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For Additional Information:
www.planetree.org
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About Planetree
The Patient Voice

Planetree’s work to advance patient-centered care is grounded in the voices, stories and insights of patients and family members who serve as our guides in charting a course to a more patient-centered future for our industry. These voices are captured largely through focus groups facilitated by Planetree team members across the United States and internationally, in which we invite individuals with recent experiences in the healthcare system to weigh in on what went well and what could have been improved.

Patient-Preferred Practices

Over the past two decades of conducting these focus groups, consistent themes have emerged about how patients define a quality healthcare experience. These themes have informed the development of the Planetree methodology for patient-centered care implementation, the criteria for the Patient-Centered Designation Program®, and the identification of patient-preferred practices, i.e. field-tested practices that respond to how patients have expressed they want their care delivered. Among these patient-preferred practices is the care partner program.

Care partner: A family member or friend appointed by the patient who is included as a member of the care team and accepts mutually-agreed upon patient care responsibilities during and between specific episodes of care.

Rather than marginalizing family members or close friends who know the patient best and who will likely be responsible for assisting the patient with home care after discharge from the hospital, healthcare organizations with care partner programs maximize their access to these important members of the patient’s social support system. The hospitalization episode is used as an opportunity to provide education, hands-on training and support to those who will serve (and likely already have been serving) as their caregiving extensions outside of the healthcare setting.
What Patients Have to Say about the Importance of Involving Family as Members of the Care Team

From the patient and family point of view, involving family as partners in care is hardly seen as an innovation. Patients have been relying on their family as caregivers, care coordinators, patient advocates and companions/confidantes as a matter of course—regardless of whether the hospital identified their loved one formally as a care partner. However, when the hospital does support family in assuming (or more likely, continuing) these roles, it does not go unnoticed. Doing so conveys a message of partnership, and reassures patients and family members alike that not only is their care in good hands while they are in the hospital, but that they are also equipped to continue managing their care when they transition to the next care setting.

“For many patients, the trust, comfort-level and shared understanding about personal routines, health history, goals and priorities they have with family members (or others who comprise their support system) is unmatched by any professional caregiver. As a result, to not involve family members in care activities and to not include them in patient education and preparation for discharge is perceived by patients as a missed opportunity.”

“I had a double mastectomy, and it would have been nice to know that my daughters could have learned the dressing changes while they were here and before I went home. We went home and it was trial and error.”

“They showed my husband how to do my dressing changes so I don’t have to come here every day. They asked him questions: Can you see it? Do you understand? For him to see, he was very informed.”

“I was here visiting my wife and father when they were here. They showed me how to operate some of the equipment. They showed me how to adjust things because they knew I would have to do this at home. They explained things to me. I was more comfortable during her recovery experience. They passed on their knowledge; they took the time.”

“As family we’ve taken care of him for nine years...we know a lot about his care. The doctors may have degrees, but we know him better than they do.”
The Case for Care Partners

1. Care partners are good for patients. One definition of patient-centered care is providing care that is focused on the individual, in the context of family and community, rather than on the disease.\(^1\) When care is focused in this way, in consideration of the social determinants of health, healing is accelerated because the patient, supported by an informed and involved family member(s), is better equipped to effectively manage their health outside of a specific care episode. In addition, studies have linked family involvement in care with improved patient outcomes\(^2\) and improved satisfaction, communication and shared decision making.\(^3\) Finally, the experience of sites with established care partner programs bears out that patients with care partners experience reduced feelings of isolation, decreased anxiety and better rest.

2. Care partners bridge the gap between hospital and home. The transition from hospital to home can a precarious time, fraught with the potential for communication breakdowns, mismanagement of care, and lapses in carrying out necessary follow-up activities. When these transitions are poorly organized, the quality of patient care suffers.\(^4\) Care partners can be a vital link, and a source of continuity, between hospital and home. Efforts initiated during the patient’s hospital stay to build care partners’ competence and confidence in carrying out care activities at home, recognizing warning signs, and coordinating follow-up care can help to facilitate a more seamless, safe and effective transition—and potentially curtail the need for a return to the hospital.

