Patient CaringTouch System: An Innovation in Patient-Centered Care

Patricia A. Patrician, PhD, RN, FAAN
Colonel, US Army (Retired)
Donna Brown Banton Endowed Professor
University of Alabama at Birmingham

Sara T. Breckenridge-Sproat, PhD, RN
Colonel, Army Nurse Corps
Regional Chief Nurse Executive
European Medical Command

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Rationale and Evolution

Patient CaringTouch System was developed to foster excellence and reduce clinical quality variance by adopting a set of internally and externally validated best practices.

1. What has worked in the Army?
   - Site visits to 3 Army Medical Centers
   - Discussions with 2 smaller Army hospitals
   - Analysis of outcomes data from Army hospitals with innovative models
   - Feedback from Campaign Planning Conference

2. What has worked outside the Army?
   - Site visits and/or interviews with Johns Hopkins, New York Presbyterian, and Cleveland Clinic
   - Discussions with VA, Navy, and Air Force
   - Interviews with key opinion leaders

3. What has evidence behind it?
   - Extensive literature review of nursing elements proven to improve patient outcomes
   - Analysis of data from the private sector

End goal: Patient CaringTouch System
PCTS facilitates transition from a “healthcare system to a system of health”

- **Focuses on the patient**, ensuring continuity of care, clear and consistent communication, and patient empowerment
- **Promotes communication and teamwork**, e.g.,
  - Nurse-to-nurse
  - Nurse-to-other providers
  - Care Team-to-patient
- **Encourages interprofessional collaboration**

“**A lot of what instills trust in Army Medicine is consistency and making the patient feel cared for and important. And PCTS does just that.**”
– Chief Nurse

“**The bedside handoff at a shift change is great. When the Care Team introduces itself, it makes a huge difference in patient satisfaction and the entire team is clear on what’s going on.**”
– Nurse Manager

“**Nurse turnover is a huge cost if you think about how much we invest in training. PCTS can reduce that turnover which is a cost savings for the Commander.**”
– Chief Nurse

- **Improves patient outcomes**, e.g.,
  - Tracks performance with nurse-sensitive metrics
  - Reduces errors with Care Teams and communication tools
  - Improves individual nursing practice with peer feedback
  - Enables nurses to improve clinical practices with nursing practice councils
  - Maintains and enhances clinical skills with regular, relevant skill building
- **Reduces the cost of care we provide**, e.g.,
  - Reduces cost of recruiting and absenteeism by improving retention and attendance
  - Reduces cost of care by reducing length of stay and costly medical errors
Patient CaringTouch System

Enhanced Communication

- Care Teams
- Peer Feedback
- Skill Building
- Optimized Performance
- Talent Management

Core Values

Patient Advocacy

- Shared Accountability
- Healthy Work Environments
- Evidence-Based Practices
- Leader Development

Centers for Nursing Science and Clinical Inquiry

Standardized Documentation

- Patient Advocacy
- Core Values
- Shared Accountability

Skill Building

- Patient Advocacy
- Care Teams
- Peer Feedback

Capability Building
PCTS is founded on ten components, and six are implemented to specific standards at the facility level.
PCTS System Level Components

- Standardized documentation – EHR
- Talent Management – Human Resources Command
- Leader Development – Required courses at specific career points (military training and nursing leadership training)
- Centers for Nursing Science and Clinical Inquiry
  - Research and EBP Centers (5)
  - Scientists (PhDs), Clinical experts (CNSs), Administrative experts (Nurse Methods Analysts)
What:
- The Army Nursing (AN) Creed is posted prominently in all areas where the nursing team works and provides care
- Incorporated into nursing staff evaluation: “I understand and commit to uphold the Army Nursing Core Values”
- Core Values introduced and celebrated as the foundation for the Patient CaringTouch System at facility and unit levels; these celebrations accomplished two goals:
  ▪ All nursing team members know what the Core Values are and how they guide their day-to-day decision making
  ▪ All nursing team members understand how Core Values, and especially the AN Creed, tie to the Patient CaringTouch System more broadly and guide, gauge, and ground our daily practice

