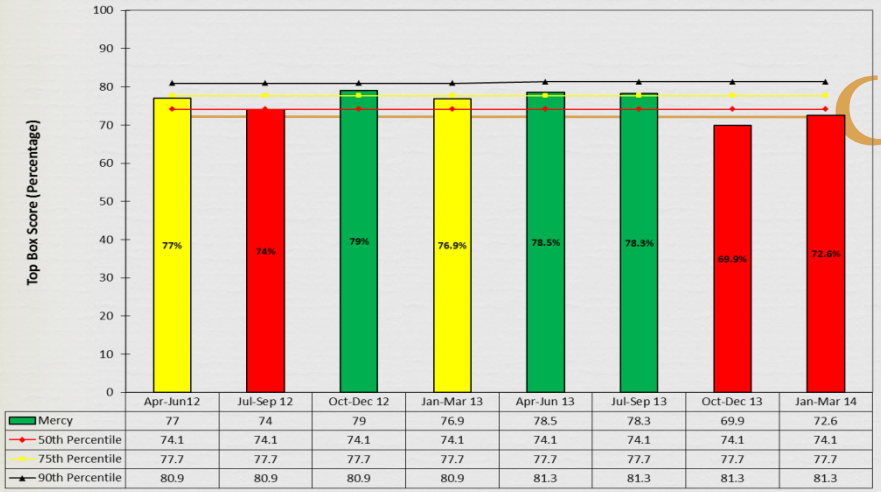
Estimated Procedure Time

PROCEDURE	DURATION
Labs	1- 1 ½ hours
X-rays	30 min – 1 hour
CT scan without oral contrast	30 min – 1 hour
CT scan with oral contrast	2-3 hours
MRI	1-2 hours
Ultrasound	1 hour
IV therapy	2-3 hours

Emergency Department Waiting Room Card

Reports

Mercy Medical Center
Patient Satisfaction/HCAHPS
Nurses Explained in a Way You Understand



	Apr-Jun12	Jul-Sep 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sep 13	Oct-Dec 13	Jan-Mar 14
Mercy	77	74	79	76.9	78.5	78.3	69.9	72.6
50th Percentile	74.1	74.1	74.1	74.1	74.1	74.1	74.1	74.1
75th Percentile	77.7	77.7	77.7	77.7	77.7	77.7	77.7	77.7
90th Percentile	80.9	80.9	80.9	80.9	81.3	81.3	81.3	81.3

Mercy Medical Center
Patient Satisfaction/HCAHPS
Area Around Room Quiet at Night

	Apr-Jun12	Jul-Sep 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sep 13	Oct-Dec 13	Jan-Mar 14
Mercy	64	66	69	66.1	67.7	62.3	57.3	61.4
50th Percentile	55.9	55.9	55.9	55.9	56.6	56.6	56.6	56.6
75th Percentile	63.1	63.1	63.1	63.1	64.4	64.4	64.4	64.4
90th Percentile	70.2	70.2	70.2	70.2	71.2	71.2	71.2	71.2

Mercy Medical Center
Patient Satisfaction/HCAHPS
Staff Describe Medicine Side Effect

	Apr-Jun12	Jul-Sep 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sep 13	Oct-Dec 13	Jan-Mar 14
Mercy	48	55	61	62.4	47.9	53.5	41.7	63.6
50th Percentile	48.7	48.7	48.7	48.7	48.6	48.6	48.6	48.6
75th Percentile	53.7	53.7	53.7	53.7	53.3	53.3	53.3	53.3
90th Percentile	58.8	58.8	58.8	58.8	58.3	58.3	58.3	58.3

Mercy Medical Center
Patient Satisfaction/HCAHPS
Room and Bathroom Kept Clean

	Apr-Jun12	Jul-Sep 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sep 13	Oct-Dec 13	Jan-Mar 14
Mercy	78	75	82	81.6	79.1	75.2	71.9	75
50th Percentile	72.2	72.2	72.2	72.2	72.2	72.2	72.2	72.2
75th Percentile	77.9	77.9	77.9	77.9	77.7	77.7	77.7	77.7
90th Percentile	83.5	83.5	83.5	83.5	82.6	82.6	82.6	82.6

Standard
('Mike and Ike')
reports
for posting in all
departments,
distributed with
Model of Caring
Bulletin

Mercy Model of Caring Bulletin

Highlights to share with your staff

April 2015

New patient handbook and teach-back tool

Why are we replacing the *Healing Binder*?

There was a general feeling that the current *Healing Binder* contained some outdated information and was underutilized by patients and staff. The new handbook and teach-back tool are consistent with best practices in place at Magnet ® recognized hospitals throughout the country.

What information is in the new patient handbook?

The new patient handbook contains information that patients need to know during and after their stay with us, including: general information about Mercy Medical Center, information for patients' families, and services that patients may need as part of their continuing care plan.

What does the teach-back tool do?

The teach-back tool is a simple, easy-to-use form – located on the back of the patient folder – that caregivers will use to guide a conversation with the patient about their care after they leave the hospital. Once the form is complete, the patient has all the critical information and next steps they need in one place.

Why is it important to use the teach-back tool on the back of the folder?