3. Having a care partner improves patient satisfaction. Hospitals with formalized family involvement initiatives routinely report increases in patient satisfaction upon implementation of the program.\(^5-6\)

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\(^5\) Advisory Board Company, “Formalizing Family Member or Friend Role as a Care Partner.” Enhancing the Patient Experience, 2012, 104-107.
4. Care partner programs are good for family caregivers. Caring for a loved one can be a very rewarding experience that fulfills family members’ desires for a greater sense of control and purpose during a loved one’s illness. Nonetheless, managing the demands of family caregiving with other responsibilities can be enormously taxing. The emotional and physical toll this balancing act exacts on family caregivers has been well-documented. However, studies also indicate that caregiver education and support programs can help to mitigate the potentially damaging impact on family caregivers’ health and well-being.

5. Empowering family is a quality imperative. It can be extremely disenfranchising for a family caregiver who has been at the patient’s side for the duration of a health event to be “sidelined” once the patient is in the care of professionals. Feeling unsure of their role—and perhaps even fearful that patient care will be compromised if they are perceived as a “bother” to staff—a family caregiver may refrain from asserting their knowledge of the patient, acquiescing to the professional opinion of the care team. On the other hand, when family is invited into conversations with the care team, when their observations are sought out, and when they are entrusted with patient care responsibilities, it creates a powerful dynamic of empowerment and partnership that is the basis for delivering optimal care. Care partners who feel respected will speak up if they don’t understand information, or if something just doesn’t seem right, such as unexpected procedures, unfamiliar medications, or an adverse reaction.

6. The involvement of care partners humanizes care. Though most family members may not have any healthcare training, they do possess invaluable knowledge about the patient’s health history, lifestyle, and personal values. To not engage family in care planning and care activities is a risky underutilization of resources because while the patient and their family certainly don’t have all the answers for yielding the best possible health outcomes, neither do healthcare professionals. Only when these two distinct knowledge bases are considered collectively can optimal care be delivered.

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7. **Family members are activated as quality and safety monitors.**

   When it comes to quality and safety, there is no such thing as too much vigilance. Formalized family involvement initiatives contribute to a safer environment of care by enlisting care partners as our allies in safety and infection control, such as ensuring visitors are practicing proper hand hygiene. Care partners can also be educated about when and how to initiate a rapid response team should they notice any alarming change in the patient’s condition or who to notify if they have any concerns about the quality of patient care.

8. **Quality care can be delivered more efficiently.** Time invested to orient care partners and educate them to carry out mutually agreed upon care activities pays off in the long-run by reducing the amount of time professional staff are responding to requests that could be easily handled by the care partner. Anecdotal evidence from sites with established care partner programs corroborates that involving family can lead to a reduction in the number of call lights (as well as patients’ perceptions of responsiveness), the number of redundant requests for information from numerous family members (with the care partner serving as the central spokesperson managing these) and fewer adverse safety events, such as falls.

9. **It can make difficult decisions and discussions a bit easier.**

   Engaging with family in a spirit of genuine partnership promotes transparency, open communication and mutual trust. It reinforces that all parties are working toward a common aim: doing what is best for the patient. This basis of understanding is particularly important when it comes to decision making and utilization of resources during critical events. When family is engaged as partners well before discussion of these difficult topics is necessary, the conversations can be entered into with greater trust and understanding. Doing so reduces the likelihood of patient/family complaints and litigation\(^\text{16}\), and may also help to alleviate guilt-ridden feelings of family members in cases where difficult decisions must be made.

10. **Care partner programs promote holistic care delivery.** In a holistic approach to care, the full range of patients’ spiritual, emotional, physical and psychological needs are addressed. Nonetheless, our healthcare system remains primarily focused on the treatment of disease. Involving family can help narrow this divide. With greater reliance on family’s knowledge of the patient and their presence in the patient’s life outside of the hospital, we can develop more holistic care plans that address the immediate disease process AND accommodate the patient’s personal preferences and priorities. Doing so promotes health and wellness in the broadest sense.

Components of a Care Partner Program

Awareness of the opportunity to participate as a care partner and the benefits to patients and family members are proactively promoted through a variety of communication channels, including program brochures, signage, and the patient handbook. Materials about the program are provided in advance to patients with a planned admission.

With the understanding that participation is completely voluntary (to accommodate family caregivers for whom the hospitalization of their loved one is an opportunity for respite), and in collaboration with the patient and the care team, an appropriate care partner is identified. Steps are taken to clearly convey the care partner’s role to all members of the care team. Examples include a special name badge and/or wrist band designating them as a care partner and a notation on the communication board in the patient’s room.

The care partner is oriented to their role and to the environment of care, including locations of supplies and nourishment centers, hand hygiene measures, who to contact with quality or safety concerns, support services available, etc. The orientation process also includes a review of the potential ways s/he may participate in their loved one’s care.

