

JCMC Nursing Strategic Plan – Track 1 Professional Practice Model

Patient Centered Family Focused Care - Implementation Planning Worksheet\*

**Track of Work/Strategic Map Priorities: Modify the Patient Centered Family focused Care model to further integrating patient/family/community and transitional care**

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Strategic Objectives:

1. Promote engagement by modifying and educating staff RNs, regarding Patient Centered Family Focused Care Model
2. Strategies/resources/infrastructure needed to support new model are identified and planned
3. Promote continuity of care across the continuum by designing a transitional model
4. Integrate patient/family/community centered care with transitional care model
5. Promote and develop interprofessional team that practices within framework of patient/family centered care and transitional care
6. Establish how to methods, processes, approaches for operationalizing modified model
7. Define and communicate new expectations and accountabilities within modified models
8. Evaluate consistent implementation of new models of integrated care
10. All levels of leadership are full partners in advancing modified model

Results/Tactics for Specific Strategic Objectives	Deadline	Resources/ Actions Needed
<b>Define model of care that</b> further integrate patients, family members, and community members in all decisions related to care.	11/8 complete power point  11/15 upload power point on MC Strategies  1/1/14 Completion date by all staff	Reinforce JCMC Professional Practice Model of care to Nursing Staff with a newly revised educational power point  Develop Power point for MC strategies
Bring in a speaker to promote awareness and present on Patient center Family focused Care	January 2014	Find a qualified speaker  Book rooms  Select target audience
Increase awareness regarding Patient Centered Family Focused Model by hosting a hospital wide <b>Patient Centered Family Focused Fair</b>	February 2014	Schedule ad hoc meeting for Fair planning  Include department such as housekeeping dietary, security, physicians, nursing patient engagement reps,  Posters will focus on individual department PCFF goals for 2014
<ul style="list-style-type: none"> <li>• Scripting to increase engagement and hospitality</li> </ul>	11/1– scripting and pamphlet completed  11/7 present	Scripting for Admission, Discharge, transfer, and Hourly Rounding  Develop Pamphlets to be given to patients prior to transfer to other levels of care.

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	<p>pamphlet and scripting to Clinical Directors meeting</p> <p>11/6 Present to Nursing councils</p> <p>January 2014 - Unit based in-service to reinforce scripting and process for administering pamphlet – collaborate with unit educators</p> <p>February 2014 – Official Roll Out</p> <p>May 2014 – Conduct Audits</p>	<p><i>Information to include in pamphlet</i></p> <ul style="list-style-type: none"> <li>• Scrub colors</li> <li>• Visiting Hours</li> <li>• Unit Mission or Specialty level of care</li> <li>• Rounding and bedside report</li> <li>• Notes section on the back of pamphlet</li> </ul> <p>Establish a clear Process: Admitting RN will provide pamphlet to patient, RNs will reinforce upon transfer. Education will be documented in Soarian</p> <p>Add pamphlet education documentation to Soarian and perform monthly audit.</p> <p>Get pamphlets professionally printed – Nursing administration budget.</p>
<ul style="list-style-type: none"> <li>• Develop a standardized/scripted approach for discussion and response to patient and family concerns/needs</li> </ul>	<p>1<sup>st</sup> Quarter of 2014 – Develop standardized approach</p>	<p>Develop a task force comprising of all units to establish a clear process for Nursing Staff</p> <p>Once process is established provide education via MC strategies and reinforce with unit based education.</p> <p>Obtain tools currently available in house</p> <p>Do literature review to identify evidence based tool to assist nursing staff with addressing family concerns/needs</p> <p>Develop or update any additional tools / strategies needed.</p> <p>Clarify/reinforce with other department service recovery tools to increase awareness</p> <p>Coordinate Education with Education, HR, other supporting Departments</p> <p>Roll out without education and tools with PCC's, Nursing Directors, etc.</p>
<p><b>Interdisciplinary Rounding</b></p> <ul style="list-style-type: none"> <li>▪ Include patient and family in all aspects of care</li> <li>▪ Develop action plans specific to units</li> <li>▪ Initiate rounding with the family/patient... define what it means and the</li> </ul>	<p>10/30<sup>th</sup> – Task force members identified, charter completed , meeting request sent</p>	<p>Establish a task force with monthly meetings</p> <ul style="list-style-type: none"> <li>• Schedule monthly meeting dates for 11/13 through 12/14</li> <li>• Establish membership <ul style="list-style-type: none"> <li>○ Dr. Telesford</li> <li>○ Leigh Bailey</li> <li>○ Nursing managers/PCC</li> </ul> </li> </ul>

