Patient and Family Engagement Practices 1 and 2: Pre-admission and discharge checklists

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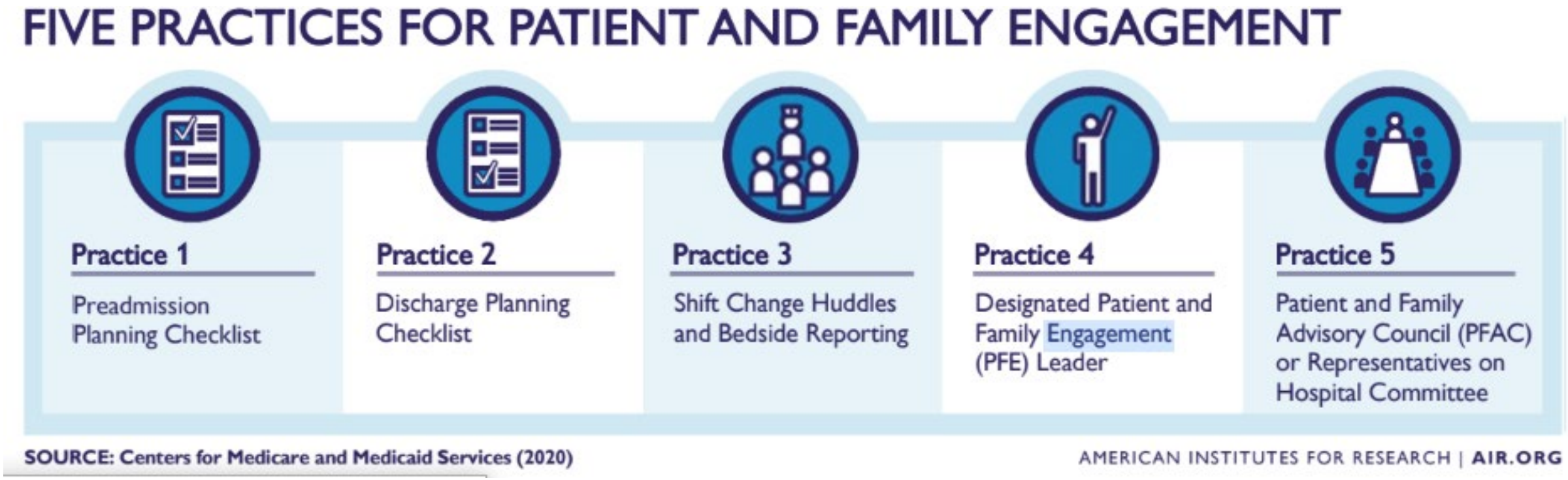
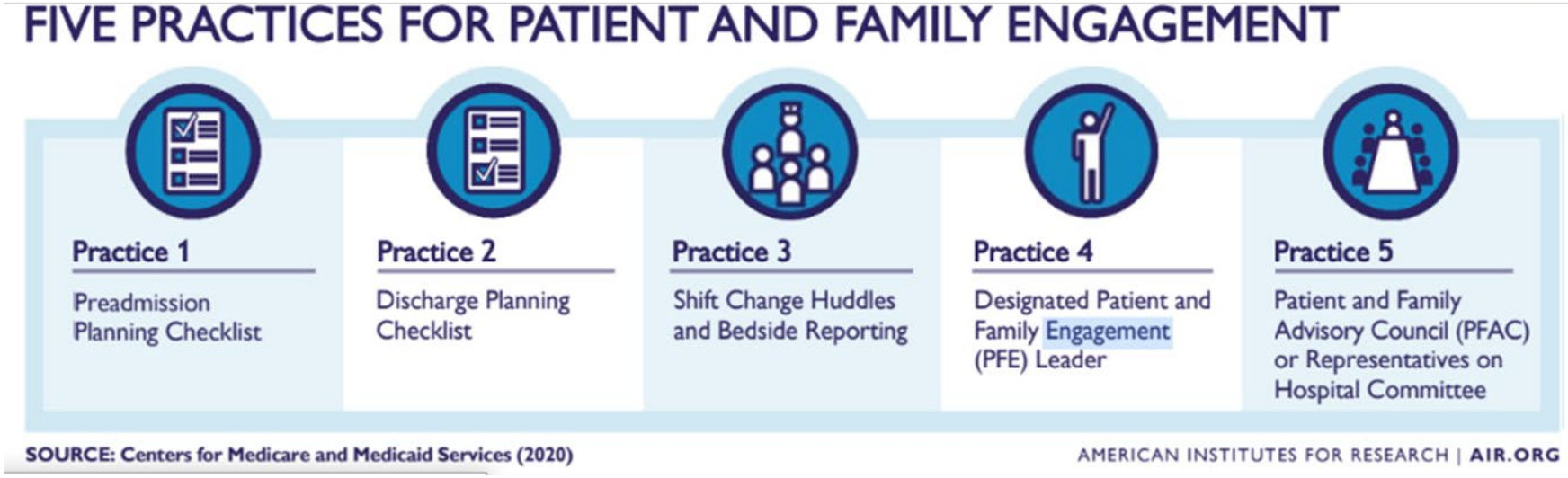
PFE best practices