Who:
- The Chief Nurse should drive and be prominently involved in the celebration of our Core Values to emphasize their importance to daily nursing practice and the Patient CaringTouch System
- A Core Values Champion will orchestrate the celebration of our Core Values at the facility level and support Unit Core Values Leaders in their efforts around Core Values
- Unit Core Values Leaders are responsible for Core Values efforts on their units

Structure:
- At Patient CaringTouch System launch:
  ▪ The facility and all units should hold ceremonies around the AN Creed and how it ties to the Patient CaringTouch System
  ▪ Leaders should use these ceremonies as an opportunity to celebrate and reflect on our Core Values and the kick-off of broader Patient CaringTouch System implementation
- **After Patient CaringTouch System launch:** Core Values Champions and Unit Core Values Leaders will develop plans to continuously refresh the nursing team’s focus on various Core Values
Core Values Documents

Army Nursing Team Creed

I am a member of the Army Nursing Team.

My patients depend on me and trust me to provide compassionate and proficient care always. I nurture the most helpless and vulnerable and offer courage and hope to those in despair. I protect the dignity of every individual put in my charge.

I tend to the physical and psychological wounds of our Warriors and support the health, safety, and welfare of every retired Veteran. I am an advocate for family members who support and sustain their Soldier during times of War. It is a privilege to care for each of these individuals and I will always strive to be attentive and respectful of their needs and honor their uniquely divine human spirit.

We are the Army Nursing Team.

We honor our professional practice standards and live the Soldier values. We believe strength and resiliency in difficult times is the cornerstone of Army Nursing. We embrace the diversity of our team and implicitly understand that we must maintain a unified, authentically positive culture and support each other’s physical, social, and environmental well-being. We have a collective responsibility to mentor and foster the professional growth of our newest Team members so they may mentor those who follow.

We remember those nursing professionals who came before us and honor their legacy, determination, and sacrifice. We are fundamentally committed to provide exceptional care to past, present, and future generations who bravely defend and protect our Nation.

The Army Nursing Team: Courage to Care, Courage to Connect, Courage to Change

Embrace the Past, Engage the Present, and Envision the Future

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THE ARMY VALUES

L • LOYALTY: Bear true faith and allegiance to the U.S. Constitution, the Army, your unit and other Soldiers.

D • DUTY: Fulfill your obligations.

R • RESPECT: Treat each as they should be treated.

S • SELFLESS SERVICE: Put the welfare of the nation, the Army, and your subordinates before your own.

H • HONOR: Live up to all the Army Values.

I • INTEGRITY: Do that is right, legally and morally.

P • PERSONAL COURAGE: Face fear, danger or adversity (physical or moral).
STANDARDS: Optimized Performance

- **What:** The regular collection and reporting of ten priority metrics\(^1\), as defined in the Patient CaringTouch System Optimized Performance unit dashboard, for all units in Army facilities.

- **Who:**
  - Unit Optimized Performance Leaders who are responsible for compiling unit data as per the collection methodologies defined in the dashboard and sharing with nursing team on unit.
  - Optimized Performance Champions who train Unit Optimized Performance Leaders, oversee data consistency, collect facility-level metrics, and report on facility and unit performance.
  - Facility points of contact (POCs) who are sources of necessary data (e.g., Patient Safety Manager).

- **Structure:**
  - Unit nurses collect, report, and track their performance against the ten priority metrics, using the Patient CaringTouch System Unit Dashboard instructions to ensure consistent collection and reporting.
  - Units add relevant metrics to dashboard, once ten priority metrics are established, to make the data and the component most applicable to the unit’s staff and patients.
  - Unit level data is reported at the facility, region, and corporate levels.

