Santa Rosa Memorial Hospital
ST. JOSEPH HEALTH SYSTEM

ST. JOSEPH HEALTH SYSTEM SONOMA COUNTY

TITLE: PATIENT CARE BUNDLE **POLICY # P 01.0**

MANUAL: CLINICAL PROCEDURE MANUAL

Effective Date:11/22/09 Approval *\/s/ Kathy Hardin*
Reviewed/Revised: Katherine Hardin, RN, JD, CNO

I. VALUE STATEMENT:

Our value of excellence calls us to continually improve the health and quality of life for those in the communities we serve.

II. PURPOSE:

The Patient Care Bundle is a model of patient care that focuses on behaviors that drive nursing quality and ensure nursing excellence for the patients we serve. Nursing excellence is achieved when a patient perceives the care to be delivered by competent and caring professionals and when the care is individualized for each patient. The Patient Care Bundle consists of evidence based practices which are founded in clinical research and will drive improved clinical outcomes and enhanced patient and nursing satisfaction.

III. POLICY:

Upon admission, the nurse will inform the patient of the components of the Patient Care Bundle and why they are being done. (Refer to key words addendum for keywords at key times.)

The following components of the Patient Care Bundle will be done on the appropriate units:

Component	**Description**	**Units/Depts**
Hourly Rounding	Staff checking on patients proactively every hour using the 4 P's: Pain, Positioning, Personal Needs and Placement	All Nursing Units
Lead Nurse Rounding	Lead Nurse rounds on each patient each shift asking key questions.	All Nursing Units
Individualized Care	Staff ensuring that each patient's expectations of excellent care are defined and achieved.	All Nursing Units
Bedside Shift Report	Staff giving shift report at the bedside and including the patient.	All Nursing Units
Discharge Phone Calls	Creating a process to make follow up phone calls to the patient after discharge	In process and encouraged for all nursing units

PATIENT CARE BUNDLE

KEY WORDS TO USE

Explanation of Nursing Bundle upon Admission:

"At SRM Hospital, we want you to be very satisfied with your care. We practice the Patient Care Model of Nursing Excellence, which involves:

Hourly Rounding:

We will be rounding on you on an hourly basis to anticipate and meet your needs. In fact, you probably won't have to use your call light because we will be in here about every hour. We will be checking on your pain, comfort, and position.

Individualized Care:

Because we want to be sensitive to your individual needs, we will be asking you for your idea of what excellent care for you would be.

Bedside Report:

Because we want to keep you informed about your condition, we will be giving a brief report at your bedside at each shift change. During this time, we will be asking your visitors to step out in order to protect your privacy."

IV. PROCEDURE:

A. HOURLY ROUNDING

1. Hourly Rounding protocol is as follows: (hourly, from 7 AM until10 PM, then every 2 hours from 10 PM until 6 AM.)
2. The nurse assigned to the patient will be responsible for ensuring that hourly rounding is done. At the beginning of the shift, remind the patient that someone on the unit team will be doing hourly rounds.
3. Each hour, the patient will be rounded on to assure that all their needs are met. The rounds do not have to be done 60 minutes apart, but sometime during each hour.
4. Use opening key words to reduce the patient's anxiety. "Hello Mr/Mrs/Ms I am here to do my hourly rounds."
5. Perform scheduled tasks, which allows for inclusion of scheduled work in the rounding process so that everything can be accomplished in one trip.
6. Assess and address the 4 P's of Pain, Personal Needs, Placement and Positioning. By addressing each of these proactively, you can reduce call lights, patient falls, decubiti, and enhance the patient's sense of comfort.
7. Use closing key words to see if the patient needs anything else. "Is there anything else I can do for you while I am here?" or "Is there anything else I can do for you? I have the time."
8. Explain when you or others will return. This helps the patients begin to cluster their requests around your rounds.
9. Document the round in the appropriate way (unit specific policy) so that the patient and family know you were there.
10. If the patient is asleep, do not wake the patient up. You must still do the environmental check and document the rounds.
11. If the patient is not in the room at the time of round, make notation on white board where patient is at the time.
12. With each hourly round, the patient's perception of pain will be assessed and documented on white boards, patients pain 0-10 will be marked on board.

