

Chapter 1 : Supporting Family Caregivers in Providing Care - Patient Safety and Quality - NCBI Bookshelf

Resources for Optimal Care of the Injured Patient is intended as an instructive tool to assist surgeons and health care institutions in improving the care of injured patients.

Describes the intention of how one or more practitioners intend to deliver care for a particular patient, group or community for a period of time, possibly limited to care for a specific condition or set of conditions. Care Plans are used in many areas of healthcare with a variety of scopes. They can be as simple as a general practitioner keeping track of when their patient is next due for a tetanus immunization through to a detailed plan for an oncology patient covering diet, chemotherapy, radiation, lab work and counseling with detailed timing relationships, pre-conditions and goals. They may be used in veterinary care or clinical research to describe the care of a herd or other collection of animals. In public health, they may describe education or immunization campaigns. This resource takes an intermediate approach to complexity. It captures basic details about who is involved and what actions are intended without dealing in discrete data about dependencies and timing relationships. These can be supported where necessary using the extension mechanism. The scope of care plans may vary widely. Multi-disciplinary cross-organizational care plans; e. Decision support-generated plans following specific practice guidelines e. Self-maintained patient or care-giver authored plans identifying their goals and an integrated understanding of actions to be taken This resource can be used to represent both proposed plans for example, recommendations from a decision support engine or returned as part of a consult report as well as active plans. The nature of the plan is communicated by the status. Some systems may need to filter CarePlans to ensure that only appropriate plans are exposed via a given user interface. However, activities can also be defined using references to the various "request" resources. These references could be to resources with a status of "planned" or to an active order. It is possible for planned activities to exist e. CarePlans can be tied to specific Conditions however they can also be condition-independent and instead focused on a particular type of care e. An ImmunizationRecommendation can be interpreted as a narrow type of Care Plan dealing only with immunization events. Where such information could appear in either resource, the immunization-specific resource is preferred. CarePlans represent a specific plan instance for a particular patient or group. It is not intended to be used to define generic plans or protocols that are independent of a specific individual or group. CarePlan represents a specific intent, not a general definition. Protocols and order sets are supported through PlanDefinition.

Chapter 2 : Good Heart Failure Care Follows Patients Home

Module 6 includes information on the Care for the Caregiver component of the CANDOR process, which focuses on providing emotional support to caregivers following a CANDOR event.

The financial burden on the health care system is considerable as well: The good news is that many health care providers are successfully employing a specific set of interventions to improve CHF care for patients in the hospital and after discharge, resulting in fewer hospitalizations and readmissions. It takes a lot of coordination and leadership. While most hospitals perform many of these steps, few perform all of them reliably; doing so, says IHI, carries the most promise for producing better outcomes for patients. This is challenging enough, but Fitzgerald says there is a more fundamental challenge that must be met first. With prompts, the doctor chooses the appropriate medications – ACE inhibitor or ARB – based on the results of the left-ventricular heart function assessment. Because the flu and pneumococcal immunizations recommended for CHF patients are important preventive measures for everyone, all patients are offered these shots as part of their routine admission process. And third, we ask if they want to meet with Pulmonary Rehab to talk about smoking cessation. Discharge instructions are critically important for patients with CHF, who will be responsible for monitoring their health and working with clinicians to make appropriate adjustments in diet or even medications once they return home. But here again, Baystate saw a broader opportunity for improvement. So Baystate developed better discharge information for all patients, shared on admission. Those who lack the information, resources, or the support to manage their condition outside the hospital tend to bounce back in. And other factors can also create difficulties. Teach Back entails asking patients to repeat back in their own words what they have learned. Clinicians are trained to use this technique in a way that does not feel to the patient like a test, but rather a double-check on how well the clinician has explained things. What weight gain should you report to your doctor? What foods should you avoid? What symptoms should you report to your doctor? Currently, Bradke says the Teach Back rate of correct patient responses is greater than 80 percent. The written materials are short and clear, says Bradke. Patients are also given refrigerator magnets with information about when to call the doctor. Kaiser Permanente is piloting a program at two of its California locations that combines more intensive human support with advanced technology for home monitoring. The registry includes all Kaiser patients known to have CHF. Some patients in these pilot programs are referred to a home telemonitoring program, which involves training them on the use of a device that measures their weight, blood pressure, heart rate, and even blood glucose if they are also diabetic. The patients use the device each morning, and data is automatically transmitted by modem to a call center monitored by nurse case managers. The software sorts the data, putting first on the list any patients whose data falls outside acceptable parameters defined by their doctors. Madvig reports that this careful daily monitoring not only keeps the patient on target with medication and diet, but also serves as a training tool. Madvig says that the two Kaiser centers that have piloted this program have cut the rate of hospitalization and readmission for CHF patients to about a third of the average rate system-wide. Kaiser is currently in the process of implementing the program in all 16 of its Northern California hospitals, and other Kaiser regions are watching and learning from the Northern California experience, says Madvig, with an eye toward integrating this program into their own CHF programs as appropriate.

