Patient Family Centered Care Council on an Adult Medical Nursing Unit

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Abstract

Patient satisfaction is a primary concern in today's healthcare and is a measurement that elicits a patient's rating or scoring describing his or her care. One facet of patient satisfaction that needs increased focus is the perception of care of the patient and family members. Patient & family-centered care focuses on working in partnership to develop new ideas, understandings, and interventions to achieve the most positive outcomes for patients, their families and health care providers. While there has been much research and literature regarding this type of partnership in the pediatric and maternity environments, there is a need to have understanding and knowledge formed around the adult delivery of care. This paper will provide a rationale for the application of a patient and family-centered care concept within the adult setting in an acute telemetry nursing unit by establishing a patient and family-centered care council. It will include background information supporting this application, a review of the literature, an actual business plan proposal for the creation of a care council, and professional role implications for the Advanced Practice Nurse in this initiative. The council's primary objective is to create a venue where the patient and family have a platform to voice feedback to a listening multidisciplinary team which generates knowledge and increases understanding in patient and families' perspectives and experiences. By obtaining and clarifying the patient and family's perception of care, the healthcare multidisciplinary team can then formulate interventions that would strive to improve patient and family satisfaction in the acute-care setting by improving the patient/family experience.

Keywords: Patient-Family-Centered Care Council, PFCC, medical nursing unit, patient satisfaction, perception of care, multidisciplinary team

Acknowledgments

"There will come a time when you believe everything is finished. That will be the beginning."

Louis L'Amour

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Patient Family-Centered Care Council on an Adult Medical Nursing Unit

In the United States, patient and family satisfaction is a driving indicator in today's healthcare environment and is reported and viewable for anyone to access (Hospital Compare, 2012). Individuals choose a health system for care by considering multiple variables, including where one would receive the most optimal care with the best outcomes. The consumer or patient's opinion is becoming more prevalent in shaping today's healthcare reorganization. The customer-centered healthcare study (CCH study) (2012) recommends that healthcare providers become more holistic within the patient's health experience, listen with intention and value the voice to the patient and family (Donahue, 2013). As such, perception can influence one's reality (Burton et al., 2003). The initiation of a Patient-Family-Care Centered (PFCC) council on a nursing unit could drive the understanding of patient and family's perception of care by bringing together a multidisciplinary team to develop new processes and work flows to improve outcomes and satisfaction based on developing a partnership with the patient and family. This paper will include:

- rationale for the application of a patient and family-centered care concept within the adult setting in an acute telemetry nursing unit by establishing a patient-family centered care council.
- background information supporting the application of a patient and family centered care council
- review of the literature
- business plan proposal for the creation of a care council
- professional role implications for the Advanced Practice Nurse
- concluding reflections

Introduction

Background

While completing part of my Master of Nursing practicum practice, I had the opportunity to participate in a pediatric PFCC committee meeting where the multidisciplinary team members came together to discuss their upcoming committee meeting. Their mission goal was simply to improve patient and family care. Participants included social work, case management, pastoral care, nursing representatives (floor, ER and CNS), physicians (ER and floor), patient relations and child life delegates. The agenda consisted of reviewing results from a recent discharge survey that were given to patients and their families or guardians, updates from key individuals with specific responsibilities, and planning for the next PFCC committee meeting. It was illuminating to witness dialogues that included review of patient and family concerns around coordination of care, communication, and trust with interventions to address and improve each of these areas. I observed the deliberate effort of the multidisciplinary team to be reflective and honest, while reviewing the results of the survey data. The team was really trying to comprehend the patient's and families' point of view. For me, observing this team was watching holistic praxis in action.

Additionally, I had the opportunity to go to the 2012 PFCC conference sponsored by PFCC Partners, National Health Foundation and Hospital Association of Southern California. This regional partnership, established in 2010, pioneered this concept into actualization. This group brought together national speakers, clinicians, caregivers, patients and family members to collaborate, listen, and learn from each other and our experiences. The conference had one-hour break-out sessions divided into four topic areas – engaging and empowering the PFCC team, PFCC innovations, PFCC culture & environment, and impacting practice. Each topic area had

four presentations from different groups from around the country who shared educational information, successful processes, ideas, or first-hand experiences of the PFCC concept. It was a wonderful day full of meaningful interactions, active listening, deep understanding and learning in aspects of all areas of the healthcare arena.

My professional conscience had me ponder reasons why our telemetry floor did not engage in the same type of interactions, especially when there seems to be such positive responses and outcomes. Our pediatric PFCC committee had history, good satisfaction outcomes and evoked a sense of collaboration and mutual respect between the multidisciplinary team members and family representatives – it benefited all involved. Historically, the Institute for Healthcare Improvement (2011) encouraged the inclusion of patients and family members in discussions of safety and quality of care (Balik et al. 2001). Also, the Joint Commission's Leadership Standards and National Patient Safety Goal 13 explicitly states that the organizational culture needs to include patient and family communications are able and encouraged to report concerns about safety (Smith, 2009). Sadly, our culture shift is slow in achieving these requirements.

Patient Satisfaction and HCAHPS Scores

Patient satisfaction is recognized as a primary concern that is prevalent in today's healthcare. One method of receiving patient satisfaction scores is through the use of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, which asks specific questions to measure a patient's perception about her or her hospital experience (HCAHPS Fact Sheet, 2012). For example, one survey question is "during this hospital stay, how often did nurses listen carefully to you" with possible answers of "never, sometimes, usually, and always." This question has historically produced results that show decreased rates

of satisfaction and is an area of practice that warrants further understanding. Some health-care workers could have a lack of understanding or an absence of consideration of how the delivery of care or care plan affects a patient and family member's experience or their perception of the intention of the care.