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\(^1\) All units / clinics will input 6 of 10 priority metrics (falls rate, falls with injury rate, pain (re)assessment rate, medication administration error rate, medication administration error with harm rate, and voluntary turnover). All other metrics will auto-populate from system interfaces. Ambulatory clinics may need to tailor metrics or data sources for collection.
## Optimized Performance Metrics

<table>
<thead>
<tr>
<th>Metrics</th>
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<tbody>
<tr>
<td>1. Falls rate</td>
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<tr>
<td>2. Falls with injury rate</td>
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<tr>
<td>3. Absentee rates</td>
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<tr>
<td>4. Total nursing care hours (TNCH) per patient day or encounter</td>
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<td>5. Nursing satisfaction / intent to leave</td>
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<td>6. Patient perception of care</td>
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<td>7. Voluntary turnover rate</td>
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<tr>
<td>8. Pain assessment and reassessment rate</td>
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<tr>
<td>9. Medication administration error rate</td>
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<td>10. Medication administration with harm rate</td>
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Care Teams standards

- **What:** Care Teams are structured on all units\(^1\) to provide quality, coordinated patient and family centered care

- **Who:**
  - A Lead RN is the primary point of contact and is responsible for the delivery of care throughout a patient’s entire length of stay on the unit
  - Additional Care Team members (covering RNs, LPNs, CNAs, Medics) complete tasks that are directed and delegated by the Lead RN, according to scope of practice / scope of competency

- **Structure:**
  - Charge Nurses assign Care Teams to each patient to facilitate continuity of care and to utilize the skills of each team member
  - Nurse Manager assumes responsibility for balancing skills and experience of nursing team members to ensure appropriate, quality care and mentorship
  - Teams identify and use communication tools to most effectively communicate patient needs (e.g., whiteboards, huddles, hourly rounds)
  - Teams utilize best practice clinical practice guidelines to deliver evidence-based care

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\(^1\) Although Care Team sizes and members will vary based on patient acuity and number of staff on a unit, all units should implement Patient CaringTouch System Care Teams (including ambulatory clinics)
Peer Feedback standards

- **What:** Peer Feedback is a process in which all licensed members of the Army Nursing team reflect on their own practice and that of their peers

- **Who:** All licensed members of the nursing team\(^1\) (RNs and LPNs) provide and receive feedback

- **Structure:**
  - Anonymous reviews are conducted at least twice yearly against the ANA Scope and Standards of Nursing Practice
  - Unit managers assign 3+ Assessors to provide feedback on each Recipient\(^2\), chosen by:
    - Frequency of exposure to the Recipient
    - Same licensure as the Recipient (e.g., RN to RN, LPN to LPN)
  - The Nurse Manager collects feedback from Assessors and shares with Recipients in a manner that ensures the anonymity of the Assessors and is timely; the Nurse Manager will support the Recipients as they reflect on their feedback and develop goals for their practice
  - Feedback will be used primarily as a tool for self-reflection and, if validated, will help inform performance evaluations
  - Annual performance ratings and plans will reflect participation in process

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\(^1\) Over time, units may choose to implement similar processes for other team members (e.g., APNs, CNLs, CNAs, Medics) or non-clinical staff

\(^2\) Number of Assessors may be smaller if units do not have enough licensed nursing staff to support or may combine peers from like-units Nurse Managers and UPCs to guide this process, as needed
**STANDARDS: Skill Building**

- **What:** Skill Building sessions are conducted at both the facility and unit level and provide opportunities for all members of the nursing team to develop and improve their nursing skills through consistent, evidence-based training.

- **Who:**
  - The Skill Building Champion is responsible for overall execution of the Skill Building component, as well as monthly Nursing Grand Rounds.
  - The Unit Skill Building Leaders are responsible for driving a consistent program of relevant Skill Building sessions on their units.
  - All members of the nursing team are responsible for identifying topics for Skill Building sessions.