Chapter 3 : How the Four Principles of Health Care Ethics Improve Patient Care

As part of its goal to support a culture of patient safety and quality improvement in the Nation's health care system, the Agency for Healthcare Research and Quality (AHRQ) sponsored the development of patient safety culture assessment tools for hospitals, nursing homes, ambulatory outpatient medical offices, community pharmacies, and ambulatory surgery centers.

An interaction between a patient and healthcare providers for the purpose of providing healthcare services or assessing the health status of a patient. Amongst them are ambulatory, emergency, home health, inpatient and virtual encounters. An Encounter encompasses the lifecycle from pre-admission, the actual encounter for ambulatory encounters, and admission, stay and discharge for inpatient encounters. During the encounter the patient may move from practitioner to practitioner and location to location. Because of the broad scope of Encounter, not all elements will be relevant in all settings. The class element is used to distinguish between these settings, which will guide further validation and application of business rules. There is also substantial variance from organization to organization and between jurisdictions and countries on which business events translate to the start of a new Encounter, or what level of aggregation is used for Encounter. For example, each single visit of a practitioner during a hospitalization may lead to a new instance of Encounter, but depending on local practice and the systems involved, it may well be that this is aggregated to a single instance for a whole hospitalization. Even more aggregation may occur where jurisdictions introduce groups of Encounters for financial or other reasons. Encounters can be aggregated or grouped under other Encounters using the partOf element. See below for examples. Encounter instances may exist before the actual encounter takes place to convey pre-admission information, including using Encounters elements to reflect the planned start date or planned encounter locations. The Hospitalization component is intended to store the extended information relating to a hospitalization event. It is always expected to be the same period as the encounter itself. Where the period is different, another encounter instance should be used to capture this information as a partOf this encounter instance. The Procedure and encounter have references to each other, and these should be to different procedures; one for the procedure that was performed during the encounter stored in Procedure. This status information is often used for other things, and often an analysis of the status history is required. This could be done by scanning through all the versions of the encounter and then checking the period of each, and doing some form of post processing. There is no direct indication purely by the status field as to whether an encounter is considered "admitted". Statuses of "arrived", "triaged" or "in progress" could be considered the start of the admission, and also have the presence of the hospitalization sub-component entered. The "on leave" status may or may not be a part of the admission, for example if the patient was permitted to go home for a weekend or some other form of external event. The location is also likely to be filled in with a location status of "present". At a minimum, we do believe that a patient IS admitted when the status is in-progress. Note that in many systems outpatient encounters which are in scope for Encounter and Appointment are used concurrently. In FHIR, Appointment is used for establishing a date for the encounter, while Encounter is applicable to information about the actual Encounter, i. As such, an encounter in the "planned" status is not identical to the appointment that scheduled it, but it is the encounter prior to its actual occurrence, with the expectation that encounter will be updated as it progresses to completion. Patient arrival at a location does not necessarily mean the start of the encounter e. An appointment is normally used for the planning stage of an appointment, searching, locating an available time, then making the appointment. Once this process is completed and the appointment is about to start, then the appointment will be marked as fulfilled, and linked to the newly created encounter. This new encounter may start in an "arrived" status when they are admitted at a location of the facility, and then will move to the ward where another part-of encounter may begin. Communication resources are used for a simultaneous interaction between a practitioner and a patient where there is no direct contact. Examples include a phone message, or transmission of some correspondence documentation. There is no duration recorded for a communication resource, but it could contain sent and received times. Associated Encounter This extension should be used to reference an encounter where there is

no property that already defines this association on the resource.