As a collaborative exercise guided by the patient’s preferences, the care partner’s interest, skills and comfort level, and the nurses’ professional judgment, the care partner agrees to specific responsibilities s/he will assume as a member of the care team. These care partner responsibilities are documented in the care plan and shared with the entire care team.

The nurse assesses the care partner’s education/training needs based on the mutually agreed upon care activities s/he will assume, and provides any necessary education to address knowledge gaps that emerge. All education provided and competency checks are documented for the care team.

The care partner is included as a formal member of the care team. Information and education is provided as needed for the duration of the patient’s hospitalization. Special effort is made to support the care partner through the provision of meal discounts and caregiver support services. The care partner is included in ongoing dialogue about the patient’s discharge plan, with an emphasis on addressing any care partner training/education gaps during the hospitalization to facilitate a smoother transition home.

All care partners are asked to provide feedback on their experience to gauge satisfaction with the program, identify trends, and uncover opportunities for improvement. This data is reviewed in concert with patient satisfaction and other quality data to more fully assess the impact of the program.
Care Partner Program Quality Checking Tool

A policy, badges and brochures alone do not make for a quality care partner program. These programmatic elements will help to generate visibility and momentum for the program, but in the absence of staff training, an evaluation plan, and comprehensive support for family members and staff in this new paradigm of partnership, the program won’t fully live up to its potential as a potent driver of patient and family engagement.

This 13-question Quality Checking Tool was developed by Planetree to support organizations in assessing the quality of their care partner program, and to help identify opportunities for strengthening the ways you partner with family members to deliver optimal patient care.

To tabulate your rating:

- Give yourself 2 points for each “YES” statement.
- Give yourself 1 point for each “PARTIALLY IMPLEMENTED” statement

Use the scoring legend on page 10 to convert your score into a set of recommendations.
## Planetree Care Partner Quality Checking Tool

<table>
<thead>
<tr>
<th>YES</th>
<th>Partially Implemented</th>
<th>No</th>
</tr>
</thead>
</table>

A comprehensive approach for involving family members as members of the patient’s care team has been adopted throughout the organization, and has been formalized in a policy outlining how those who comprise the patient’s support system will be invited to participate in mutually-agreed upon patient care responsibilities, education and preparation for discharge.

The family involvement policy does not delineate who can participate as a care partner based on relation to the patient, relying on the patient and potential care partners to opt in to participation based on their personal relationship, ongoing contact outside of the hospital and comfort-level.

Participation in the care partner program is voluntary, with patients and potential care partners given the opportunity to opt out of participation.

Written materials are available to communicate to patients and family members what it means to be a care partner.

A process has been established for ascertaining the preferences of the care partner and patient for how the care partner will be involved in care, with allowances for preferences to evolve over time or as circumstances change.

An effective process is in place for identifying a patient’s care partner, documenting how the care partner will be involved in caring for the patient, and conveying this information to all members of the care team.

An orientation process is in place to prepare care partners for their role.

When participation in hands-on care may not be appropriate and/or necessary (for instance, on a behavioral health unit where care activities are more focused on psychodynamic therapy), care partners are informed of other ways they may participate in patient care.

Patients with a planned admission to the hospital are encouraged to identify a care partner prior to hospitalization.

Front-line staff was involved in the development of the family involvement policy, processes and the companion communication materials.

Patients and family members were involved in the development of the family involvement policy, processes and the companion communication materials.

Support services are available to care partners to help them take care of themselves while they are providing essential care and support to their loved one (examples include discounts on meals, space for respite, etc.)

A system is in place to evaluate the impact of the care partner program.

