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Source	Origination Date	Last Revision
Patient Care - General	1/07	9/14
Review Dates	Approved By	
2/08, 12/11, 9/14	Peg Smith/ Julie Hoffman	

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PURPOSE

The Nursing Bundle is a model of patient care that focuses on behaviors that drive nursing quality, safety, and ensure nursing excellence for the patients we serve. Nursing excellence is achieved when a patient perceives the care to be delivered by competent and caring professionals and when the care is individualized for each patient. The Nursing Bundle consists of evidence-based practices, which are founded in clinical research and will drive improved clinical outcomes and enhanced patient and nursing satisfaction.

APPLICABILITY

Chandler Regional Medical Center

Mercy Gilbert Medical Center

POLICY

The following components of the Nursing Bundle will be done on the appropriate units:

Component	Brief Description	Units/Departments
Hourly Rounding	Staff checking on the patient on preset basis and demonstrating designated behaviors	*All inpatient Units*
Individualized Care	Staff ensuring that each patient's expectations of very good and/or excellent care are defined and every effort is mad to meet the patient's expectations. We can't always control achieving this.	*All inpatient Units*
Bedside Report.	Staff completing the shift report at ~~to~~ the bedside and including the patient.	*All inpatient Units*
Discharge Phone Calls	Discharge (D/C)phone calls are made by RN staff in the D/C Call Center. All patients are called within 2 days of discharge and ongoing calls are made to patients diagnosed with CHF and AMI up to one month post discharge	*All inpatients and ED patients*

Due to variable patient needs, status and capabilities in the ICU, adherence to all elements may vary.
Upon admission, the nurse will inform the patient of the components of the Nursing Bundle and why they are being done.

Hourly Rounding

1. Hourly Rounding protocol is determined by department and is either *hourly from 7 am – 10 pm, then every 2 hours from 10 pm – 6 am or every 2 hours, 24hours a day)*

2. The nurse assigned to the patient will be responsible for ensuring that rounding is done. At the beginning of the shift, remind the patient that you will be doing rounds.
3. The patient will be rounded on to assure that all their care needs are met. The rounds do not have to be done 60 and/or 120 minutes apart, but sometime during designated hour.
4. Opening key words should be used to reduce the patient's anxiety. Such as *"I am here to do my rounds."*
5. Perform scheduled tasks, which allows for inclusion of scheduled work in the rounding process so that everything can be accomplished in one trip.
6. Assess and address the 3 P's of pain, potty, and position. By addressing each of these proactively, call lights, patient falls, and decubiti can be reduced, and the patient's sense of comfort can be enhanced. (3 P's vary in MCH areas to meet individual needs)
7. Assess additional comfort needs for example -fluffing the pillows, straightening the sheets, filling water pitchers.
8. Conduct an environmental assessment of the room to determine if there are any needs the patient has not identified (put call light, telephone, TV control, bedside table, water pitcher within reach). Assess overall safety of the environment.
9. Use closing key words to see if the patient needs anything else. Such as, *"Is there anything else I can do for you while I am here?"*
10. Explain when the patient can expect someone to. This helps the patients begin to cluster their requests around the rounds.
11. Document the round if needed in the appropriate way. If the patient is asleep, do not wake the patient up. An environmental check must still be completed.

Individualized Care

1. At admission, the admitting nurse identifies one or two key actions from the patient's perspective that will assist in reducing the patient's anxiety.
2. The nurse documents the actions on the Care Board and explains to the patient and family how this will be used during the hospitalization.
3. At the beginning of the shift, the nurse reviews the plan of care for the shift, reviews any questions the patient has, and asks the patient what the two most important needs the patient has for that shift that if met would make them very satisfied with their care.
4. The nurse documents the plan of care for the shift, as well as the patient identified needs on the Care Board and explains to the patient and family how this will be used during the hospitalization.
5. Make sure that there is a clear differentiation between the plan of care and what is important to the patient.
6. Make sure the patient understands what is written on the Care Board. Use patient friendly language and avoid the use of abbreviations and/or medical terminology.
7. The nurse reviews the pain scale, has the patient identify the tolerable pain level, notes it on the Care Board, and when the patient can have the next pain medication, if needed.

Bedside Report

1. Patient care assignments will be ready at the beginning of the shift.
2. Oncoming nurse reviews the assignment sheet and locates off-going nurse for report.
3. Any confidential or information that cannot be shared in front of the patient communicated prior to entering the room.
4. The 2 nurses knock at door and enter.
5. The off-going nurse introduces the on-coming nurse and manages that nurse up.
6. The off-going nurse informs the patient of the bedside report for example, *"because we want to keep you informed of your condition, we are going to do change-of-shift report now."*
7. Nurse asks visitors to step out of the room, then asks the patient if they want anyone that is present to

be in the room to discuss plan of care/healthcare issues (this must be done prior to report). If the patient wants one of the visitors to be in the room the nurse will ask that person to return to the room.

8. The 2 nurses, using SBAR format, stand at the bedside and relay information regarding the patient's situation, background, assessment, and recommendations.
9. Both nurses check the supplies, IV's, monitors, equipment, and wounds as necessary.
10. Nurses ask the patient if there are any questions or if there is anything else they want discussed.
11. The off-going nurse thanks the patient.

Discharge Phone Calls

1. Initial Discharge phone calls are made within 48 hours after discharge from the D/C Call Center.
2. Phone calls are made by an RN or designee.
3. The call will focus on the patient's condition, D/C instructions, prescribed medications and follow up appointment(s).
4. The documentation regarding the call is entered into the patient's medical record.

REFERENCES

Sehgal NL, Green A, Vidyarthi AR, Blegen MA, Wachter RM. (2010)Patient whiteboards as a communication tool in the hospital setting: a survey of practices and recommendations. *J Hosp Med*.;5(4):234-9.

Laws D, Amato S. (2010) Incorporating bedside reporting into change-of-shift report. Rehabilitation Nursing: 35(2):70-4.

Weigand, Lorraine. (2013) Customer Service: The Nursing Bundle; *Journal of Emergency Nursing*: 454–5.