As reported in the recently released report of the Learning Health Care System committee (National Research Council, 2012), the inclusion of patients and families into decision-making and coordination of care is still not being actualized. While leadership of the medical-surgical telemetry unit considers patient and families' voiced concerns very seriously, there is no venue for dialogue or problem solving collaboratively or in consultation with the patients, families, and the multidisciplinary team.

A medical-surgical telemetry unit has many challenges due to the nature of the client population. The patient can be admitted via the emergency room, or as an urgent, direct admit, from a physician clinic, where hospitalization was not anticipated. This can cause a patient to be nervous, irritable, anxious, or defensive to a perception of having lack of control. There can be multiple physicians involved in the construction of the plan of care due to multiple consults and physicians schedules, especially in an academic, teaching hospital. This creates confusion for the patient or a perceived lack of care coordination which affects satisfaction scores.

The Patient and Family Perspective

Patient empowerment is actualized when the patient and family members feel confirmed or validated with active listening, having a voice, and mutual respect (Aujoulat et al., 2007b). Empowerment is defined "as a complex experience of personal change" and "may be facilitated by health-care providers if they adopt a patient-centered approach of care which acknowledges the patients' experience, priorities and fears." (Aujoulat et al., 2007a, p. 18). Initiating a patient-

family- centered care council on the adult telemetry nursing unit, where a multi-disciplinary team works together with patients and families to institute processes /improvements based on experiences, suggestions and research, can provide a venue for these interactions.

One way to influence patient and family member's perceptions positively is to invite participants to contribute, by sharing specific input and perceptions, to help guide practice changes, process improvements, and ways to enhance care delivery. The focus is on a partnership between clinical/hospital staff (physicians, nurses, rehab therapists, social workers, case managers, pastoral care, etc.) and patient and family members (present and former) where open and honest discussions can take place. Consequently, attitudes and approaches change to facilitate a better holistic environment for healing and increased communication – all which improve patient satisfaction.

The nurse's scope of practice dictates the responsibility "to assist patients and families in coping with difficulties in daily living, which are associated with their actual or potential health or illness problems" (California Nurses Practice Act, 2013). Encouraging patient and family participation in goals of care and discharge planning discussions can influence hospital stay experiences. The bedside nurse can educate the patient and family members on the accessibility of connecting with the members of the nursing unit's PFCC council for support and resources.

Review of Literature

The Institute of Medicine (2001) released a report with six recommendations to improve the delivery of care. One of the recommendations of redesign was to ensure *patient-centered care* “that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions” (p. 40). This approach shifts the thinking of healthcare delivery to follow a ‘doing with’ instead of ‘doing for’ care approach. By improving the perception of care, increased patient and family satisfaction would be anticipated, as these concepts are interrelated and influence each other.

The term ‘patient-centered care’ is an umbrella term which denotes a type of care delivery structure where a holistic approach is applied. The Institute of Medicine (2001) defines patient centered care as "a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients’ wants, needs, and preferences and that patients have the education and support they require to make decisions and participate in their own care.” This literature review was to determine what had been researched and reported about the *adult patient-family-centered care council*.

Method

The initial search of the literature using the search engine CINAHL plus with ‘patient family-centered care council’ resulted in no results but when SmartText Searching dominated the search 19,418 where referenced. The term *“patient family-centered care” + council* produced 88 articles again with the SmartText Searching overriding the search. The addition of *adult* to *“patient-family-centered care” + council* to the search exposed nine articles again utilizing the SmartText Search override, although none used the term *“adult patient-family-centered care*

council" specifically. The use of *'patient-family advisory council'* was sometimes seen in the results. This review of literature is categorized into four sections:

- Literature directly addressing PFCC for the adult patient
- Literature that supports the PFCC philosophy
- National PFCC organization website
- Nursing theory supporting PFCC principles

Literature Directly Addressing PFCC for the Adult Patient

Llewellyn Piper (2011), who is president and CEO of Onslow Memorial Hospital, wrote an article for *The Health Care Manager* that focused on the need to create a culture of PFCC in the hospital setting. He proposed that medical errors and preventable deaths could be avoided by ensuring that the patient and family are involved in the care, and the leadership team has an ethical mandate to establish and nurture a PFCC culture. The patient-family centered advisory council was one element suggested to create this culture.

Patient Education Management, who is licensed and accredited as a provider for continuing nursing education, released a newsletter in February 2009 dedicated to the concept of Patient and Family Advisory Council. The article reinforced that the philosophy of partnership must be accepted and ingrained into the culture of the organization as a fundamental underpinning for a council to be successful (2009). The commitment to intently listen, keenly hear, and responsibly respond after thoughtful and intentional discussions amongst patients, family members and healthcare team members have to be explicit for all to experience.

Patricia Sodomka, senior vice president of patient- and family-centered care at MCG Health Inc. and director of the Center for Patient and Family Centered Care, Medical College of Georgia, wrote a quality update that reports use of PFCC care is a deliberate approach that

collaboratively brings together a partnership between patient, families and healthcare providers (Sodomka, 2006). The four core concepts/principles of patient-family centered care are respect and dignity, information sharing, participation and collaboration are reinforced in the article. The importance of knowing all parts of the program, what influences the goals trying to be achieved, and answering if the program is functioning as intended all "translate vision into practice" (Patton, 2008, p. 308), which is the ultimate goal of the PFCC council.

Nancy Warren (2012) wrote, from her perspective as a Patient Care Manager, about the use of patient-family advisors in improving outcomes, and suggests that sharing of patient and family stories will assist the healthcare team learn different perspectives and vantage points when discussing experiences. Patients, care givers, and family members are "able to share their unique perspectives to help organizations and institutions with improvements in honest, accurate, timely information sharing; shared decision making that respects patient wishes; and smooth transitions between levels of care, including the transition of self-care" (Warren, 2012, p. 238). Having the patient and family members involved in advisory roles, the healthcare team can plan interventions based on recommendations and reflections of patient needs and values (Warren, 2012).