PATIENT CARE BUNDLE

KEY WORDS TO USE:

Hourly Rounding – Reducing Anxiety
"*I am here to do my hourly rounds."*

Hourly Rounding – Assessing the 4 P's
"Could you please rate your pain on a scale of 0 – 10?"
"Are you having any pain?"
"Did the pain medication I gave you help?"
"Do you need help in going to the restroom?"
"Have you been to the restroom?"
"Are you having any trouble going to the bathroom?"
"Do you need the bedpan?"
"Have you gotten out of bed and walked lately?"
"I've noticed you have been in the same position whenever I come in. I'm going to help you turn on your side."
"Can I put a pillow under your back?"

Hourly Rounding – Closing words and when someone will return
"*Is there anything else I can do for you while I am here?" or "Is there anything else I can do for you? I have the time."*
"I'll be back to round on you again in about an hour."
"Suzie, the aide, will be rounding on you again in about an hour."

B. LEAD NURSE ROUNDING

1. At change of shift, Lead Nurse report will consist of walking rounds through the entire unit, visualizing each patient and assessing any critical patient situations.
2. Lead Nurse will later round on each patient on the unit each shift. Rounding on all newly admitted patients will be a priority for the Lead Nurse.
3. Lead Nurse will document their name and phone number on patient's white board, and encourage the patient to call them for any concerns.
4. Nurse leader rounding has been determined to be one of the most important criteria in patient satisfaction.

Key Words to Use:
"I am the Lead Nurse on this unit for this shift"
"What is gong well for you today?"
"Is there anything that you need?"
"Is there anyone you would like to recognize?"

C. INDIVIDUALIZED CARE

1. On admission, the admitting nurse identifies key actions from the patient's perspective that will assist in reducing the patient's anxiety.
2. The nurse documents the actions on the white board and explains to the patient and family how this will be used during the hospitalization.

PATIENT CARE BUNDLE

3. At the beginning of the shift, the nurse reviews the plan of care for the shift, reviews any questions the patient has, and asks the patient what the 2-3 most important needs the patient has for that shift that if met would result in excellent care.
4. The nurse documents the plan of care for the shift, as well as the patient identified needs on the white board and explains to the patient and family how this will be used during the hospitalization.
5. Make sure that there is a clear differentiation between the plan of care (goals) and what is important to the patient (excellent care).
6. Make sure the patient understands what you are putting on the white board. Use patient friendly language and avoid the use of abbreviations.
7. The nurse reviews the pain scale, has the patient identify the tolerable pain level, and notes when the patient can have the next pain medication, if needed.

KEY WORDS TO USE -INDIVIDUALIZED CARE

"My goal is that you are very satisfied with your care."
"What two-three needs are most important for us to give you excellent care?"
"I'm going to write these on the board so our entire team will know what is most important for you today. We work together as a team to make sure that you are "very satisfied" with your care."
"I am writing when you can have your next pain medication, if needed, on the board."
"Please let us know at any time if your pain is higher than a tolerable level. We want to be sure you are as comfortable as possible."

D. BEDSIDE SHIFT REPORT

1. Patient care assignments will be ready at the beginning of the shift.
2. Oncoming nurse reviews the assignment sheet and locates off-going nurse for report.
3. Any confidential or information that cannot be shared in front of the patient communicated prior to entering the room.
4. The 2 nurses knock at door and enter.
5. The off-going nurse introduces the on-coming nurse and emphasizes that they work as a team.
6. The off-going nurse informs the patient that "because we want to keep you informed of your condition, we are going to do change-of-shift report now."
7. The off-going nurse asks any visitors to leave.
8. The 2 nurses, using the SBAR form, stand at the bedside and relay information regarding the patient's situation, background, assessment, and recommendations.
9. Both nurses check the supplies, IV's, monitors, equipment, and wounds as necessary.
10. Nurses ask the patient if there are any questions or if anything was missed.
11. The on-coming nurse adds name on the white board and tells the patient when to expect the nurse's return.
12. The off-going nurse thanks the patient.

