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CLINICAL CONNECTION

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The Need for Disruption in Patient Flow

Recently, I had an unusual experience throughout the health care continuum that caused me considerable frustration, and I wasn't even the patient! Perhaps those of you reading this diatribe will relate to the maze that we have created for patients and families to navigate. To begin, think about the following questions and how you would answer them:

1. Have you ever had a doctor's appointment, arrived on time, and sat in the waiting room for 30 minutes or more before being summoned to a treatment room?
2. Have you had to take off of work to have your blood drawn or have a procedure completed?
3. Did you ever have a loved one admitted to the hospital, and wanted to ask a doctor a question and were told that the doctor makes rounds at 8:30 AM so you should try to be at the hospital at that time?
4. Have you ever gone to the Emergency Department (ED) because of a serious illness, spent hours laying on a gurney while the workup was completed, and the doctor said she had to admit you, but since there were no beds available, you had to stay in the ED?
5. How are you addressing patients; do you call them by their name or are they called "honey" and "sweetie"?
6. Do you thoughtfully consider who takes care of patients when making assignments or are assignments made purely by location on the unit?

Let me speculate and say that I believe that many of you have experienced at least one of the above, and your response may elicit some angst and likely feelings of disrespect.

- Who wants to wait when you are on time for an appointment?
- Should hospital services only be offered from 7 AM – 5 PM?
- Is there a way that patients and family members can reach a physician who can answer their questions?
- How do we make patients comfortable, cared for and important when an inpatient bed is not available?
- Most important, what message do we send when patient flow is not optimal?

Perhaps relaying a personal experience will resonant with you. My mother fell in her home, and since she is independent, no one is sure how long she was on the floor even though she stated that she used her Alert button five times. Once found, she was transported by ambulance to the medical center where she was ultimately admitted. No one communicated about the admission, so this writer had to find out where she was based on personal connections, but what do those who are not "connected" do? Hospitalists managed her care even though my mother asked for her primary care physician whom she had a relationship with for almost 30 years. Once again, no one provided an explanation to the patient why her primary care physician was not involved. Nursing staff were nice, yet consistently called an elderly woman "sweetie" or "honey". Perhaps this is my idiosyncrasy, but doesn't my mother

have a name? Finally, utilization review stated that my mother was cleared medically, but due to deconditioning, she needed to go to SNF Rehab.

Truly, this was the right direction. Once in Rehab, I hear more honeys and sweeties which she was fine with, yet it grated on me like nails on a chalk board. In addition, this writer observed constant use of cell phones, requests that were never fulfilled, and additional medical conditions that were never addressed even though I was hyper-vigilant about expressing concerns.

So what's my point in telling the reader my story? Well, my point is that we have a long way to go before achieving patient centric care. ***First,*** it is critical that family and friends designated by the patient be informed. ***Second,*** at no time should a patient be left out of their plan of care. If cognitively impaired, strive for maximum function as long as possible. When discussing the plan of care, engage the patient. Everyone spoke to me rather than my mother, and finally, she asked those who were discussing her plan and her discharge instructions why they weren't speaking to her! ***Third,*** over-communicate instead of "keeping patients and families in the dark." ***Fourth,*** avoid complaints by asking patients/residents and families what they need. ***Fifth,*** use a patient/resident's name by asking them what their preference is.

Sixth, have a policy regarding the use of cell phones in the work environment and enforce the policy. ***Seventh***, make thoughtful assignments and match care providers with patients. For example, assigning a male to a female patient or female to a male patient may not be acceptable to some based on culture and religious principles. ***Eighth***, assess all of your hours of operation and work processes to determine how effi-

cient and effective they are. ***Ninth,*** if patients/families have to wait, keep them informed why they have to wait; communicate, communicate, communicate. You may be busy, yet the patient is likely anxious. ***Tenth,*** comfort is important when waiting whether it be for a bed, a medication, a physician or just because. ***Finally,*** maintain the dignity of all patients. Probably a poor analogy; place yourself on that gurney or in a bed and consciously think about hospital gowns and their fit, discussions about your illness, using a bedpan or urinal while in bed, having a bed bath and on-and-on examples when we may unintentionally expose patients to anyone and everyone.

Based on my recent experience, I like many, may be desensitized to carrying out the everyday tasks that care providers do each day when caring for patients. My goal in sharing this experience is to re-sensitize all to the caring behaviors that must not be forgotten; they must become part of every day practice like brushing our teeth since patients and families expect this of us!

"They may forget your name, but they will never forget how you made them feel."

-Maya Angelou

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