Literature that Supports the PFCC Philosophy

A qualitative study to gain knowledge on the perspective of patients regarding empowerment was conducted by Nygardh et al. (2011). This article also discusses clinical relevance for practitioners to understand the importance of empowerment and how engagement of patient's values and preferences can positively influence healthcare outcomes. This requires the practitioner to be reflective to their own biases, discerning to possible underlying barriers for patients and skilled at active listening and communication. This study's analysis produced seven

sub-themes: five which embodied empowerment and two represented non-empowerment. The one comprehensive theme emerged as "creation of trust and learning through encounter" (p.899).

Empowerment	Non-Empowerment
Accessibility according to need	Meeting with nonchalance
Confirming encounter	Lack of dialogue and influence
Trust in the competence of the healthcare staff	
Participation in decision-making	
Learning enables better self-management	

This study reinforced the concept of perception of the patient and how that affects the patient's experience.

The article written by Neuwirth et al. (2012) discussed their study completed at Kaiser Permanente Care Management Institute who used video ethnography to capture patient, family members, and caregivers' interviews and observations to be used as teaching opportunities and knowledge producing among the healthcare team. While although their interviews lacked bi-directional interactions between healthcare members and patient/family advisors, it was still seen as effective in teaching and producing an understanding in the need for better communication of the medical team members, which impacts quality care. These conclusions support the necessity for healthcare providers to utilize active listening and effective communication. One other observation that the authors revealed is the tendency for individuals to make decisions based on his/her own viewpoint which could negate the patient or family's perspective (Neuwirth et al., 2012). The creation of a PFCC council would allow for opportunity for all members of the council to ask for clarification or explanation, if needed, when discussing issues, care delivery, processes, or perceptions. The ability for individuals to be explicit would be invaluable. A PFCC council provides a forum for enhancing clarity of the patient and family's perspective.

Oates et al. (2000) completed an observational cohort study in the primary care setting that showed patient-centered communication increasing patient perceptions of care and efficiency of care. Office visits were audio-taped and then were scored for patient centered communication. All patients were over the age of 18 years of age and had 1 or more recurring medical problems. Patient's perception of patient centeredness was correlated with outcomes. One conclusion of this study recommended more medical training to practitioners which involved 'real' patients to help authentic learning. This supports the concept of the PFCC council.

Ryan Donohue, Director of Program Development at National Research Corporation wrote a recent article which describes "consumerism" as "doing what's right for the consumer" (2013, p.5). The article suggests that healthcare providers should "expand the experience, adopt a listening culture and let the customer be your guide" which promotes customer-centric healthcare to improve consumer or patient perspective of healthcare delivery (p.11). This supports the concept of Patient-Family-Centered Care council. Our patients have become medically savvy, knowledgeable in what they want and need and willing to have these conversations to help providers understand consumer perceptions and opinions.

National PFCC Organization website

The Institute for Patient- and Family- Centered Care (IPFCC) is a non-for-profit organization which "provides leadership to advance the understanding and practice of patient- and family-centered care in hospitals and other health care settings" (IPFCC, 2013). The website (IPFCC website, 2013) defines patient centered care as "an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families. It redefines the relationships in health care." There are

many resources to guide, inform, collaborate, and utilize available which all support and educate on the concept of Patient-Family Centered Care. There are checklists and tools available as resources.

Nursing theory supporting PFCC principles

The philosophy of Patient and Family Centered Care is the foundation of all interactions between staff and patient and family and encompasses respect, information sharing, participation and collaboration (http://www.ipfcc.org/index.html). The nursing model of Relationship-Based- Care (RBC) can create a solid foundation for establishing the connection between the patient and nurse where healing can take place (Dossey, 1999). The connection between the patient and caregiver is crucial for the act of healing to begin; the connection needs to be based on trust and respect. RBC focuses on three key relationships as a caregiver – one with self, one with others, and one with a patient. The first two relationships (with self and others) need to be actively acknowledged and fulfilled before a caregiver can therapeutically give to others (Campbell, 2009).

Small and Small (2011) wrote an article which integrated the principles of PFCC into the development of a standardized nursing practice model that was instituted in the Cleveland Clinic health system. One limitation of PFCC is its lack of a universal definition across a diverse health system and how it could be utilized in diverse settings (Small & Small, 2011). Despite the complexity of applying PFCC in different environments, the common thread of measuring success of application is the patient's perception. The article discussed barriers to implementation of PFCC within a health system to include non-standardization of care, variety of nursing roles and lack of engagement of nursing staff. An executive leadership team established a new practice model that melded nursing theories (Manthey's relationship-based-

care & Benner's systems thinking) and management theories (Senge's shared vision & Greenleaf's serving leader) into its theoretical framework. One driving goal was to improve nurse engagement within its complex health system thus positively affect patient outcomes (Small & Small, 2011).

Conclusion

The use of PFCC care is a deliberate approach that creates a partnership between patient, families and healthcare providers (Sodomka, 2006). To understand the consumer's (or patient's) perspective, he or she has to have a platform in which his or her voice can be heard. This can be done in surveys, formal complaints or in-person interactions, which usually are singularly directed and then dispersed as the owner of the information sees necessary. The concept of a PFCC council setting could provide a group forum where the depth of comments could be explored in a multidisciplinary and collaborative manner.

Business Plan Proposal:

Proposal for the Establishment of PFCCC on a Medical-Telemetry Unit

Executive Summary

One objective of hospitals in the United States is to improve the patient's experience to influence patient satisfaction scores positively. Although the concept of patient-centered care is not new to the healthcare arena – the ability to operationalize this concept consistently has not been fully actualized.