PFE best practices

Practice 1 - 3: Direct care

Practice 4 - 5: Organization



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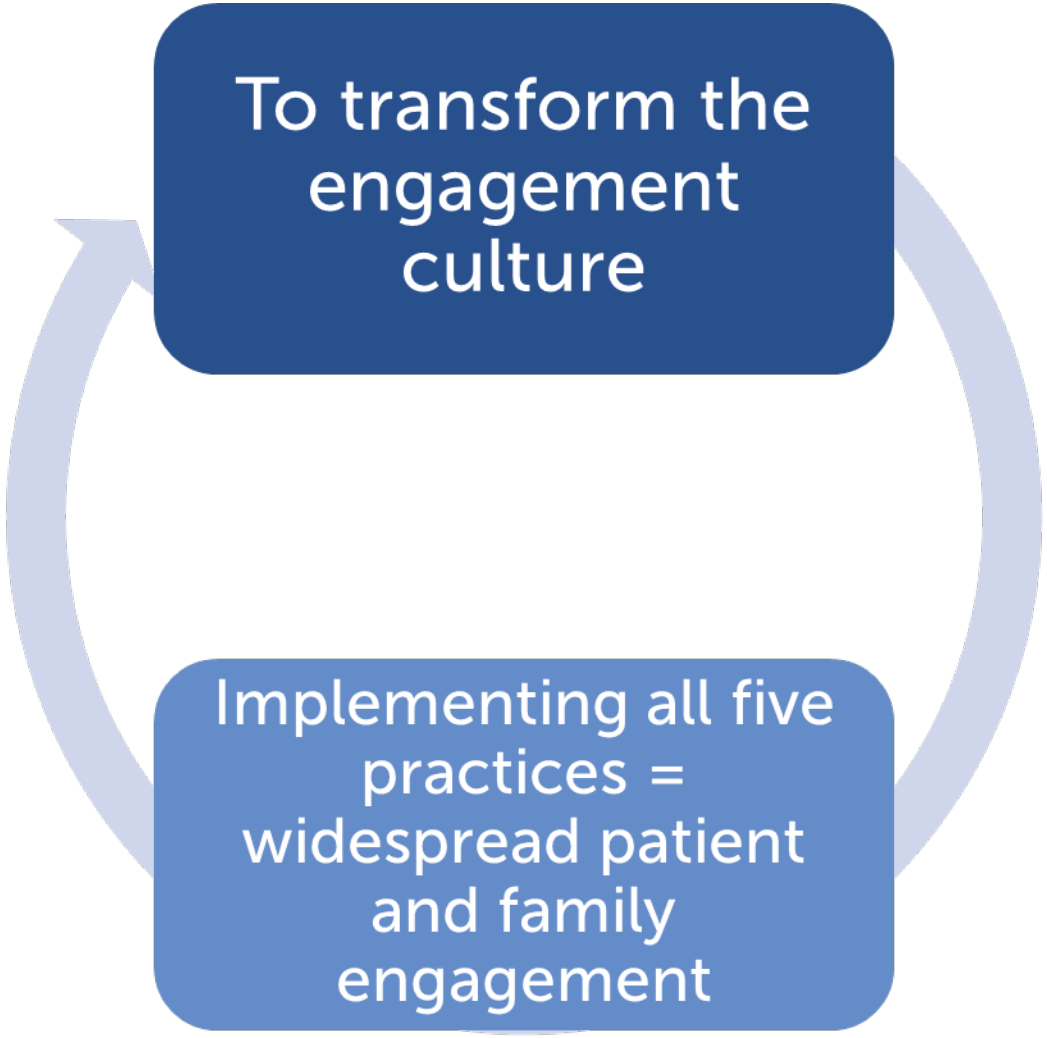
Purpose of the practices