Chapter 4 : Patient Experience: Meeting Patient Needs and Transforming the Care Experience

Health Care Payment Learning and Action Network February Characteristics of Primary Care Physicians in Patient-centered Medical Home Practices: United States,

Strategic Human Resource Management How the Four Principles of Health Care Ethics Improve Patient Care Whether your role is that of a doctor or a health care administrator, working in the field of health care is both highly rewarding and challenging. Many medical procedures and treatments have both merits and downsides, and patients have their own input and circumstances to consider. The four principles of health care ethics developed by Tom Beauchamp and James Childress in the Principles of Biomedical Ethics provide medical practitioners with guidelines to make decisions when they inevitably face complicated situations involving patients. The four principles of health care ethics are autonomy, beneficence, non-maleficence, and justice. The Four Principles of Health Care Ethics The basic definitions of each of the four principles of health care ethics are commonly known and used often in the English language, but they take on special meaning when being utilized in a medical setting. All of these principles play a key role in ensuring optimal patient safety and care. In medicine, autonomy refers to the right of the patient to retain control over his or her body. A health care professional can suggest or advise, but any actions that attempt to persuade or coerce the patient into making a choice are violations of this principle. This principle states that health care providers must do all they can to benefit the patient in each situation. All procedures and treatments recommended must be with the intention to do the most good for the patient. Non-maleficence is probably the best known of the four principles. The principle of justice states that there should be an element of fairness in all medical decisions: Case Study One hypothetical case study involves a patient who has an ovarian cyst that, left untreated, will result in kidney failure. An operation to remove the cyst is the best treatment, but the patient is frightened of needles and is against the surgery that would require a needle to give her anesthesia. Although the surgery is the best choice, forcing the patient to accept the needle would be harmful to her non-maleficence. So before making the final decision the doctor must consider all four principles of health care ethics, which will help the physician make the choice that will have the best possible benefits for both the patient and society. The Role of a Health Care Administrator Health care administrators plan, organize, and oversee the functions of the health care facilities at which they work, as well as the other members of the staff who work there, including doctors and nurses. Thus, they play a vital role in ensuring that patients are receiving high quality and ethical treatment. As science and technology further increase the abilities of doctors and advance the field of health care, the role of health care ethics will change and only continue to increase in importance. Thus, it is vital that health care administrators be properly trained to meet the current and future challenges of ethically helping patients receive the best care. Healthcare is changing and opportunity awaits. You may also be interested in [Learn More About](#).

Chapter 5 : Resource List | Patient-Centered Primary Care Collaborative

The quality of patient care is essentially determined by the quality of infrastructure, quality of training, competence of personnel and efficiency of operational systems. The fundamental requirement is the adoption of a system that is 'patient orientated'.

Family caregiving raises safety issues in two ways that should concern nurses in all settings. Second, family caregivers are unpaid providers who often need help to learn how to become competent, safe volunteer workers who can better protect their family members. This chapter summarizes patient safety and quality evidence from both of these perspectives. The focus is on the adult caregiver who provides care and support primarily for adults with chronic illnesses and chronic health problems. The focus is not on those with developmental disabilities. In the first section, we discuss the evidence for protecting the caregiver from harm. The second section addresses research aimed at protecting the care recipient from an ill-prepared family caregiver. Caregivers as Clients For centuries, family members have provided care and support to each other during times of illness. Who are these family caregivers, what do they do, and what harm do they face? What does the research tell us about ways to assess the needs of these hidden patients and evidence-based interventions to prevent or reduce potential injury and harm? This section answers these questions and highlights the need for nurses to proactively approach family caregivers as clients who need their support in their own right.