Patient-centered care is defined by the IOM as "Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" (IOM, 2001). One initiative that will achieve this goal of family-centered care is the use of a Patient-Family- Centered Care Council (PFCCC) which will provide a forum where patients, family members, and healthcare providers can come together to improve health care by collaboratively working on processes and work flows that will directly and indirectly affect planning and delivery of multidisciplinary health-care practice by understanding the patient and families' perception of care and experiences.

New knowledge will be developed when patients and family members share their hospital experiences and perspectives, in an advisory manner, where healthcare providers have an opportunity to clarify, ask questions, and continue to gain understanding. Public reporting and scrutiny of HCAHPS scores have illuminated patient and family perceptions so brightly that addressing these needs and expectations by examining hospital care are necessary and will help protect the financial health of the hospital.

Benefits of this new knowledge include:

- Assist the healthcare providers in developing patient and family relationships.

- Individualize delivery of care.
- Actualize the patient and family members' voice which is listened to with intention and openness.

This business plan will define the council and its purpose and value, the marketing plan, description of operations, financial implications, key assumptions, and organizational structure.

Proposal for the Establishment of PFCCC on a Medical-Telemetry Unit

Definition and Purpose

A Patient- Family- Centered Care Council (PFCCC) or Patient Family Advisory Council (PFAC) is a multi-disciplinary team (either service-line or departmental) whose members work together and institutes processes/improvements based on experiences, suggestions and research utilizing the PFCC philosophy of:

- Respect and dignity – with intent listening and individuality and uniqueness
- Information sharing – communication sharing of facts with options
- Participation – supported in decision-making
- Collaboration – among all healthcare providers and patients and families

for all interactions and partnering between clinical staff and patient/family members. The foundational philosophy is based on respectful sharing of information from the perspective of the patient's lens through participation and collaboration in initiatives and delivery of care.

Product Value

The complexities of human interactions are multifaceted. Patient engagement increases positive patient outcomes and decreases costs associated to providing care (Veroff et al, 2012). Patient-family-centered care is a deliberate approach of communication where the consumer (i.e. patient) partners with healthcare providers to make all clinical decisions based the individual patient's needs, preferences, while honoring his/her or her values.

An interactive Patient-Family- Centered Care council would:

- Demonstrate the continuum of patient engagement within the health system organization.
- Devise care delivery improvements which are decided upon from progressive conversations and generation of knowledge.

- Empower patients and family members by validating and hearing their concerns, opinions, and beliefs of what does and doesn't work in the patient's experience.
- Cultivate the consumer-health provider relationship.

The concept of evaluating a patient's perception of care is complex and has never been given an adequate amount of attention from healthcare providers. There is a lack of understanding or consideration of how the delivery of care or care plan affects a patient and family member's experience or perceived intention of care by healthcare providers.

The PFCC Council format works well in other environments (pediatrics/maternal) so it is plausible to be effective in the adult environment. There has been much research in the pediatric environment on PFCC. For example, Brown et al (2007) demonstrated the application of PFCC care with parents/family members wanting to be present with their children for procedures or resuscitation in the Emergency Room. Even if adverse events occurred, studies have shown that family member's presence during these times decreased the parent or family member's anxiety and increased overall satisfaction because of open communication and a sense of being heard and understood.

This PFCC council concept will have frontline caregivers and patients/family members collaboratively work together to discuss and develop process improvements, changes in practice, trial them and evaluate responses respectfully and effectively. A deeper understanding of perception of patients and families' experience would be achieved. New, creative ways of delivering care would be developed. The success of today's hospital depends on Leadership to reexamine how we deliver care – does it enhance or take away from the patient's experience? The formation of a PFCC council on a medical telemetry nursing unit can exhibit the institution's commitment to consumer's perspective and being responsive in making the

necessary changes in delivery of care. Our health system will become more responsive to patient needs; satisfy our customers, while engaging staff and patients and families together in ways that achieve better outcomes and efficiencies.

Marketing Plan

All hospital employees need to be knowledgeable and engaged because patient satisfaction is recognized as a primary concern that is prevalent in today's healthcare. Communicating this hospital-wide initiative to staff can be done as listed below.

Teaching Staff via:

- Huddle messages
- Video clips
- Newsletters
- Hospital website

Teaching Patient/family members via:

- PFCC information Pamphlet
- Daily Physician rounds
- Patient Relations Office
- Care Coordinators

Strategies for success:

- All staff members (clinical and non-clinical) should be informed to be able to refer patients and family members. An overview of the status of the PFCC Council should be a standard agenda item for staff meetings to encourage referrals of potential patient and family member advisors.
- Potential advisor referrals could come from clinicians and staff, leadership rounds, patient and family member complaints, or volunteer office.
- An application form will be available to submit to the PFCC Council Administrators for consideration. The intent of the application is to obtain demographic information, availability, and general reason the person wants to become an advisor. It would also ask for the affiliation of the applying individual – former patient, family member, or

concerned citizen. The application form would illustrate the required timeframe commitment to ensure awareness of such. See Appendix A for example of application form from UCLA Health System (2013).

- A database will keep all applying candidates' information regardless of selection. Careful selection of potential patient and family members would be required.
- After reviewing and screening the application forms, an interview of all potential patients and family members should take place to further discuss the motivation of a new patient advisor. During this interview, the ability to articulate ideas or perspectives could be observed, as well as, inappropriate agendas or behavior. The interviewer requires expertise in communication techniques, yet utilizes an unscripted openness to ensure all perspectives and opinions have a voice to be heard. See Appendix B for example questions for interview from UCLA Health System (2013).
- An orientation package would be supplied to each patient advisor prior to participating on the council. Included would be a written copy of the hospital’s mission and vision, a confidentiality statement.
- A unit bulletin board would be dedicated to showcase the Medical Telemetry PFCC council with a full description of objectives of the committee and request for potential volunteers on the medical telemetry unit.