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Direct care

If individuals feel their beliefs, desires and culture are considered in their care, they are more likely to follow their care plan.

If individuals are able to communicate effectively with their providers and have a prominent role in making healthcare decisions, they will receive better care, can more effectively manage their health and may receive appropriate preventive care while relying less on emergency or urgent care.

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Epstein RM, Street RL, Jr. Patient-Centered Communication in Cancer Care: Promoting Healing and Reducing Suffering. National Cancer Institute, NIH Publication No. 07-6225. Bethesda, MD, 2007.

What do patients understand?

Best practices and tools

Best practices

- PFE 1: Preadmission Planning Checklist
- PFE 2: Discharge Planning Checklist

Tools

- Shared Decision Making
- Teach-back

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Metrics and tools

PFE 1: Preadmission Planning Checklist

PFE 1

Implementation of a planning checklist for patients who have a planned admission

At least one unit at the hospital has a physical planning checklist that is discussed with every patient prior to or at the time of any scheduled admission (e.g. surgery, procedure, test, delivery). The checklist can be a stand-alone document or integrated into other patient education materials.

PFE 1: Intent

- To establish an active partnership between the patient and the hospital from the very start of inpatient care.
- To identify specific needs and preferences that can inform care.
- To ensure that patient and family concerns are heard and understood.
- That patients and family caregivers feel comfortable asking questions and actively participating in their care.

Benefits of a planning checklist

Patients and families

- Clarify expectations about what will happen before, during and after their hospital stay.
- Feel more confident about being active partners in the quality and safety of their care.
- Get to know the clinicians and staff on their care team and their roles.
- Be prepared to participate in key discussions about their care including bedside rounding, shift change huddles and discharge planning meetings.
- Share information and ask questions about potential safety issues including those related to discharge planning.