Description of Caregiver Population The terms family caregiver and informal caregiver refer to an unpaid family member, friend, or neighbor who provides care to an individual who has an acute or chronic condition and needs assistance to manage a variety of tasks, from bathing, dressing, and taking medications to tube feeding and ventilator care. Recent surveys estimate there are 44 million caregivers over the age of 18 years approximately one in every five adults. Those caring for someone 50 years or older are 47 years old on average and working at least part-time. About two out of three older care recipients get help from only one unpaid caregiver. Nurses have a limited view of this interaction. Caregiving can last for a short period of postacute care, especially after a hospitalization, to more than 40 years of ongoing care for a person with chronic care needs. On average, informal caregivers devote 4. More than half of family caregivers provide 8 hours of care or more every week, and one in five provides more than 40 hours per week. But those concepts do not adequately capture the complexity and stressfulness of caregiving. Supervising people with dementia and observing for early signs of problems, such as medication side effects, are serious responsibilities as family members are often unable to interpret the meaning or the urgency. Family caregivers often feel unprepared to provide care, have inadequate knowledge to deliver proper care, and receive little guidance from the formal health care providers. Due to inadequate knowledge and skill, family caregivers may be unfamiliar with the type of care they must provide or the amount of care needed. Family caregivers may not know when they need community resources, and then may not know how to access and best utilize available resources. Health professionals in emergency departments and inpatient hospital settings do not adequately determine the after-care needs of older patients when they are being discharged. Effective discharge planning is impeded by gaps in communication between the hospital and community interface, such as illegible discharge summaries and delays in sending information to the physician. Many caregivers felt abandoned at a critical time, and none of the focus group participants had been referred by any health care professional in the hospital to community-based organizations for emotional support or any other kind of support. Caregivers are hidden patients themselves, with serious adverse physical and mental health consequences from their physically and emotionally demanding work as caregivers and reduced attention to their own health and health care. Declines in physical health and premature death among caregivers in general have been reported. Elderly spouses who experience stressful caregiving demands have a 63 percent higher mortality rate than their noncaregiver age-peers. These researchers found that, with a high level of caregiving activities, the odds of the caregiver not getting rest, not having time to exercise, and actually not recuperating from illness were also high. In addition, caregivers were more likely to forget to take their prescriptions for their own chronic illnesses. Providing care poses a threat to the overall health of caregivers, which can compromise their ability

to continue to be caregivers. If caregivers are to continue to be able to provide care, relief from the distress and demands of maintaining the required care must be considered. Both highly negative and highly positive consequences of providing care may exist simultaneously. Picot and colleagues 41 , 42 worked primarily with African American caregivers and found that the rewards perceived by caregivers were more important than coping. A specific Picot Caregiver Reward Scale of 25 items exists and has been widely used to show that both rewards and costs can exist in the same care situation. Caregivers who attempt to balance caregiving with their other activities, such as work, family, and leisure, may find it difficult to focus on the positive aspects of caregiving and often experience more negative reactions, such as an increased sense of burden. They have difficulty maintaining work roles while assisting family members. Overall, financial concerns cause particular distress for caregivers during long treatment periods, 52 , 53 as resources become depleted. Higher-income families, with greater financial resources to purchase needed care, might not become as distressed or burdened as those with limited resources. The constant concern for managing disruptive behaviors such as turning on stoves, walking into the street, taking too many pills, yelling, screaming, or cursing also affects the caregivers negatively. Pain management is an intractable problem for caregivers that results in substantial caregiver distress, as caregivers assist with both nonpharmacologic and pharmacologic pain-management strategies.

Interventions for Caregivers as Clients The literature provides substantial evidence that caregivers are hidden patients in need of protection from physical and emotional harm. Interventions directed to the family caregiver should serve two purposes see Evidence Table. First, interventions can support the caregiver as client, directly reducing caregiver distress and the overall impact on their health and well-being. In this intervention approach, the caregiver is the recipient of the direct benefit and the patient benefits only secondarily. Second, interventions can be aimed to help make the caregiver become more competent and confident, providing safe and effective care to the patient, which can indirectly reduce caregiver distress by reducing their load or increasing their sense of certainty and control. In this section, we focus on the research evidence supporting caregivers as clients. Evidence Table Supporting Family Caregivers in Providing Care Despite the importance of information and support to help family caregivers, studies on interventions to increase support for family caregivers have lagged far behind those provided for patients. Few randomized clinical trials of educational interventions directed toward family caregivers have been conducted or published, and there is limited research to inform us about skills training for caregivers to prevent back injuries, infection, and other potential risks inherent in the caregiver situation.