KEY WORDS TO USE

<u>Bedside Report -Starting</u>

"*Mrs. Jones, It is time for me to go home now. I am going to give report to Michael. I'm going to tell him what's most important about your care. Please listen and if I leave out anything that is important to you, or if you have any questions, please let us know before I leave."*

PATIENT CARE BUNDLE

"I know an important part of excellent care is helping you understand your health condition. That is why we give report to each other at your bedside so you can be involved an hear what our plan is for your care"

Bedside Report - Visitors
"*I am going to ask (visitors) to step outside for about 5 minutes while we complete report. This is to ensure your privacy."*

Bedside Report – Share that all members of the staff work as a team.
"Let me introduce Michael. He will be your nurse this evening. I have known Michael for over 12 years. He is a great nurse and you will be in very good hands. I know you will be very satisfied with your care"
"Let me introduce Michael. He will be your nurse this evening. He is part of our great day shift."
"Let me introduce Michael. His patients love him (I hear the patients say what good care he gives, how caring he is)!"

Bedside Report – Asking patients if any additional information needed
"Mrs. Jones, do you have any questions, or is there anything you'd like to add?"

Bedside Report - Ending
Off Going nurse: "Thank you for allowing me to care for you"
On Coming Nurse: Adds name to board, and says "I'll be back to check on you in about an hour."

Bedside Report – Potential Issues
Patient has lots of questions, report taking too long-
Off Going Nurse: "Mr. Smith, I need to get report on my other patients, and I know you have more questions. I am going to finish report, and when I come back in to do my hourly rounding, I will spend more time with you answering your questions."

E. DISCHARGE PHONE CALLS –THIS ELEMENT IS STRONGLY ENCOURAGED BUT NOT REQUIRED.

1. Nurses call all discharged inpatients daily. A maximum of three calls are to be made over a period of three days. If the nurse was unable to contact the patient after the third call, a letter is sent to the patient's home.
2. The discharging nurse explains the purpose of the Discharge Phone Calls, and tells them to expect one.

DISCHARGE PHONE CALL KEY WORDS

"Mr./Mrs./Ms. ___________________________________ (circle one – patient / family)
This is ______________________________, a nurse at Santa Rosa Memorial Hospital. I am calling to check to see how you are doing. Is this a good time to talk?"
[Pause/Listen]
"I also wanted to make sure you understood all of your discharge instructions.
[Pause/Listen/Respond]

"If you have any questions, I can give you our phone number or you can find it on the discharge instructions."
"Mr./Mrs./Ms. ___________________________________, we always want to make sure that our patients are very satisfied with their care. How was your care?"
[Pause/Listen]

"Was there anything we could have done differently to make your stay in our hospital more comfortable?"
[Pause/Listen]
"Would you return to our hospital?"
[Pause/Listen]
"Would you recommend our hospital to your family & friends?"
[Pause/Listen]
"Are there any individuals you would like me to compliment for the care you received? I would be happy to take their names."
"You may be receiving a survey in the mail. We appreciate your taking the time to fill the survey out as your feedback will help us improve our care."
"Thank you so much for allowing Santa Rosa Memorial Hospital to care for you."

DISCHARGE PHONE CALL LOG (sample)
Signature of caller: ____
DC Date ____________
DC Floor ______________
MR# _______________________
Opportunity for Improvement ________________________________
Staff Recognized ____________________________________
Return to our Hospital ____
Recommend to Family and/or Friends ____________________

Author/Department: Eileen Jensen RN MSN
References:

1.Meade, Christine, et al "Effects of Nursing Rounds on Patient Call Light Use, Satisfaction and Safety", American Journal of Nursing Sept. 2006, Vol. 106
2. The Joint Commission. 2009 National Patient Safety Goals.

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