- **Structure:**
  - Nursing Grand Rounds will occur monthly under the supervision of the Skill Building Champion and will be open to all nursing staff.
  - Each unit will conduct 1-2 Skill Building sessions per month, using a combination of in-services and provider talks.
  - The Unit Skill Building Leader, Unit Practice Council, and Nurse Manager will work together to develop a set of Skill Building guidelines that maximize the effectiveness of the program based on their unit’s unique characteristics.
What: Unit Practice Councils (UPCs) represent the nursing staff of units with 100% elected representatives, and they primarily address:
- Implementation of practice innovations, including clinical practice guidelines
- Professional accountability of nursing staff
- How to best implement Patient CaringTouch System components at the unit level
- Quick wins to develop momentum and energy at the unit level that will better position the unit for success

Who:
- Council is open to all nursing staff, and composition is reflective of the unit
- Council members consult constituents and gather perspectives and ideas
- Council works with other Practice Councils (e.g., Facility Nursing Practice Council; FPC), the Nurse Managers, and facility resources to address issues

Structure:
- Meets at regular, protected meeting time
- Shares due-out dates, meeting minutes, progress, and work on bulletin board and/or website with constituents and broader community on a regular basis
- Presents updates and innovations twice yearly to Facility NPC

1 Some units, such as small ambulatory units, may combined with others to form a council together
Facility NPC standards

- **What:** The Facility Nursing Practice Council (NPC) represents the nursing staff of the facility and primarily addresses:
  - Implementation of practice innovations at the facility level
  - How to best implement, monitor, and foster the Patient CaringTouch System across the facility
  - Quick wins to develop momentum and energy at the facility level and position the facility for success

- **Who:**
  - Council is elected from Unit Practice Councils (UPC) and select members of the facility leadership
  - Council membership should include significant bedside nursing staff representation
  - Council works with other facility groups (e.g., pharmacy, maintenance) to address issues
  - Constituents are represented by Facility NPC members:
    - UPC representatives consult their units and UPCs
    - Non-UPC members consult the facility constituents/leadership that they represent

- **Structure:**
  - Meets at regular, protected meeting time ~1-3 times quarterly
  - Regularly shares achievements with broader community (e.g., via bulletin board, website, emails, meeting minutes)
  - Conducts semi-annual ‘UPC Round Up’ with all UPCs presenting on five topics:
    - Quick win achievements
    - Traction on Patient CaringTouch System component implementation
    - Progress on performance metrics
    - Lessons learned
    - Goals over the next 6 months
  - Elects member(s) to Regional NPC
  - Presents updates and innovations to Regional NPC twice yearly
Inpatient Metrics

Improvements in select PCTS priority metrics across Army Medical Department (comparing 2011-2012)

**Average falls rate with harm**
Falls/thousand patient days

- Implementation 2011: [Graph]
- Sustainment 2012: [Graph]
- Decrease: -60%

**Average falls rate**
Falls/thousand patient days

- Implementation 2011: [Graph]
- Sustainment 2012: [Graph]
- Decrease: -31%

**Average medication error**
Med error /thousand patient days

- Implementation 2011: [Graph]
- Sustainment 2012: [Graph]
- Decrease: -6%

**Average medication error rate with harm**

- Implementation 2011: [Graph]
- Sustainment 2012: [Graph]
- Increase: 7%

**Average absentee rate**
Sick hours as % of total scheduled hours

- Implementation 2011: [Graph]
- Sustainment 2012: [Graph]
- Decrease: -6%

**Average voluntary turnover rate**
Voluntary separations as % of total staff

- Implementation 2011: [Graph]
- Sustainment 2012: [Graph]
- Decrease: -42%
Patient Caring Touch System

- Care Teams
- Enhanced Communication
- Patient Advocacy
- Skill Building
- Core Values
- Standardized Documentation
- Talent Management
- Shared Accountability
- Capability Building
- Evidence-Based Practices
- Leaders Development
- Optimized Performance

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