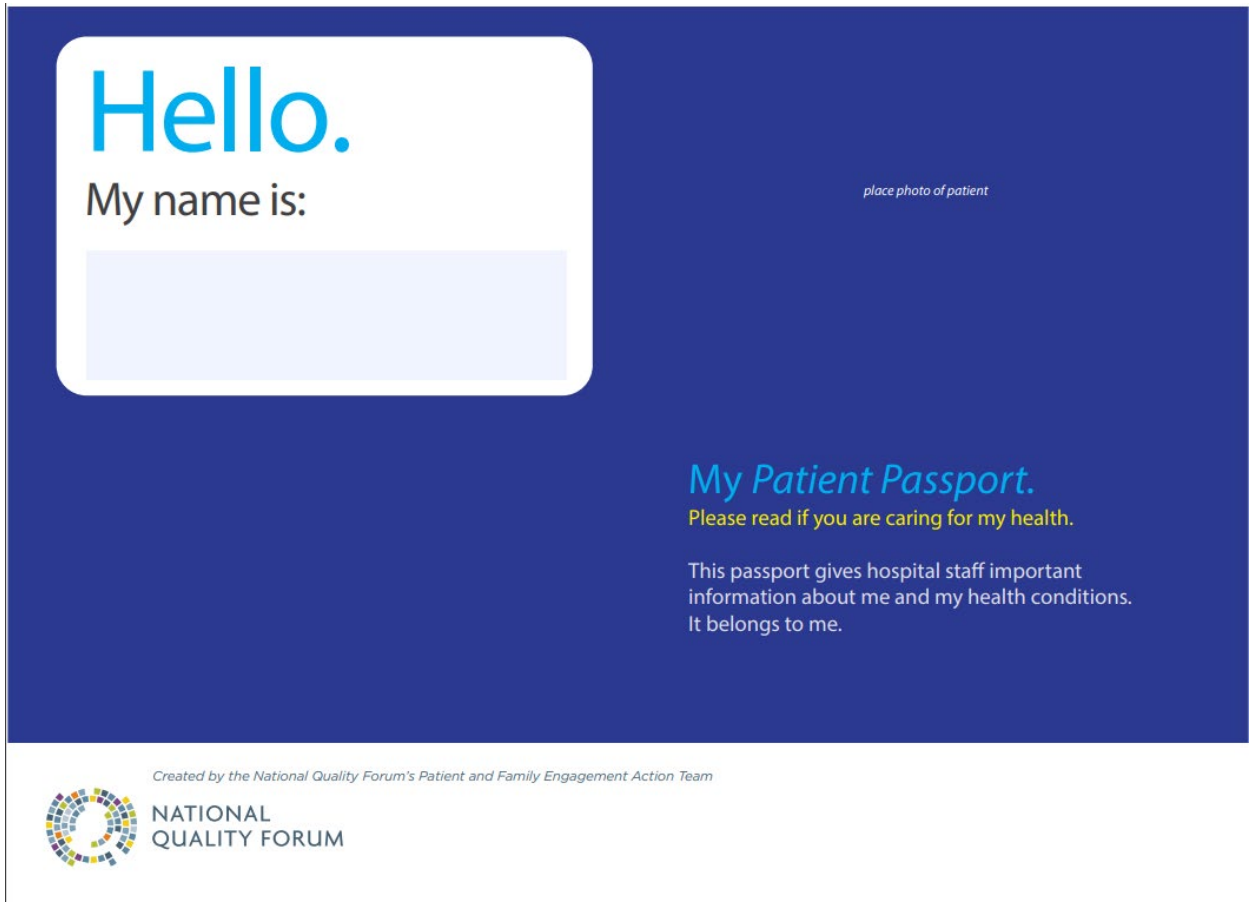
Staff and clinicians

- Understand the patient's specific care goals, preferences, needs and concerns.
- Identify the person who will serve as the patient's care partner helping in care and care planning during and after the stay.
- Invite patients and their care partners to be active members of their healthcare team.
- Understand preadmission medication regimens and therapy, allowing for better medication reconciliation and identification of potential medication errors.
- Identify and proactively address potential safety issues, risks and care needs
- Prepare patients and care partners and plan for a safe discharge.

The checklist = facilitated conversations

- what patients should expect during their stay (e.g., course of care, pain management);
- patients' concerns and preferences for their care;
- potential safety issues (e.g., preadmission medicines, history of infections);
- identification of a family member or friend who is serving as a care partner and preferences regarding their involvement in care; and
- relevant home issues that may affect discharge, such as needs for additional support, transportation and care coordination.

Checklist examples



Includes:

- Triage
- Physicians' info
- Patient info
  - The following would help me feel more comfortable while I'm in the hospital. . .
  - Things I need extra help with are. . .
  - I cope well with my health conditions when. . .
  - When I get home, I need to do the following. . .