Interventions To Reduce Burden and Distress Recent meta-analyses of caregiver interventions found mixed results, which are important to note. Multicomponent interventions, rather than single interventions like support groups or education, significantly reduced burden. Reasons for this are unclear. The effectiveness of caregiver interventions lasts approximately 7 months. Few studies are funded for long-term followup. Comprehensive counseling sessions for spouses caring for a person with dementia help reduce depression. An automated, interactive voice-response telephone support system for caregivers reduced burden for those caregivers with a lower sense of control over their situation. Home visits and enhanced social support also can help reduce caregiver depression.

Interventions To Improve Competence and Confidence Smeenk and colleagues 80 investigated the quality of life of family caregivers who received a home care intervention that consisted of a specialist nurse coordinator, a hour nurse telephone service with access to a home care team, a collaborative home care dossier and case file, and care protocols. The care dossier was used to assist with communication and coordination between caregivers and health professionals. From these reports, specific patient intervention approaches were developed. The intervention significantly improved caregiver quality of life at 1 week and 4 weeks after discharge from the hospital. Houts and colleagues 81 describe a prescriptive program that is based on research on problem-solving training and therapy. COPE teaches caregivers how to design and carry out plans that focus on medical and psychosocial problems that are coordinated with care plans of health professionals. Although proponents of this program assert it has positive outcomes for caregivers, a formal evaluation of COPE was not found.

Caregivers as Providers Twenty-five years of research have documented that the work of family caregiving can be stressful. That stress can adversely harm both the caregiver and the care recipient. This section addresses research aimed at protecting the care recipient from an ill-prepared or emotionally stressed family caregiver. It describes the

link between the work of caregiving and patient harm, and examines interventions that aim to make the caregiver a better worker and less likely to harm the patient. The Potential for Harm Caregivers can place their family members at risk in two ways, and both situations are preventable. First, despite their good intentions and hard work, if caregivers do not have the knowledge and skills to perform their work, they may unintentionally harm their loved one. This risk for injury is directly related to lack of knowledge and competence, which can be improved through caregiver education and support. For example, a recent study confirmed that patients had many negative outcomes when untrained informal caregivers managed their home enteral nutrition or tube feeding. A second concern is that the demanding work of caregiving can put caregivers at risk of engaging in harmful behaviors toward their care recipients, particularly among caregivers of persons with cognitive impairments. Caregivers who are at risk of depression while caring for spouses with significant cognitive or physical impairments are more likely to engage in neglect or abusive behaviors, such as screaming and yelling, threatening to abandon or use physical force, withholding food, hitting, or handling roughly. They also might not understand the standard for quality and might not provide the level of care that is needed. The risk of elder abuse The presence of dementia and cognitive behavioral problems put the care recipient at risk for abusive behaviors by the caregiver. Caregiver neglect may occur because the dementia patient is unable to communicate and the caregiver is unable to understand or know how to deal with nutritional intake and pain management. Mittelman and colleagues 88 , 89 found that counseling and support for caregivers who face disruptive behaviors from their ill family members will decrease their stress over their multiyear caregiving responsibility. A substantial number of community-dwelling elders do not recall receiving any instructions on taking their medications. Travis and colleagues 12 found that caregivers manage between one and 14 medications on a daily basis, have difficulty keeping so many prescriptions filled, and often miss doses due to their work schedules. Their responsibility to monitor for adverse or toxic effects in family members who are not capable of reporting problems themselves is important in preventing dehydration brought on by vomiting and diarrhea, and even more serious emergency situations. When caregivers themselves are distressed, burdened, or depressed, they might leave elders alone for long periods of time, ignore them, or fail to provide any companionship or interaction. The amount of care demands and time per week, impaired sense of own identity, clinical fluctuations in the patient, and nocturnal deterioration in the patient predict the caregiver breaking point. When there is family conflict, there is less assistance to the patient. Bourgeois and colleagues 94 looked at the consequences of disagreement between primary and secondary caregivers and found divergence in perceptions. There was, however, more agreement on patient behaviors and caregiver strain. Primary caregivers with pessimistic secondary caregivers were less distressed than those with optimistic ones. Given and Given 18 found that secondary caregivers left the care situation over time and only returned with increased physical care needs. Caregivers may also relinquish caregiving when they are unsuccessful in maintaining a relationship or when the care becomes difficult, such as when the care recipient loses cognitive function. Conflicts can also occur with unfulfilled or mismatched aid. Negative interactions with kin include despairing comments on caregiving, caregiver health status, and criticisms of care decisions. Interventions for Caregivers as Providers Interventions designed to help the caregiver become a more competent and confident provider are important to ensure that the patient receives safe and effective care. These interventions are aimed at: In these situations, interventions, such as role playing and rehearsal, are designed to help the caregiver better understand how to communicate with the care recipient and manage negative reactions, or remove the care recipient from a dangerous caregiving situation. A focus on the former may help prevent the latter. Caring for patients ranges from providing direct care, performing complex monitoring tasks e. Each type of involvement demands different skills and knowledge, organizational capacities e.