**TABULATE YOUR SCORE: 2 POINTS FOR EVERY “YES”; 1 POINT FOR EVERY “PARTIALLY IMPLEMENTED”**
<table>
<thead>
<tr>
<th>If you scored</th>
<th>Is this your current state?</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-26 points</td>
<td>Your organization has embraced the essential ways that partnering with family members can enhance the quality of patient care.</td>
<td>With your organization’s policy and practice around family involvement seemingly well-aligned, now is the time to turn your attention to fine-tuning and continuous quality improvement. If you are not already doing so, develop a process for evaluating the impact of your care partner program. Collect data on both process and outcomes measures so that you can assess the degree to which the processes outlined in the policy are being consistently carried out, as well as how execution of those processes is having an impact on quality outcomes. Inviting those who have been (or have had) care partners to participate in a focus group about their experiences will connect process improvement efforts to the voices of those the initiative is designed to benefit. Consider program adaptations to accommodate the needs of behavioral health patients as well as patients with little family support. See strategies for sustainability for additional next steps.</td>
</tr>
<tr>
<td>10-19 points</td>
<td>Foundational programmatic elements are in place for an effective Care Partner Program, but they may be implemented inconsistently or perhaps without the cultural underpinning of a true embrace of family as partners on the care team.</td>
<td>Navigating the shift from regarding family members as visitors to embracing them as partners in care takes time, but your organization is taking the necessary steps to make that transition. The development and deployment of consistent materials and processes will accelerate this transition and minimize discrepancies in how the program is rolled out unit-to-unit, shift-to-shift, and caregiver-to-caregiver. Taking steps such as developing a care partner badge and care partner agreement, adding a care partner field in the electronic medical record, and creating a write-in field on patient room communication boards for the care partner to be identified all reinforce the Care Partner Program as a common expectation for how care is delivered within your hospital. Taking these steps also reinforces to the patient, family and staff that being a care partner entitles a loved one to more than cafeteria and parking discounts, but rather establishes them as integral members of the care team. Staff buy-in is critical. To this end, offer refresher training on why involving family as partners in care is a quality imperative, and build knowledge of the “mechanics” of implementing the program into staff competency checks.</td>
</tr>
<tr>
<td>&lt; 10 points</td>
<td>Your organization is underutilizing family as advocates, care coordinators and informal caregivers, and family members are missing out on opportunities to support their loved one’s healing process.</td>
<td>Implementation of a formalized approach for involving family (however family is defined by the patient) as members of the patient’s care team should be made a priority. To start, recruit a small multidisciplinary team to lead the charge of developing a care partner program. Invite members of your patient and family partnership council to participate in these early development efforts to ensure that your research into the scientific literature and best practices are accompanied by an understanding of the lived experiences of your patients and family members. Follow the step-by-step implementation plan in this workbook to guide the work of this newly formed team.</td>
</tr>
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</table>
## Care Partner Implementation Plan

<table>
<thead>
<tr>
<th><strong>STEP 1</strong></th>
<th>Do your research.</th>
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<tbody>
<tr>
<td><strong>Care Partner Implementation Plan</strong></td>
<td>Read up on other organizations’ efforts to implement a care partner program. If you are a Planetree member, mine the sample policies, forms and communication materials available through My Planetree (myplanetree.org). Consult with your patient and family partnership council to explore patients’ and their loved ones’ interest and experience related to family involvement in care. Explore with staff their experiences, as well as what initial misgivings or concerns they may have about welcoming the involvement of family in this way. Familiarizing yourself with common or anticipated barriers to implementation will be important so that they can be proactively addressed in subsequent steps of this implementation plan.</td>
</tr>
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<tr>
<th><strong>STEP 2</strong></th>
<th>Identify physician and nursing champions.</th>
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<tbody>
<tr>
<td><strong>Care Partner Implementation Plan</strong></td>
<td>These champions serve a vital role as credible subject matter experts and meet with departments to listen and respond to concerns with the ultimate goal of moving the institution toward implementation.</td>
</tr>
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<tr>
<th><strong>STEP 3</strong></th>
<th>Form a multidisciplinary task force to lead the charge.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care Partner Implementation Plan</strong></td>
<td>Enlist representatives from nursing and the medical staff, as well as case management, home care, nutrition services, behavioral health, communications and the patient and family partnership council. This group consolidates the findings from the research conducted earlier with their own brainstorming and ideas for how to tailor a care partner initiative to the specific needs and abilities of the organization. They are charged with developing program materials for promoting the concept to patients and family members, and processes for identifying, orienting, training and documenting care partners and their activities.</td>
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<tr>
<th><strong>STEP 4</strong></th>
<th>Conduct a small scale test of change.</th>
</tr>
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<tbody>
<tr>
<td><strong>Care Partner Implementation Plan</strong></td>
<td>Identify a specific area(s) that is willing to pilot care partners for a specified period of time. It is recommended that you begin with a medical surgical unit. Before the pilot, collect baseline data from the unit, including: patient satisfaction scores, readmission rates, the number of call lights and the number of phone calls to the unit staff for patient updates. Roll out the pilot, testing the processes for identifying, orienting, training and documenting care partners and their activities. Continue collecting data on the same metrics identified above to measure the impact of the change. Round on patients and family members on this unit(s) to explore in greater depth their experiences with the program. Be sure to talk to those who participate in the program, as well as those who opted out to understand both perspectives. Meet regularly with staff on the pilot unit(s) to retool processes that are not working and to share stories of success.</td>
</tr>
<tr>
<td>STEP 5</td>
<td>Educate staff and physicians.</td>
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<tr>
<td>STEP 6</td>
<td>Establish a roll-out plan for house-wide implementation.</td>
</tr>
<tr>
<td>STEP 7</td>
<td>Refine communication materials to promote the care partner program.</td>
</tr>
<tr>
<td>STEP 8</td>
<td>Recognize champions.</td>
</tr>
<tr>
<td>STEP 9</td>
<td>Monitor and measure to hardwire the practice.</td>
</tr>
</tbody>
</table>

