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
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)
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
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 displaced more than...
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

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
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
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.
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.
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)
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?
“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.”
“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.”
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.”
“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,...”
‘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.
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.
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.
Key features included processes to ensure **computers are accessible/working**; improvements to the electronic ‘**Caring Model Flow sheet**’; and implementation of **Patient Interactive Systems**.
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 2010
Prepared by: Art Nociola, Mercy Planning Department, July 19, 2010

[Graph showing trends in patient satisfaction for Mercy Medical Center - Dubuque for various categories such as rate hospital, recommend hospital, and nurse courtesy.]
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

<table>
<thead>
<tr>
<th>Topic</th>
<th>Presenter</th>
<th>Speaker Time Frames</th>
<th>Media/Materials Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction/evidence</td>
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<tr>
<td>MMOC Overview (Caring Model Principles/Guiding Behaviors)</td>
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<tr>
<td>Maintaining hope and faith in patient/customer</td>
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<tr>
<td>Knowing the Patient/Customer</td>
<td>Marie Desider</td>
<td>8:30 – 8:45</td>
<td>MMOC handout, whiteboard, handout, “Who is a Patient?” by Dr. Otto Zorn et al.</td>
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<tr>
<td>Taking the Patient/Customer</td>
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<tr>
<td>Doing for the Patient/Customer</td>
<td>Art Roche</td>
<td>8:45 – 9:30</td>
<td>Whiteboard, “Taking the Patient/Customer” by Dr. Otto Zorn et al.</td>
</tr>
<tr>
<td>Facilitating Care for the Patient/Customer</td>
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<tr>
<td>Break</td>
<td></td>
<td>9:30 – 9:45</td>
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<tr>
<td>We support each other in serving our patients/customers and communities</td>
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<tr>
<td>We trust and assume the goodness and intentions</td>
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<tr>
<td>We communicate openly, honestly, respectfully and directly</td>
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<tr>
<td>We are fully engaged</td>
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<tr>
<td>We are all one</td>
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<td>We are strong</td>
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<tr>
<td>overview of Model of Care</td>
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<tr>
<td>Thank you</td>
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## Medication Side Effects Fact Sheet

### Cardiac Medications

<table>
<thead>
<tr>
<th>Reason for Medication</th>
<th>Name of Medication</th>
<th>Possible Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-platelet</td>
<td>Aspirin</td>
<td>Bleeding, Ulcer, Stomach</td>
</tr>
<tr>
<td>Blood thinner</td>
<td>Dalteparin</td>
<td>Bleeding, Ulcer, Stomach</td>
</tr>
<tr>
<td>Blood thinner</td>
<td>Enoxaparin</td>
<td>Bleeding, Ulcer, Stomach</td>
</tr>
<tr>
<td>Blood thinner</td>
<td>Fondaparinux</td>
<td>Bleeding, Ulcer, Stomach</td>
</tr>
<tr>
<td>Blood thinner</td>
<td>Heparin</td>
<td>Bleeding, Ulcer, Stomach</td>
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### Estimated Procedure Time

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Duration</th>
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<tbody>
<tr>
<td>Lab</td>
<td>1 – 1 ½ hours</td>
</tr>
<tr>
<td>X-ray</td>
<td>30 min – 1 hour</td>
</tr>
<tr>
<td>CT scan without oral contrast</td>
<td>30 min – 1 hour</td>
</tr>
<tr>
<td>CT scan with oral contrast</td>
<td>2-3 hours</td>
</tr>
<tr>
<td>MRI</td>
<td>1 hour</td>
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<tr>
<td>Ultrasound</td>
<td>1 hour</td>
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<tr>
<td>IV therapy</td>
<td>2-3 hours</td>
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</tbody>
</table>
Standard (‘Mike and Ike’) reports for posting in all departments, distributed with Model of Caring Bulletin
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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Oct-Dec 2013 Score (MoC kick-off)</th>
<th>Jan – Mar 2015 Score</th>
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</thead>
<tbody>
<tr>
<td>Communication with Nurses</td>
<td>78.5</td>
<td>84.0</td>
</tr>
<tr>
<td>Room and bathroom kept clean</td>
<td>71.9</td>
<td>80.9</td>
</tr>
<tr>
<td>Staff describe medication side effects</td>
<td>41.7</td>
<td>54.5</td>
</tr>
<tr>
<td>Responsiveness</td>
<td>67.2</td>
<td>76.4</td>
</tr>
</tbody>
</table>
Nursing Professional Practice Model (updated 2015)
Questions?

Thank You!

Kay L. Takes
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