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TITLE: Patient-Centered Report (PCR)

PURPOSE: The purpose of this policy is to establish a standardized nurse to nurse communication process that incorporates the patient and family along with other members of the nursing care team known as Patient-Centered Report (PCR). The purpose of PCR is to improve patient safety and outcomes, enhance patient and family satisfaction, improves nursing time management and increase accountability between nursing staff.. PCR has also been shown to improve the patient and family experience and is essential to establishing a culture of patient and family-centered care.

POLICY STATEMENT: The seven-step PCR process listed below is "Your Hospital" standard for change of shift handoffs between nursing professionals, inclusive of the patient and their family. The process begins with a Unit Safety Huddle followed by nurse to nurse handoff with the patient and family at the bedside using the following procedure.

PROCEDURE:

A. Orienting the Patient/Patient Education: On admission and/or at most appropriate time for the patient and family, the nurse educates the patient and family on the process for PCR on their unit and establishes the patient's preferences for participation. Topics might include:
   1. What is PCR?
   2. Why is PCR best practice?
   3. Who will participate?
      a) Patient participation encouraged
      b) Family friends to be included
   4. How does PCR occur on the unit?

B. Setting the Stage: Before change of shift, the nursing team will use hourly rounds to prepare the patient for the upcoming handoff. At this time, if the patient and family share specific needs related to the process, the nursing team will do their best to accommodate.

C. Safety Huddle: The oncoming shift will assemble in the designated space. The off-going Charge Nurse will lead the huddle and review key data for the upcoming shift in collaboration with the oncoming Charge Nurse. Key points to include:
   1. Census, Anticipated Discharges, Admissions, Transfers, Open Beds
   2. Safety concerns
   3. Patients at risk
   4. Staffing issues/needs
   5. Facilitation of PCR handoffs for special circumstances such as resource nurse needing to leave to go to next assignment or coming from another unit, off-going nurse with multiple on-coming nurses to report out to, etc.

D. Seven Step Bedside Process: At the patient's bedside, the oncoming nurse will receive report from the off-going nurse, review key assessments, medications and orders and identify patient goals for the day using the following format:
   1. EPIC: Bring the computer in the room or access the computer in the patient's room to view the patient's chart
      a) Bring the computer in the room or access the computer in the patient's room to view the patient's chart
      b) Complete Patient-Centered Report Documentation
   2. Introductions & invitations

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a) Introduce the oncoming nurse to the patient and family
b) Invite the patient and family to participate in PCR

3. Conduct a verbal report using SBAR format
   a) Engage with the patient and family
   b) Use words that the patient and family can understand
   c) Verify patient information

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4. Focused Assessment
   a) Conduct a focused assessment of the patient and a safety assessment of the room
   b) Visually inspect all LDAs, etc.
   c) Visually sweep the room for any physical safety concerns
5. Review tasks
   a) Labs or tests needed
   b) Medication review/updates
   c) Other tasks
6. Identify concerns and set goals
   a) Work with the patient and family to identify a goal for the day
   b) Share the plan of care for the day and ask for feedback
   c) Tell the patient when you will next return
7. Complete filling in of the white board with date, nurse team and patient identified goal for the day

MONITORING PLAN:

Process Measure

A. 80% compliance per nursing unit (based on ~~PRISM~~ Epic report available on nurse manager dashboard). Compliance to be reviewed quarterly at Patient Experience Global Council and subsequent information will be provided to Service Line Councils.

Outcome Measures

A. HCAHPS Scores – 85% (top decile)
   - Nursing Communication Domain

B. Press Ganey 'Satisfaction Question' – 75% "Very Good" or Mean score (90th Percentile UHC Peer Group)
   - Nurses kept you informed

C. Press Ganey "What Happened Questions"
   - Did the nurse give a report at your bedside during shift change – 95% "Yes"
   - During your stay were you encouraged to speak up and actively participate in your care – 90% "Yes"

D. Nurse Satisfaction scores (based on satisfaction survey)

E. Fall rate and injury data – below national benchmark (accessed via patient safety and/or falls committee)

STANDARDS:

The Joint Commission. The Joint Commission E-dition. TJC, 2020. Web. 24 April 2020.

PC.02.02.01 The hospital coordinates the patient's care, treatment and services based on the patient's needs.

REFERENCES:

1. Agency for Healthcare Research and Quality. (2013). Strategy 3: Nurse Bedside Shift Report. Retrieved from: http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/patfamilyengageguide/strategy3/index.html
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3. Cairns, L.L & Dudjak, L.A. (2013). Utilizing bedside shift report to improve the effectiveness of shift handoff. *The Journal of Nursing Administration, 43*(3), 160-165.
4. Griffin, T. (2010). Bringing change-of-shift report to the bedside: A patient- and family-centered approach. *Journal of Perinatal & Neonatal Nursing, 24*(4), 348-353.
5. Olson-Sitki, K., Weitzel, T. & Glisson, D. (2013). Freezing the process: Implementing bedside report. *Nursing Management*, *44*(7), 25-28.
6. Radtke, K. (2013). Improving patient satisfaction with nursing communication using bedside shift report. *Clinical Nurse Specialist*, 19-25

REVIEWERS:

APPROVING OFFICIAL:

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Appendix A

Patient-Centered Report Checklist

- ❑ Bring the computer in the room or utilize the computer in the patient's room to access EPIC and complete Patient-Centered Report documentation.
- ❑ Introduce the nursing staff to the patient and family. Invite the patient and family to take part in the bedside shift report.
- ❑ Conduct a verbal SBAR report with the patient and family. Use words that the patient and family can understand.

  S = **Situation**. What is going on with the patient? What are the current vital signs?

  B = **Background**. What is the pertinent patient history?

  A = **Assessment**. What is the patient's problem now?

  R = **Recommendation**. What does the patient need?

- ❑ Conduct a focused assessment of the patient and a safety assessment of the room.
  - Visually inspect all wounds, incisions, drains, IV sites, IV tubing, catheters, etc.
  - Visually sweep the room for any physical safety concerns
- ❑ Review tasks that need to be done, such as:
  - Labs or tests needed
  - Medication awareness/updates
  - Other tasks: (i.e. dressing changes)
- ❑ Identify the patient's and family's needs or concerns.
  - Ask the patient and family what the goal is for the next shift. This is the patient's goal — not the nursing staff's goal for the patient
    - Follow up to see if the goal was met during the verbal SBAR at the next bedside shift report
- ❑ Complete filling in of the white board.
  - Date
  - Nurse team names
  - Patient identified goal for the day