**Looking for more support in implementing a Care Partner Program??**

Planetree offers a range of on-site coaching and training opportunities to support your organization in implementing patient and family engagement strategies. Our Experience Advisors will partner with you to develop and implement a customized implementation plan. For more information, contact Jim Kinsey, Planetree’s Director of Member Experience, at 610-733-5140 or jkinsey@planetree.org.
Sample Care Partner Program Guidelines
(Reprinted with permission from Sharp Coronado Hospital, Coronado, California)

CARE PARTNER PROGRAM

Introduction

The Planetree Philosophy of patient-centered health care promotes personalized, respectful, and compassionate care in a healing and nurturing environment.

The Care Partner Program at Sharp Coronado Hospital supports this model in offering patients the opportunity to involve family, friends, and loved ones in their care during their hospitalization.

The goal is to minimize the change in patients experience when hospitalized from what they are used to in their own homes.

The Sharp Coronado Hospital health care team supports the belief that family and friends have an important role in the healing process. To honor our commitment we invite patients to select a family, friend, or significant other to be involved in their care as a Care Partner.

Program Benefits

Patient Benefits
- Decreases feelings of isolation, fear, and anxiety
- Creates a family environment
- Improves pain management
- Enhances sleep
- Ensures successful transition to home

Care Partner Benefits
- Increases family involvement and patient satisfaction
- Increases knowledge and decreases anxiety
The Role of the Care Partner

You are probably wondering about the benefits a Care Partner can bring to a patient. The most important role you play is to support the healing process with a familiar voice or touch. You and the patient are the decision makers in your level of involvement. Below are some ways that other Care Partners have made a difference:

- Sits with the patient
- Holds hands
- Reads
- Takes calls
- Assist patient with meals or feedings
- Help patient select meals
- Assist with personal hygiene care
- Provide ice, water, and linens
- Communication support and to let us know about questions or concerns
- Therapy assistance (physical, occupational, etc)
- Wound care and dressing changes
- Colostomy care

Care Partner Orientation

If a patient’s support person agrees to be a Care Partner, an orientation to the department and review of information will be initiated.

To communicate that a Care Partner is part of the team we have a badge to wear identifying your special role. You will receive 2 cafeteria meal tickets daily as our thanks to you. Feel free to enjoy your meal in the cafeteria, healing garden, 2nd floor great room or dine with the patient. Care Partners wearing the Care Partner Badge can obtain the meal tickets at the front desk.
CARE PARTNER INFORMATION

Patient Name______________________________________

Care Partner Name _________________________________

Relationship to Patient_______________________________

Phone Number (s)___________________________________

How I can participate as a Care Partner during the patient’s hospital stay:

(    ) Be the spokesperson for the family and friends about the patient’s progress
(    ) Sit with the patient and offer support
(    ) Assist with meals, menu selection, or feed the patient
(    ) Provide water, juices, and snacks
(    ) Obtain blankets, gowns and other linens as needed
(    ) Walk with the patient in the hall
(    ) Be available during the night
(    ) Help with baths and personal care
(    ) Record intake and output
(    ) Learn simple treatments and wound care for home care.
(    ) Be available for educational opportunities to learn about patient’s diagnosis and treatment
(    ) Other____________________________________________________________

Care Partner tour of the unit including exits and resource person given

by____________________________________ Date_____________________

Care Partner Signature___________________________ Date_______________
Example of Care Partner Documentation System

**Care Partner Note**

- **Name of Care Partner:** 
- **Relationship to Patient:** 

**Tour of unit given?**
- Yes
- No

**Tour of unit given by:**

**Level of Care Partner Participation**

- Level 1: Sits with patient, holds hands, reads, takes calls, helps with menu selection
- Level 2: Supervises pt. to commode, assists in personal care, has access to ice water and frequently needed items
- Level 3: Pt. feedings, therapy assistance, catheter care, wound care, incontinence care, discharge planning

**Comments**
Sample Care Partner Agreement

What is a Care Partner?

