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# CLINICAL ENGAGEMENT

*A reciprocal commitment from staff and their organization to improve patient's satisfaction*

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Remaining in the hospital when a patient no longer requires an acute care setting puts them at risk for many reasons: nosocomial infections, physical deconditioning, and decreased mental status. The longer the Length of Stay (LOS) exacerbates these results in poor clinical outcomes and dissatisfied patients and families. In hospitals we, the care providers, are overwhelmed and are often task focused, which prohibits us from not focusing on progression of care. We need to be go back to basics and put the focus back on the patient and providing quality care.

## CLINICIANS AND CARE PROVIDERS

- **Engage Earlier**
  Start engaging the patient and the family about their goals of care on the day of admission.

- **Make Care Coordination Patient Focused in Real Time**
  Assign a target Estimated Date of Discharge (EDD) on the day of admission and continue to review it daily as the patient progress through their care journey to discharge. Discharge can be to their home or transition to an alternate care setting.

- **Be Proactive**
  Discharge planning must be proactive not reactive.

- **Identify barriers and delays on a daily basis**
  Focus on patient flow daily to identify any barriers, delays or interruptions in the patient journey. These barriers should be identified and acted upon daily in real time to ensure the patient is receiving the best care, the right level of care and having progress in their care path daily. Keeping patients involved in their daily care and hospital LOS goals with improved communication and collaboration puts the patient first and will improve patient satisfaction.

## THE ORGANIZATION

- **Standardize Processes**
  Hospitals need to standardize their patient flow processes, make them visible, and communicate across the organization.

- **Encourage Collaboration**
  Embrace a culture where every member of the Multidisciplinary team is involved in the care plan of the patient which includes the discharge plan. Although many hospitals now have discharge planners, social workers, patient flow coordinators to facilitate discharge plans, it is still the responsibility of all members of the care team.

Care delivered must be a value-add to the patient. We do not want our patients sitting around wondering what is happening with their plan of care. Communication is key amongst the care delivery team and more importantly with the patient and their family. We have all heard the term happy wife happy life, for the clinicians out there happy patient happy nurse.

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