Results/Tactics for Specific Strategic Objectives	Deadline	Resources/ Actions Needed
<p>implementation process</p>	<p>1<sup>st</sup> Quarter of 2014 – roll out process on one pilot unit</p> <p>2<sup>nd</sup> Quarter of 2014 – at least 50% of the medical surgical units will be rounding with patient and family members and/ or providing telephone updates</p> <p>3<sup>rd</sup> Quarter of 2014 75% achieved</p> <p>4<sup>th</sup> Quarter 100%</p>	<p>Send out meeting request to members with charter attached and goals</p> <p>Establish process for interdisciplinary rounding with family members on each individual unit</p> <ul style="list-style-type: none"> <li>• Meet with Leigh Bailey to obtain buy in from case management and social services</li> <li>• Start on individual pilot units and expand</li> </ul> <p>Establish a process to call family member with update on the patients plan of care</p> <ul style="list-style-type: none"> <li>• Develop policy and procedure for initiating calls to family members</li> <li>• Establish automated phone line for updates</li> </ul> <p>Promote family initiated rapid response calls</p>
<p>Evaluate consistent implementation of patient centered/family-focused care</p> <ul style="list-style-type: none"> <li>▪ Patient and family focused groups held quarterly or biannually</li> <li>▪ Ongoing monitoring of patient/family satisfaction scores and other outcome scores related to the new model</li> </ul>	<p>1<sup>st</sup> quarter 2014 – have first focus group</p> <ul style="list-style-type: none"> <li>• March 2014</li> <li>• September 2014</li> </ul>	<p>Establish criteria for target audience</p> <p>Advertise focus group to target audience</p> <p>Obtain Moderator for focus group</p> <p>Establish meeting place</p> <p>Refreshments for focus groups</p>
<p>Identify strategies/resources/infrastructure needed for patient centered/family-focused care</p> <ul style="list-style-type: none"> <li>▪ Option for Interprofessional rounds with the family</li> <li>▪ Family rooms: kiosks, educational materials</li> </ul>	<p>Spring of 2014</p> <p>11/13 Schedule meeting with Bill Cook</p>	<p>Establish designated family rooms on 6<sup>th</sup> or 7<sup>th</sup> floor solarium.</p> <ul style="list-style-type: none"> <li>• Need to schedule meeting with Bill cook to coordinate and discuss project</li> <li>• Fund Raising- speak to foundation</li> <li>• Decorate Room (Goldman Sacs project)</li> </ul> <p>Educational materials</p> <p>Advertise room - Press Release – Mark Rabson</p>
<p>Define Role of direct care providers in discharge planning (not just a discharge planner responsibility)</p>	<p>11/1/13 Complete Patient Centered Education Course for all RN</p> <p>11/1/13 roll out teach back and Zones</p>	<p>Establish process to emphasize the discharge education begins on admission and continues throughout the patients stay</p>

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	March 2014, provide education to nursing staff regarding nurses roles in discharge planning	Educate nursing staff regarding the nurses' role in discharge planning.
Integrate Patient/Family Centered Care with Transitional Care Model: <ul style="list-style-type: none"> <li>▪ Refocus assessment to go beyond isolated episode of care on particular unit to connect current episode to primary care include:               <ul style="list-style-type: none"> <li>Why there?</li> <li>Why they showed up</li> <li>What failed in primary care</li> <li>What do we need to do to prepare for discharge and reconnect with primary care</li> </ul> </li> </ul>	January 2014 identify questions, place on Soarian, and notify nursing staff  March 2014 begin auditing process	Establish an enhanced assessment process <ul style="list-style-type: none"> <li>• Review Literature</li> <li>• Develop enhanced assessment questions</li> <li>• Establish process to address concerns addressed on admission</li> <li>• Include Enhanced assessment on all patients</li> <li>• Work with Informatics department to place questions in Soarian</li> </ul> Incorporate enhanced assessment post discharge: Use Relay Care Readmission management call back system to follow up on patients with CHF, COPD, CABG, Pneumonia, Diabetes, and AMI
Promote an Interprofessional team that is patient/family focused	Last Quarter of 2013	Establish interprofessional patient centered family focused committee <ul style="list-style-type: none"> <li>• Develop meeting schedule</li> <li>• Invite key members to participate               <ul style="list-style-type: none"> <li>• Dietary</li> <li>• Housekeeping</li> <li>• Physicians/Residents</li> <li>• Nursing/PCTs</li> <li>• Patient Engagement representatives</li> <li>• Etc.</li> </ul> </li> </ul>

\* This is a three year plan and work sheet is subject to change as the modified model is applied and evaluated by nursing staff.