Description of Operations

Frontline staff members, including physicians, nurses, social workers, case managers, physical therapists, dieticians, patients, family members, Nursing and Physician Leadership, and Hospital Administration representatives would be represented during the council meetings.

Meeting Format:

- Monthly meetings where the healthcare multidisciplinary team collaborates in a setting that focuses on sharing of ideas, services, strategies improvements, processes, and recommendations by listening and honoring patient and family perspectives and choices.
- Bylaws or guiding principles would be agreed upon and finalized by council members during the first meeting of the PFCC council, setting the foundational values that would guide all decisions that are made. This would be reviewed annually.
- Good communication skills are essential for all Council members where information is shared in an unbiased manner.
- Meeting agendas and minutes would be developed to follow a strategic and consistent manner. For example, reviewing the most current quality dashboard would become a standing agenda item for each meeting for strategic planning and discussions. Decision makers (i.e. leadership) for patient care and practice would have to be present at council meetings.
- Whenever a process change is to take place – a change theory or model of organizational change would be required to assist the change process. For example, following a proposed change in practice, utilizing Kanter's wheel of change would strategize planning and lead effective change with a comprehensive preparation utilizing the ten spokes or elements (Kanter, 2011). They are:
    - Common Theme and Shared Vision – ensuring this is communicated and transparent to all involved in the change process.
    - Local Innovations and Quick Wins – celebrate small wins to encourage and support as change can be a difficult transition.

    - Symbols and Signals – Leadership should model the new behavior for all to see the congruence with the communicated message.
    - Communication – Much communication is required for change to occur.
    - Governance and Accountability – build in accountability to track the progress.
    - Structure, Procedures, Policy – ensure the process is written for referencing, sharing, and determining that it doesn't contradict any other policies or procedures.
    - Education, Training, Action Tools – educational plan will ensure all needed participants are instructed and informed of process change.
    - Feedback Mechanisms – construct the process change to be able to measure progression.
    - Champions – enlist some people to help promote and cheerlead the process on especially when the leaders are not present.
    - Rewards and Recognition – celebrate small advancements of the process to encourage and reinforce positive change.
- All types of communication (staff meetings, emails, posters, huddle messages, signage) could be utilized to share knowledge, inform practice changes and trial new ways of delivering care.
- Case studies could be developed to share perspectives of patient and family member's experiences.
- The council's work will be transposed into a reference binder/resource sheet that can be used as an educational tool to inform all current patients and families about the availability of a PFCC council and its workings. The unit's dashboard with quality data

points (i.e. number of falls, infections, etc.) along with the HCAHPS scores would be transparent for all to see the trends.

Financial Implications

The two Chairpersons that would lead the PRCC Council are the Advanced Practice Nurse, who is skilled in leadership and collaboration, and a patient/family member advisor, who is committed to the pro bono role for at least one year, preferably two. The following chart outlines the costs associated with the formation of the council.

PFCC Council Monthly Meeting Budget			
Items	**Cost per meeting**	**Covered by current unit budget**	**Need Funding**
Conference Room	N/A	yes	
Utilitites	N/A	yes	
Paper/Office Supplies	$20	yes	
Parking (5 patient/family)	$55	no	$55
Beverages (up to 20 people)	$25	no	$25
Meal (up to 20 people)	$200	no	$200
Administrative Costs	4-5 hours/month	yes	
Total			$280/monthly

Key Assumptions

Bisognano (2012) challenges that the way to have "sustainable, long-term change at the front lines of care" (p.70) is to have senior leadership invest and support having patients and families involved in activities on improvement programs or projects by coming "together in cooperative, cross-functional teams and dig into the basic work of improvement" (p.71).

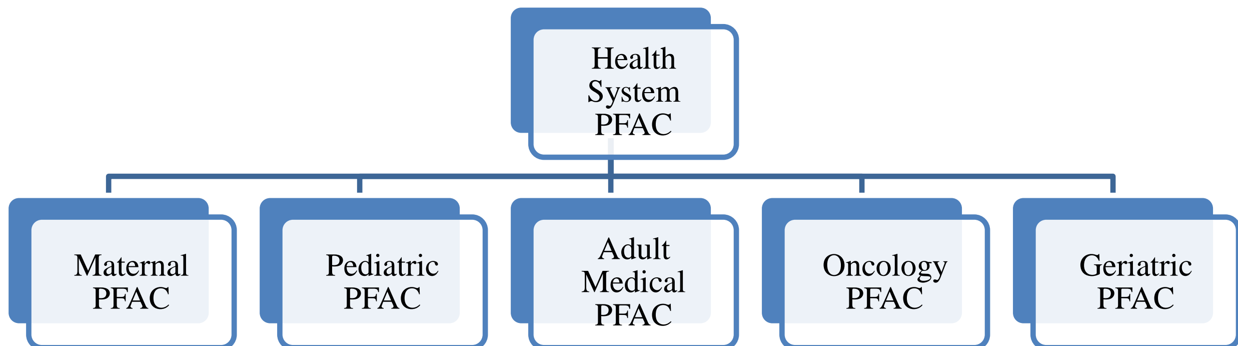
Key Assumptions:

- Prioritize what needs immediate attention.

- All membership on committee has to commit to service on predetermined timeframe (preferable length of time - 2 years)
- All members of the PFCC council will be educated on the process of HCAHPS scores, PICKER surveys, and reporting websites to decrease the knowledge gap and re-confirm the goal of the PFCC council.
- Collaborate with other PFCC councils similar in composition to learn workings, communication techniques, workings and barriers to implementing improvements.
- Do not reinvent the wheel when it is already working elsewhere.