Managing your health can be overwhelming and people need extra support and care by your side as you travel the road to optimal well-being. Working together, the Care Partner provides an additional role in helping manage health problems and concerns.

Who is a Care Partner?

A person who helps a patient, family, or friend with health problems or concerns. Care Partners are a vital part of a patient's support team. Care Partners can build health confidence! For more information on building health confidence, please visit: www.howyouroveryhealth.org

Care Partner Agreement

Relationship to Patient:

Primary Nurse Name:

Patient Name:

Primary:

Secondary:

What are the benefits of a Care Partner Program?

- The Care Partner receives information and education on health condition.
- Care Partners develop skills to help others become more confident in managing their health problems and concerns.
- Care Partners receive a badge that allows them to provide help with scheduling and transportation.

How does a Care Partner work?

- Care Partner helps a patient with health problems or concerns.
- Care Partner helps the patient create a Care Plan.
- Care Partner helps the patient set goals and monitor progress.
- Care Partner helps the patient stay on track with medications, meals, bathing, and other care needs.
- Care Partner helps the patient understand and communicate with healthcare providers.
- Care Partner helps the patient manage health problems and concerns.

Who is a Care Partner?

Care Partners can be volunteers, family members, or patients. Care Partners are not paid. Care Partners can help make a person feel more comfortable and relaxed. Care Partners can help ease anxiety and stress.

What does a Care Partner need to do?

Care Partners have to do three things:

1. Help the patient.
2. Help the family.
3. Help the Care Partner.

Contact Us:

For more information on the Care Partner program, please contact the Care Partner program coordinator at 516-424-4242 or email: CarePartner@Planetree.org

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Working Together to Build Health Confidence

Patient: ___________________________
Care Partner: _______________________
Nurse: _____________________________

Has been reviewed and explained.

Please sign below to indicate that this care partner agreement has been reviewed and explained.

No, it will take place on: ___________________________ (am, pm)
Yes: ____________

If needed, has training been completed? ____________

Please describe any other needs or concerns:

CARE NEEDS

- Help patient move (walk, get up and down) safely
- Assistance with meals and feeding
- Help with medication
- Help with personal care (grooming, etc.)
- Connect patient with spiritual support staff in hospital
- Offer support and encouragement

EMOTIONAL SUPPORT NEEDS

- Leaves the hospital
- Discusses patient’s needs and preferences for well after he or she leaves the hospital
- Helps patient understand “My Medication List”
- Provides patient with materials to help understand his or her illness

EDUCATIONAL NEEDS

- Updates friends and family about patient’s progress
- Helps patient communicate with healthcare team (ask questions, etc.)
- Help patient manage pain
- Be aware of a set of eyes and ears, be a spokesperson for patient

HEALTHCARE NEEDS

- Nurse to make sure they are comfortable with the activity
- Assistance: Care Partners assist with these activities will be provided by a nurse to make sure they are comfortable with the activity

Thank you for participating in our Care Partner Program. Below is a list of
**Personalizing the Care Partner Experience**

Though having standardized processes and materials helps to minimize variations in how the care partner program is implemented and formalizes family involvement as a standard expectation for how care is delivered in your organization, it is important to note that no two care partner experiences will be the same. The initiative, therefore, must be developed with flexibility in mind to accommodate individual patients’ and care partners’ interests, abilities, comfort level and availability. Recognizing that the degree and scope of involvement in care of each care partner will be specific to the particular patient and care partner’s needs, the list below provides examples of the range of ways care partners can be engaged as members of the care team.