Chapter 6 : Molecular Testing and Patient Care - McKesson Medical-Surgical

Welcome to the Primary Care resources page. We have listed the most important resources related to primary care services. To search for additional documents, directives, handbooks, or other information not listed here, please visit the VHA Publications webpage.

Molecular testing products What is molecular testing? The technique is used to diagnose and monitor disease, detect risk, and decide which therapies will work best for individual patients. From a practical viewpoint, the relevance of molecular testing is nothing short of a revolution in providing lab diagnostic information for certain disease states, including infectious diseases. Speed of results tests that once took days can now be completed in hours or less and accuracy how sensitive and specific test results can be offer benefits including antibiotic stewardship and reduction of empirical antibiotic prescription. Some molecular tests can offer sensitivities that are 10 times greater¹ than legacy methods or more, and are also specific for the substance being tested. Acquisition of a good throat, wound or nasopharyngeal swab has been a concern for microbiology testing, particularly for rapid lateral flow antigen detection methods. A significant advantage of molecular testing for infectious agents is the amplification of the substance being tested for, which is inherent in molecular tests. This reduces the concerns about swab sample collection techniques and reduces the number of false negatives inherent in rapid diagnostic methods needing enough specimen to react with the antibody and generate a result. Molecular testing is a growing market Molecular testing offers significant advantages in laboratory testing by improving prospects for accurate, timely diagnosis of diseases, which has become a major reason for their adoption in infectious disease testing. Molecular tests for cancer diagnosis and treatment monitoring are the next fastest growing test segment and include new tests to guide immunotherapy decisions. The future of molecular testing: New tests, new entrants All signs point to increasing adoption of molecular tests for detection of known disease markers, including influenza and enteric pathogen detection. Even more importantly, molecular assays are creating a frontier of new tests for tumor markers and disease pre-disposition BRCA1 and BRCA2, for example that promise earlier, more accurate diagnosis, especially for cancer and inherited diseases. Emerging companies like Epigenomics are exploring new markers for colorectal, lung and other cancers. From the perspective of ease-of-use and market adoption, molecular tests are becoming easier to use, with friendly test formats and sophisticated software and hardware that brings this sophisticated technology into more and more laboratory sites. Many other tests are CLIA moderate. Suppliers are competing for increased ease-of-use, more available tests and faster turn around times, all factors that show promise for wider adoption of these tests and the opportunity for better patient care. Underpinning this legislation is the need to reduce the cost of health care, improve patient outcomes and improve patient satisfaction. There can be no doubt that increased adoption of current molecular tests and the development of exciting new tests is creating a true revolution in laboratory testing and, more importantly, in patient care. Molecular testing is driving much of the future of lab testing in key disease state detection and management.

Chapter 7 : Encounter - FHIR v

The Care Coordination Quality Measure for Primary Care (CCQM-PC) is a survey of adult patients' experiences with care coordination in primary care settings. The CCQM-PC builds on previous AHRQ work to develop a conceptual framework for care coordination and fills a gap in the care coordination measurement field.

Chapter 8 : AARP Resources for Caregivers and their Families

Self-maintained patient or care-giver authored plans identifying their goals and an integrated understanding of actions to be taken This resource can be used to represent both proposed plans (for example, recommendations from a decision support engine or returned as part of a consult report) as well as active plans.

Chapter 9 : What is the ASAM Criteria

Respondents reported taking many resource-intensive actions to reduce the impact of drug shortages on patient safety and to ensure patients receive the required treatment. Secure and maintain products. Most respondents reported actions that have significantly increased drug costs because of drug shortages.