Organizational Structure

The below organizational chart depicts how each service line PFAC can help support the mission and vision of the entire health system. This communication tree exposes the Executive Leadership to hear persistent concerns or deficiencies. This type of feedback will also help guide institutional initiatives and strategies.



Summary

The restructuring of healthcare and the delivery of care is transforming in every health system across the nation. Patient and family perspectives and experiences need to be a top priority in ensuring patient satisfaction and quality care. The creation of a PFCC Council on a medical telemetry nursing unit will facilitate meeting this imperative strategy. The healthcare consumer is becoming empowered, educated, enabled and engaged. This council will give them a forum to voice and be heard.

The PFCC Council and the APN

The 2013 PFCC Conference was held recently and the experience reflected the current healthcare state. The tone of the conference, from the patient perspective, reinforced empowerment and enthusiasm, and the energy was palpable. Patients are continuing to become engaged, informed, asking questions, wanting answers and demanding quality care. The instituting of this council on a medical telemetry nursing unit in an acute care center would have many benefits. The position of the Advanced Practice Nurse would be strategically appropriate to chair this council or co-chair with a patient advisor. The co-chairing of the PFCC Council with a patient family advisor displays partnership and cooperation and confirms the desire to listen and hear requests and concerns of patient and family members.

The Canadian Nurses Association (2008) distinguishes an advanced practice nurse competency as being able to collaborate, communicate, and consult across many sectors of the healthcare continuum. His or her ability to mentor and empower, form therapeutic relationships with patients and family members to facilitate healing and growth, and provide holistic care all support the APN role to co-chair a PFCC council on an adult telemetry nursing unit. This ability will assist in understanding the patient and family's perception of care by bringing together a multidisciplinary team to discuss, develop and initiate new processes and work flows to improve outcomes and satisfaction.

Delving into this area of practice, and completing my MSN studies, I believe the competencies of the Advanced Practice Nurse (APN) would fulfill the necessary skill set to lead this health system initiative. The Canadian Nurses Association (2008) published a national framework that categorizes competencies into four areas: clinical, research, leadership, and

collaboration/consultation. The APN would utilize and need to be skilled in all four levels of competencies to managing the workings of the PFCC Council.

Clinical Perspective

The APN has a unique position on the nursing unit, one of clinical expertise and one of leadership. The advanced knowledge and praxis of this role holds an understanding of the unit's workings and culture. He or she can maneuver between staff members and patients/family members and tailor ideas, concepts, and instructions appropriate for the audience.
While chairing the PFCC council, the APN nurse has the background comprehension of all health system policies, procedures and processes and its grounding theory and history. Guiding or coaching patients and family members, an understanding of the direct implication of new initiatives, is vital to prevent chaos or dangerous shortcuts in care delivery. The role of the APN on the nursing unit allows observation and assessment of nursing practice and advancement of the care of the patient, especially while instituting some proposed changes. Understanding the health system workings will be crucial in navigating suggested process improvements of the PFCC Council.

Conversely, the APN can communicate to patients and families using a holistic approach where the patient/family member is at the center of the interaction. Comprehending patient's perceptions and expectations is the first step in developing ways to improve patient and family satisfaction. Being part of the unit's leadership team, the APN can decrease patient and family anxiety and increase engagement by doing bedside rounding and deliberate inquiry. These findings can be useful to discuss at the PFCC Council meetings.

This added responsibility on the APN's list of tasks is one that can be just as difficult, as it is beneficial. Listening for areas for improvement is not easy or pleasant, but the necessity for

the Leadership team to proactively round on inpatients demonstrates an important illustration of commitment to improve.

Research Perspective

The role of the APN is multifaceted in regards to the research competency. Evidence based practice is an expectation that is demanded in healthcare due to advancements in research and the importance of quality and safety of care. The nursing unit APN's practice integrates research utilization, performance and evaluation into the care of the patient.

Decisions the PFCC Council will make will be guided by all three components (i.e. research utilization, performance and evaluation) of the research competency and required the advanced knowledge of the APN to navigate through. Suggestions to changes in practice need to ensure nothing conflicts with national clinical standards and hospital policies, which the APN understands and is able to advise patients and family members. One clinical responsibility of the APN is to give in-services to the nursing staff regarding the initiative of the PFCC Council and is present to observe all interventions in action. The evaluation process and results can be critiqued to see if interventions are making positive and intended impacts. After this evaluation, the APN can share this research in a scholarly way through national forums, organizations, and associations. The disseminating of "improving the patient and family experience" interventions influences the healthcare environment and, ultimately, advances quality of care.

Leadership Perspective

The leadership competency is weaved throughout all other competencies. I see the APN role as being a change agent and this initiative captures professional practice from beginning of council's inception, to all interventions, to evaluating results, and then reporting these results for others to benefit from. A discerning APN will develop effective and dynamic leadership

techniques and communication skills which are needed to coach, mentor, and strategize effective change. One can never relax or compromise integrity without jeopardizing the process of the PFCC Council workings.

The knowledge generated for practitioners to gain by learning through appreciative inquiry and communication with patients and family members, and developing thoughtful, purposeful and strategic interventions based on real time feedback are examples of the benefit of the collaborative approach to being a patient-centered organization (Havens et al. 2006).

Having the background knowledge of a proposed change in practice and the history of development needs to be communicated to the frontline staff so they can see the value and embrace the new way of practice. Since change is not always easy or looked at positively, the APN needs to purposefully utilize a change theory to execute and accomplish these improvements. This approach would also need to extend to the multidisciplinary team members, in addition to, the front line staff. One strategy is to preface all statements with “Listening to the patient’s perspective…” or “Patients have requested we…” When the patient is always placed as the reason we are doing something, staff are more receptive to change.