<table>
<thead>
<tr>
<th>Social Support &amp; Companionship</th>
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</thead>
<tbody>
<tr>
<td>• Offer support and encouragement</td>
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<tr>
<td>• Read books, magazines</td>
</tr>
<tr>
<td>• Assist with phone calls</td>
</tr>
<tr>
<td>• Bring in food from home, as appropriate</td>
</tr>
<tr>
<td>• Pray with the patient</td>
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<tr>
<td>• Connect patient with spiritual support</td>
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<tr>
<th>Advocacy</th>
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<tbody>
<tr>
<td>• Serve as family spokesperson to keep others updated on loved one’s progress</td>
</tr>
<tr>
<td>• Liaise with physicians for questions/updates</td>
</tr>
<tr>
<td>• Manage visitors / protect patients’ sleep</td>
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<table>
<thead>
<tr>
<th>Meeting Daily Needs</th>
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</thead>
<tbody>
<tr>
<td>• Assist with menu selection</td>
</tr>
<tr>
<td>• Assist with feeding</td>
</tr>
<tr>
<td>• Provide assistance with walking</td>
</tr>
<tr>
<td>• Escort patient on short wheelchair trips</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Personal Care/Grooming</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assist with bathing</td>
</tr>
<tr>
<td>• Provide back rubs</td>
</tr>
<tr>
<td>• Nail care</td>
</tr>
<tr>
<td>• Hair brushing/shaving</td>
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<tr>
<th>Patient Safety Monitoring</th>
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<tbody>
<tr>
<td>• Initiate a rapid response team when an alarming change of condition is noticed</td>
</tr>
<tr>
<td>• Educate visitors on proper hand hygiene</td>
</tr>
<tr>
<td>• Alert staff to any quality or safety concerns</td>
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<tr>
<th>Patient Education/Information Support</th>
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<tbody>
<tr>
<td>• Provide materials to help patient understand his/her illness/condition.</td>
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<tr>
<td>• Participate in discharge education</td>
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<tr>
<th>Patient Care Activities</th>
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<tbody>
<tr>
<td>• Assist with simple dressing changes</td>
</tr>
<tr>
<td>• Take patient’s temperature</td>
</tr>
<tr>
<td>• Monitor tube feedings</td>
</tr>
<tr>
<td>• Take blood pressure</td>
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<tr>
<td>• Flush catheter</td>
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<tr>
<td>• Monitor fluids by recording intake/output</td>
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<tr>
<th>Care Coordination</th>
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<tr>
<td>• Maintain patient’s personal medical records</td>
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<tr>
<td>• Maintain patient’s personal medication list</td>
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<tr>
<td>• Make follow-up appointments</td>
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<tr>
<th>Manage Comfort</th>
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<tr>
<td>• Assist with changing of bedding</td>
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<tr>
<td>• Adjust surroundings for patient’s comfort, e.g. adjust room temperature, get extra blankets, close blinds, etc.</td>
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<tr>
<td>• Assist with positioning</td>
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<tr>
<td>• Non-pharmaceutical pain management</td>
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<tr>
<th>Prepare for Transitions of Care</th>
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<tr>
<td>• Manage filling of prescriptions</td>
</tr>
<tr>
<td>• Accompany patient to therapies</td>
</tr>
<tr>
<td>• Arrange for transportation out of hospital</td>
</tr>
<tr>
<td>• Prepare home environment for patient’s return</td>
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<tr>
<td>• Learn skills to prepare for home care</td>
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Strategies for Sustainability

Monitoring for consistent practice is an essential component of any organization’s care partner implementation plan. Doing so thwarts off complacency and promotes consistent practice unit-to-unit, shift-to-shift, caregiver-to-caregiver. Below are some suggestions to support you in hardwiring the practice.

Develop a care partner program evaluation
Asking care partners to complete a brief evaluation of the program before the patient is discharged will provide valuable insight into how well the program is meeting care partners’ needs and identify opportunities for improvement. Sample questions to incorporate (with a 5-point response scale of 1-5, 1=strongly disagree; 5=strongly agree) include:

- I was well prepared for participation in this program.
- I was comfortable in my role.
- The education and hands-on experience were valuable to me.
- I feel better prepared for my role in the discharge process.
- My questions/concerns were taken care of in a timely manner.
- I was able to find all the supplies I needed to care for the patient.
- How would you rate the overall program? (1=poor; 5=excellent)

Regular unit huddles
Routinely schedule a huddle with all unit staff to discuss their experiences with the care partner program, both what has gone well and what has been a challenge. Review with them the findings from the program evaluations and enlist their participation in addressing any improvement opportunities that surface through the evaluation.