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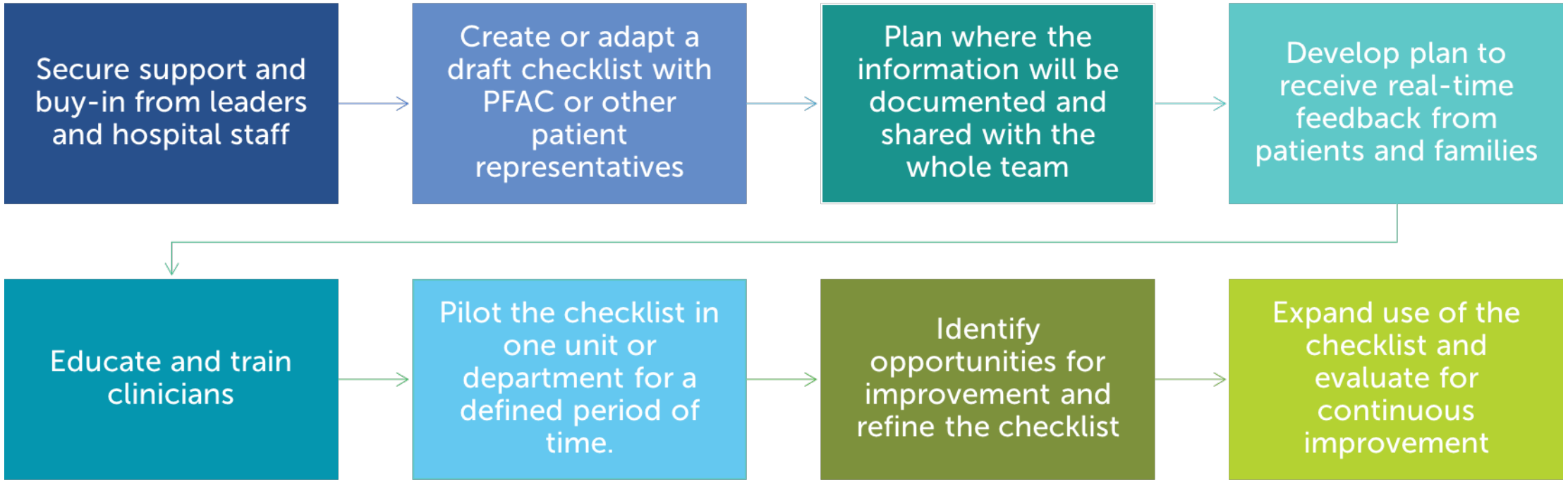
Steps


Secure support and buy-in from leaders and hospital staff
Create or adapt a draft checklist with PFAC or other patient representatives
Plan where the information will be documented and shared with the whole team
Develop plan to receive real-time feedback from patients and families
Educate and train clinicians
Pilot the checklist in one unit or department for a defined period of time.
Identify opportunities for improvement and refine the checklist
Expand use of the checklist and evaluate for continuous improvement

Best practices and tools

Best practices

- PFE 1: Preadmission Planning Checklist
- PFE 2: Discharge Planning Checklist

Tools

- Shared Decision Making
- Teach-back

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Metrics and tools

PFE 2: Discharge Planning Checklist

PFE 2

Implementation of a discharge planning checklist

At least one unit at the hospital has a physical discharge planning checklist that is discussed with every patient prior to discharge. The checklist can be a stand-alone document or integrated into other discharge papers.

PFE 2: Intent

Patients and their care partners are included as full partners in the discharge planning process.

Patients understand how to successfully continue their recovery after they leave the hospital.

Promotes a guided conversation with patients and care partners.

To include family and care partners about being discharged prior to leaving the hospital. Ideally, patients and families also receive a physical copy of the checklist.

The checklist = facilitated conversations

- what life at home will be like (e.g., foods and activities to avoid);
- medications (e.g., purpose of each medicine, what and how to take it, and potential side effects);
- warning signs and problems and who to contact if there is a problem;
- test results, either explaining them or letting the patient know when they should hear about results, and whom to call if they don't get the results; and
- follow-up appointments, including offering to schedule them.