Collaboration/Consultation Perspective

The ability to work together with other disciplines, patients and family members takes much work, dedication to a common goal and communication, communication and more communication. The APN will need to successfully articulate the patient and family’s perspective to the multi-disciplinary team members not present on the council, be convincing in the sharing of new ideas and suggestions from the patient and family to all frontline staff, and have the persistence and perseverance to instill trust and accountability with clinical competence to exhibit why these changes are beneficial.

Summary

This project, of a patient-family-centered care council on a medical telemetry nursing unit, is an initiative possibility that would give the healthcare consumer a forum to their voice concerns, suggestions and perspectives. Hospitals that place emphasis on patient engagement will strategically address and encourage ownership and accountability. The ability to get feedback from the consumer about how they receive the care delivered to them is what needs to happen so that hospital leadership can make decisions based on solid recommendations from those who will be directly affected. The patient and family members are the most important stakeholders.

Concluding Reflections

My journey through the University of Victoria's Master of Nursing program – Advanced Practice Leadership track began in 2010 and presently, is in its closing stage. This program has challenged my thinking and changed my nursing perspective, approach and beliefs. It has taught me nursing's history, the different frameworks and varied philosophical approaches. My discovery and realization demonstrated that I needed to refine these foundational concepts in my own professional practice. This concluding section of my project paper will summarize newly acquired knowledge and behavior changes in my professional practice in reference to the Advanced Practice Nurse's four spheres of influence: the interprofessional health spheres, the patient/client sphere, the nurses/nursing sphere, and the health systems/organization sphere.

The Interprofessional Health Sphere

My understanding of the APN role within an interdisciplinary team links the physician and other disciplinary leadership teams with the bedside clinician. It is necessary and essential for quality care to be delivered to have healthy, collaborative, working relationships. The APN also needs to have full understanding of processes and implications so the best decisions can be made for the patients, families, staff and the health system.

The APN's responsibility, being the spokesperson for the frontline nurses, is imperative for sharing of information and negotiating possible changes in practices or routines. This requires him or her to be explicitly knowledgeable in the clinical area of discussion. It will also require having refined communication skills with ability to compromise and solid relationships with the multidisciplinary team members.

Consequently, the APN is to have a constant commitment to being current in clinical practice, to have patience and tenacity to teach to the multidisciplinary team, and creatively

engage and encourage nurses to grow in his or her own professional practice. One requirement that I continually observed in my practicum, is the APN's need to educate, reeducate and further educate, sometimes the same disciplines, the role and responsibilities of the nurses. This reinforced the professional call to keep calm and even toned, not displaying frustration or exasperation. At times, one can become tunnel-visioned when passionate about some process or aspect of care, not recognizing other negative implications that could be actualized if not presented in a respectful and professional manner. A prudent APN would be watchful of this behavior in him/herself.

The Patient/Client Sphere

The APN has advanced knowledge that can optimize a patient and family's experience in the healthcare setting. Being engaged and passionate about the APN role, one advocates for patients and families in coping and understanding disease conditions and implications utilizing a nursing theory, such as Watson's Caring theory. This theory, along with Relationship Based Caring model, reinforces and helps direct my approaches to patients and families that I am in contact with. By having the philosophical class early in the MN program, one of the first questions that I now ask to all patients and family members are "what is the most important thing to you" as this helps guide the plan of care and allows for the patient's views, beliefs and goals to be included in each case. Trying to create an caring environment, using Chinn's (2008) descriptive "PEACE powers" instead of "Power-over" approaches, really impacted my practice of nursing with patients and families so that the building of the relationship is the foundational beginning of interactions.

My MN project also helped deepen my understanding for the APN role and its direct relationship that can affect patients and family members. Patient satisfaction and understanding

the patient's perspective can really direct interventions and processes that strive towards providing quality care. By being part of the nursing leadership team and completing bedside rounds on the inpatient nursing unit allows for real time feedback for sharing of this information. Our nursing leadership classes and the evaluation class helped reinforce the importance of reflection on my belief systems regarding health inequalities and approaches with communication.

The Nurses/Nursing Sphere

The MSN program and its leadership classes illuminate the nurse to nurse sphere the most. While I work in a Magnet-designated hospital, the advanced education helped explain and gave the foundational framework clarification of Magnet status, thus I can continue to expand this awareness to the bedside nurse, especially those who graduated from a school of nursing diploma program, who might not have had this historical perspective. Historical perspective is a pivotal teaching point that I value and see as imperative to share with staff for understanding of the importance of (i.e. new regulations) besides being the right thing to do. The bedside nurse has to have an understanding of the 'why' and 'what's affected' whenever a new process or regulation is instituted for better compliance. Nurses need to know what constitutes good practice and the supporting evidence to change to new ways.

As an APN student, learning to utilize Kanter's change model, to strive for excellence and collaboration when any group is brought together, was so instructive and tangible on how to facilitate a change process. Aligning the initiative with strong supporters and managing individuals with informal power may also need to be considered. When all members of a team feel empowered and authentically heard, better outcomes, collaborative teamwork and staff engagement should naturally occur. Allowing all people who will be affected by a new process

(i.e. policy, procedure or workflow) a chance to ask questions, give input and fully understanding the reasoning behind the change is vital for compliance with change in behavior or workflows. This change model will provide a structure to reference for all initiatives that I am asked to implement.

The Health Systems/Organization Sphere

During my clinical practicums, I saw the collaborative and consultation competency of this sphere being crucial for the APN's success in his/her role. Having the advanced knowledge of the health system can also acknowledge barriers or operational system flaws that can impede quality care. This will allow the APN to advocate for initiatives or process changes. The APN can network with the appropriate department leadership to collaborate for improvements. Being open minded, able to compromise, and insightful of all competing variables in the operational aspect of running a health system is necessary and required of the APN to be the most effective.