While we provide each patient with detailed discharge instructions, some of the most crucial information our patients need is often buried in mountains of paperwork. The teach-back tool was specifically designed to provide our patients with clear, concise instructions on the most important things they need to do when they are discharged from the hospital.

Responsiveness to patient needs

The Responsiveness Work Group has standardized the process of 'attaching' caregivers to patients in the Rauland (Responder 5) patient communication (nurse call) system, with the primary nurse in the first notification spot and the CNA in the second notification spot. The goal is that patients NEVER go unassigned.

Additional Oversight and Emerging Work

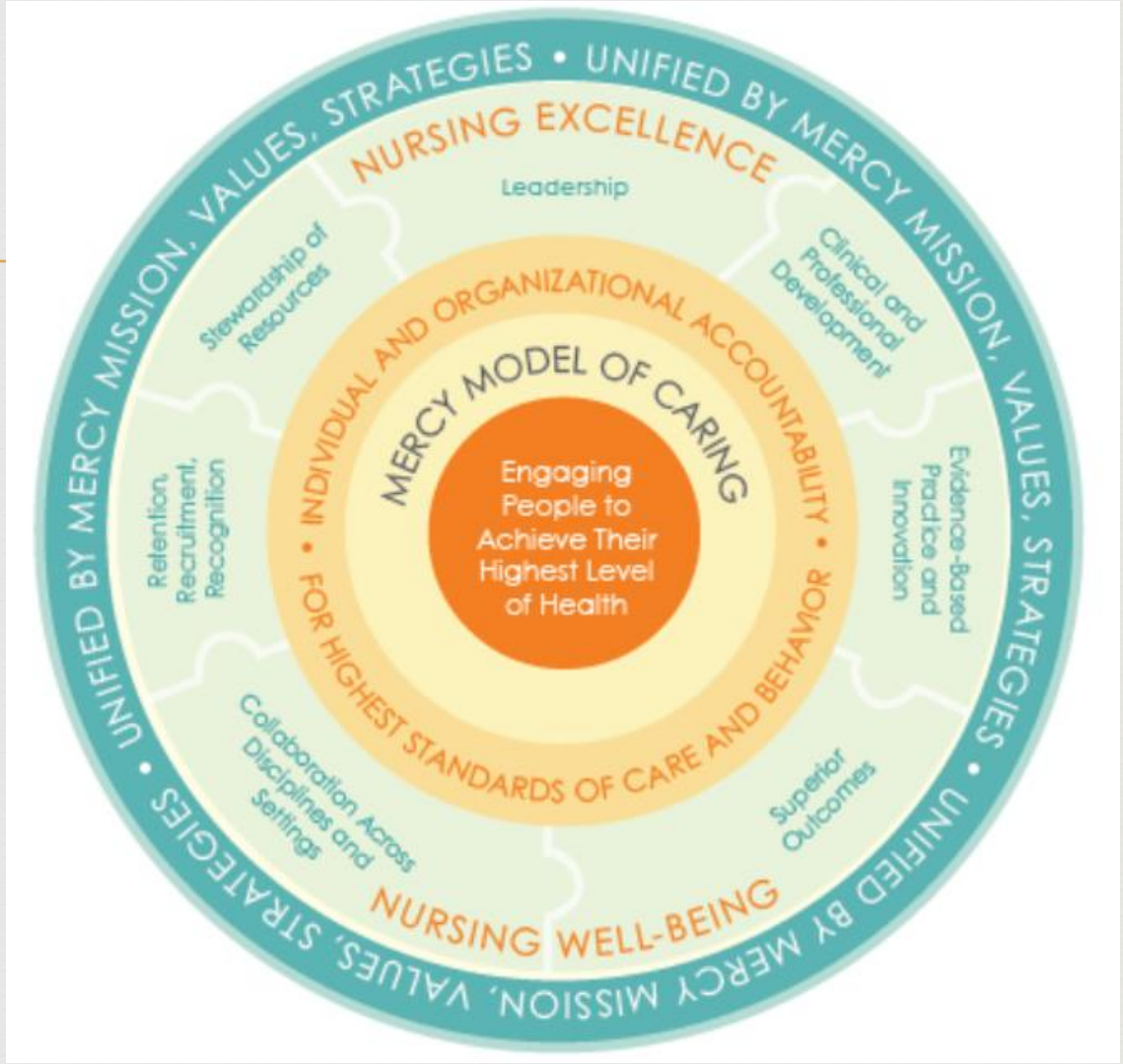
- Patient/Family Advisory Council
- Pain and Spiritual Care Subgroups
- Patient Interactive System Implementation (Engaging the patient in taking accountability for his or her health)

Success Through the Years

- Incremental process
- Broad associate representation
- Strategic imperative
- Transparency of results
- Well integrated; Model of Caring serves as the backdrop for all that we do
- Positions us for success in Value Based Purchasing Program

Indicator	Oct-Dec 2013 Score (MoC kick-off)	Jan – Mar 2015 Score
Communication with Nurses	78.5	84.0
Room and bathroom kept clean	71.9	80.9
Staff describe medication side effects	41.7	54.5
Responsiveness	67.2	76.4

Nursing Professional Practice Model
(updated 2015)



Questions?

Thank You!

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