Benefits

Patients and families

- Reduces complications post-discharge
- Reduces readmissions and length of stay
- Increases understanding of care needed at home
- Reduces anxiety
- Increases patient satisfaction

Staff and clinicians

- Reduces complications post-discharge
- Reduces readmissions and length of stay
- Increases understanding of care needed at home
- Reduces anxiety
- Increases staff and clinician satisfaction

Discharge checklist examples

- ❑ Diagnosis
- ❑ Medications/Prescription
- ❑ Vaccines (card given)
- ❑ Pain Management
- ❑ Diet
- ❑ Activity/Restrictions
- ❑ Equipment
- ❑ Treatments/Procedures
- ❑ Referral Services
- ❑ Follow up Appointment

Preparing for My Discharge

(Things that I should make sure I know before I leave the hospital.)

- ❑ I have been involved in decisions about what will take place after I leave the hospital
- ❑ I understand where I am going after I leave the hospital and what will happen to me once I arrive.
- ❑ I have the name and phone number of a person I should contact if a problem should arise after my discharge from the hospital.
- ❑ I understand what my medications are and when to take them.
- ❑ I understand the potential side effects of my medications and whom I should call if I experience them.
- ❑ I understand what symptoms I need to watch out for and whom to call should I notice them.
- ❑ I understand how to keep my health problems from becoming worse.
- ❑ My doctor or nurse has answered my most important questions prior to leaving the hospital.
- ❑ My family or someone close to me knows that I am coming home and what I will need once I leave the hospital.
- ❑ I know how to make or have been scheduled for a follow-up appointment with my doctor, and will have transportation to this appointment.

Questions I Have

Discharge checklist examples

- What's ahead
- Your health
- Recovery and support
- For the caregiver
- My drug list
- My appointments
- Resources

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Discharge checklist examples

Care Transitions from Hospital to Home: IDEAL Discharge Planning
Implementation Handbook

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:

1. Describe what life at home will be like
2. Review medications
3. Highlight warning signs and problems
4. Explain test results
5. Make followup appointments

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

Assess how well 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 and family's goals, preferences, observations, and concerns.

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What message are you sending?

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Steps (Same as PFE 1)

1. Secure support and buy-in from leaders and hospital staff.
2. Create or adapt a draft checklist with PFAC or other patient representatives.
3. Plan where the information will be documented and shared with the whole team.
4. Develop plan to receive real-time feedback from patients and families.
5. Educate and train clinicians.
6. Pilot the checklist in one unit or department for a defined period of time.
7. Identify opportunities for improvement and refine the checklist.
8. Expand use of the checklist and evaluate for continuous improvement.

Who should own the checklists?

- Developed in partnership with patients
- Can live in:
  - Case management
  - Nursing
  - Anywhere it will be consistently used

For both preadmission and discharge checklists

Include prompts or questions about Social Determinants of Health

- Be prepared with answers.
- Be prepared with Community-based Organization referrals.

Document the conversation

- Patient preference, concerns and expectations expressed by patients/family members.
- Share with the entire hospital care team for ongoing communication.
- Patients and families should retain a copy of the checklist.

Best practices and tools

Best practices

- PFE 1: Preadmission Planning Checklist
- PFE 2: Discharge Planning Checklist

Tools

- Shared Decision Making
- Teach-back

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Best practices and tools

Shared Decision Making

Steps to shared decision making

1. Identify the decision.
2. Find patient decision aids.
3. Identify barriers and explore ways to overcome them.
4. Implement decision aids and support.
5. Provide training.
6. Monitor use and outcomes.

Shared decision making essentials

- Provides opportunities for better communication and understanding.
- Involves patients and healthcare providers partnering two-way information sharing about:
  - diagnosis;
  - available treatment options;
  - pros and cons of each option, including patient preferences, goals and values; and
  - treatment plan is developed together.

Best practices and tools

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Best practices and tools

Teach-back

Implementing teach-back

1. Obtain leadership buy-in and identify a champion.
2. Train all team members on the teach-back method.
3. Strategize how it will be used.
4. Have clinicians practice with patient/family representatives.
5. Implement.
6. Evaluate and refine.

Teach-back essentials

- Provides opportunities for better communication and understanding.
- Teach the patient
- Have the patient repeat it back in their own words

Thank you.

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