The core research classes and evaluation elective class in the MSN's program was invaluable and so instructive in learning different research methods, the variables in qualitative and quantitative research and critiquing research. The APN is responsible to facilitate advancing nursing knowledge by having the skill set to construct qualitative and quantitative research studies and differentiate through research literature for value and quality.

During my practicums, I also experienced observing the APN role outside the hospital setting. The first example was in a clinic setting where different theories (i.e. Benner's theory of novice to expert and the adult learning theory) were observed to guide the learning of patients and families in a physician's practice. This also allowed for the APN to delve into areas of the patient and family's health that is often not addressed in a hospital admission.

The second example extended to national organizational conferences where the APN is able to advocate for and increase his or her patient population's awareness of such support groups, organizations or community resources. Seeing a community thrive in supportive relationships was heart-warming and results in increasing health promotion. People are the best experts at what they need so if you, as the APN, can support them with options and outlets, hopefully they can flourish in returning to their best state of health.

Conclusion

My Master's program has been a wonderful journey of learning, experiencing and planning. Acknowledging my professional practice before and how much it has changed after the program course work is a direct reflection of this new understanding and application. I look forward to continue to apply my knowledge in action, affecting positive change, and advancing nursing knowledge. This is a pivotal time in the healthcare arena. My wish is to walk alongside with other leadership to ensure quality exemplary care is available to all with healthcare research and advocacy.

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Appendix A

UCLA Health System

Patient Advisory Program

Membership Application

UCLA Health System Patient Advisors play an important role in our commitment to deliver compassionate patient care. As a patient advisor, you will be the voice of other patients and families by providing insight and constructive feedback on how we can better serve our patients.

Please complete this form so that we may identify appropriate opportunities for you to help. We will be in touch shortly regarding next steps, which may include an informal interview.

Return completed forms to UCLApatientadvisory@mednet.ucla.edu or to the Patient Affairs Office (information on the back).

Please PRINT all information clearly.

1. Name:______________________________

   Address: ______________________________

   City/State/Zip Code: ______________________________

2. Contact Information:

   Primary Contact Number: ___-___-____

   Email Address: ____________________

   a. Best Way to Contact You: ☐ Phone ☐ E-mail

3. When is the best time for you to attend meetings (if necessary)? Please choose all that apply.

   ☐ Weekday Mornings ☐ Weekday Nights
   ☐ Weekdays at Noon ☐ I am flexible

4. Languages Spoken: ____________________

5. Have you or your family member been seen at UCLA in the past year? ☐ Yes ☐ No

6. What department(s) has provided care for you or your family member?

   ☐ Cardiology ☐ Neurosurgery ☐ Pediatrics
   ☐ Emergency Medicine ☐ Obstetrics & Gynecology ☐ Psychiatry & Behavioral Health
   ☐ General/Family Medicine ☐ Oncology ☐ Urology
   ☐ Gastroenterology ☐ Orthopaedics ☐ Transplant
   ☐ Geriatrics ☐ Rehabilitation ☐ Other: __________
   ☐ Neurology ☐ Palliative Care

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Appendix A page 2

7. You are a:
   - ☐ Current patient
   - ☐ Past patient
   - ☐ Family Member of current patient
   - ☐ Family Member of past patient

   a. If a family member, you are the patient's:
   - ☐ Spouse/significant other
   - ☐ Parent
   - ☐ Daughter/Son
   - ☐ Other (Please describe-e.g. legal guardian, etc.)________________
   - ☐ Sibling
   - ☐ Grandparent
   - ☐ Grandchild

8. Where have you or your family member received care? Please choose all that apply.
   - ☐ Westwood Emergency Department
   - ☐ Ronald Reagan UCLA Medical Center
   - ☐ UCLA Community Physicians Offices
   - ☐ UCLA Outpatient Surgery Center
   - ☐ Santa Monica Emergency Department
   - ☐ UCLA Medical Center, Santa Monica
   - ☐ Resnick Neuropsychiatric Hospital
   - ☐ Mattel Children's Hospital UCLA

9. Why would you like to be a patient advisor?

____

____

____

Please check which group(s) you would like to be involved in.

☐ **Patient Family Advisory Council (PFAC):** Meet with other patients, family members and hospital staff to discuss ways to improve patient care for specific clinical areas.
(2-5 hours per month; monthly meetings held at night)

☐ **Health System Committee Member**: Help address topics such as patient education, quality-of-care, policy review and patient satisfaction.
(Times vary based on availability; 2-20 hours per month; meetings typically held during the day)

☐ **E-advisor**: Answer electronic surveys to provide feedback about UCLA Health System services.
(15 minutes per survey)

☐ **I would like to help but am not sure what would be best.**

Applicant's Signature ________________________________ **Date** ______________

Please return the completed application to:
Patient Advisory Program
UCLA Health System Patient Affairs
757 Westwood Boulevard, Suite 1107
Los Angeles, CA 90095
Or Email: UCLApatientadvisory@mednet.ucla.edu

For questions or comments, please contact Frances Watts at (310)-794-9340 or

UCLApatientadvisory@mednet.ucla.edu.

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Appendix B

Prospective Patient Advisor Interview Form

Interview Date ______________________

Potential Patient Advisor Name ______________________________

1. Tell me why you are interested in becoming a Patient Advisor.
2. In your experience, what could the organization have done to improve the quality, safety and experience of your (family members) care.
3. Please describe any previous committee experience (ie. School board, church group, etc.)
4. In your experience, what did the organization provide that was most helpful in your (family members) care experience.
5. What is the most important change you would like to see in the organization?
6. Are you comfortable speaking in front of people?
7. How will you be able to attend meetings?
8. Will the time commitment work for you and your family?

Please let us know your selection via UCLApatientadvisory@mednet.ucla.edu. Thank you!