Leadership rounding
Have leaders inquire of staff about their experiences with implementation of the care partner program during leadership rounds. Ask about how they’ve seen the program benefit patients and families, what challenges they’ve encountered, and how including care partners as members of the care team has affected their own work flow and care delivery processes. It is important to incorporate these types of questions into leadership rounds during the initial implementation process, but it is also worthwhile for organizations with established care partner programs to use this strategy to ensure that the practice remains alive and well within the organization.
**Patient rounding**
When rounding on patients, ask them if they have a care partner, and if yes, what that experience has been like for them. If they don’t have a care partner, explore whether that is a matter of preference, inappropriateness for the specific patient, a lack of awareness that such an opportunity exists or a misunderstanding of the function of the program or why having a care partner could benefit them.

**Staff competency checks**
Incorporate content into initial and annual competency checks to keep practices around care partner identification, orientation, documentation, and training top of mind for all staff.
Additional Resources:

Planetree Patient-Preferred Practice Primer Care Partners Webinar

- Coming Soon!

Additional Patient-Preferred Practice Primers available through Planetree:

- Shared Medical Records
- Patient-Directed Visiting
- Bedside Shift Report
- Patient and Family Partnership Councils and Beyond: Solutions for Making Good on the Promise of Partnering with Patients

Patient-Centered Care Improvement Guide

- A free download available at www.patient-centeredcare.org

Long-Term Care Improvement Guide

- A free download available at www.residentcenteredcare.org

The Putting Patients First Field Guide: Global Lessons in Designing and Implementing Patient-Centered Care

- Available to purchase at the Planetree Storefront at www.planetree.org
Reputation

Planetree, Inc. is a mission based not-for-profit organization that partners with healthcare organizations around the world and across the care continuum to transform how care is delivered. Powered by focus groups with more than 50,000 patients, families, and staff, and over 35 years of experience working with healthcare organizations, Planetree is uniquely positioned to represent the patient voice and advance how professional caregivers engage with patients and families. Guided by a foundation in 10 components of patient-centered care, Planetree informs policy at a national level, aligns strategies at a system level, guides implementation of care delivery practices at an organizational level, and facilitates compassionate human interactions at a deeply personal level. Our philosophical conviction that patient-centered care is the “right thing to do” is supported by a structured process that enables sustainable change.

Approach

A very common adage asserts that where there’s a will, there’s a way. If only good intentions were enough to achieve a patient-centered healthcare system, but experience has proven time and time again that desire alone does not generate change. Planetree provides the pathway to change, a structured methodology for

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<th>Process</th>
<th>Practice Examples</th>
<th>Cultural Shift</th>
<th>Impact</th>
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| **P**ersonalize | Patient-Directed Visitation Care Partner Programs  
                         Patient-Friendly Billing  
                          Healing Environment | Accommodation of patients’ individualized needs, values and preferences | Improved patient experience  |
| **H**umanize    | Experiential staff retreats  
                         Behavioral standards  
                         Patient-Centered Process Improvement  
                         Care for the Caregiver | Inspired staff reconnected to their purpose | Superior clinical quality  |
| **D**emystify  | Shared Medical Record  
                         Same Page Transitions of Care  
                         Shared Decision Making  
                         Patient and Family Partnership Councils | Activated patients and families | Improved patient safety  
                                                                                                      Reduced costs
humanizing, personalizing and demystifying the patient experience, customized to your organization’s culture and needs. Informed by the stories and insights of patients, long-term care residents, family members and healthcare professionals, the Planetree approach guides organizations in making patient-centered care the centerpiece of a cohesive strategy that accelerates quality improvement and positions your organization to create change that will last through:

- Development of infrastructures to support change
- Implementation of patient-preferred practices
- Transformation of organizational culture.

Solutions

To achieve this, Planetree offers a range of solutions, including on-site assessments and staff development, virtual training, speaking engagements and immersion programs to steer organizations toward a patient-centered future. Fundamental to our approach is the belief that connecting staff with the purpose of their work, and educating them with new skills in a supportive, empowering environment unleashes their potential as effective change agents. Our menu of coaching, education and experiential offerings focuses on:

- Discovering the most powerful levers of change in an organization
- Activating caregivers to problem solve and create change
- Advancing these efforts in the spirit of continuous quality improvement, and
- Innovating to raise the bar for what patients, families and caregivers can expect from a patient-centered healthcare experience.

Planetree provides an unparalleled opportunity to tailor a set of solutions that will advance any organization’s culture change effort.

For more information on coaching and training available to support you in implementing a care partner program or developing your patient-centered culture, visit [www.planetree.org](http://www.planetree.org) or contact Jim Kinsey, Planetree’s Director of Member Experience, at 610-733-5140 or jkinsey@planetree.org.