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# Season 2 Episode 2 Built Environment Impacts on Operations and the Patient Experience (Recorded at the ASHE Health Care Facilities Innovation Conference on July 21, 2024) —Transcript—

[“Skip to My Lou” by Neal Caine Trio plays.]

# Sponsorship

[00:00:01] **Bridget McDougall:** This episode of *Between the Lines with FGI* is brought to you by the American Society for Health Care Engineering: Optimizing health care facilities.

[Music fades out.]

# Opening

[00:00:14] **Jeff O’Neill:** You often get, does the environment reflect the care they’re getting, or does the care they’re getting reflect their opinion of the environment? And I think that’s where we think that they run hand in hand.

[“Skip to My Lou” by Neal Caine Trio plays.]

# Intro

[00:00:29] **Bridget:** Welcome to *Between the Lines with FGI*, a podcast brought to you by the Facility Guidelines Institute. In this podcast series, we invite you to listen in on casual conversations related to health and residential care design and construction. Coming to you from Washington state, where there have been more sightings of Bigfoot than in any other state is FGI’s very own John Williams, vice president of content and outreach and chair of the 2026 Health Guidelines Revision Committee. [Have] you ever seen Bigfoot, John?

[00:01:02] **John Williams:** No. I know several rather, uh, hirsute gentlemen, but none of them I would necessarily classify as a Sasquatch.

[00:01:11] **Bridget:** Can I first compliment you on using the word hirsute.

[00:01:15] **John:** It’s one of my favorite words.

[00:01:17] **Bridget:** It’s a really good one. Thank you. Hopefully, if you do see Bigfoot, you leave him alone because in one county in Washington that I read about, Skamania—another great word—there’s a 1969 law that makes it illegal to hunt Bigfoot. So, bows and arrows down, John.

[Sound of a creature growling.]

[00:01:36] **Bridget:** Oh dear. Here’s the legend himself. Hello, Bigfoot.

[00:01:40] **John:** Speaking of legends, coming to you direct from St. Louis, Missouri, is our own Bridget McDougall, associate editor with FGI. Missouri is also home to a legendary writer and humorist Samuel Clemens, also known as Mark Twain, who was born in Florida, Missouri. The name of the town is Florida, but it’s in Missouri.

[00:02:00] **Bridget:** I was going to ask, which one is it, Florida or Missouri?

[00:02:04] **John**: That’s the name of the town. Go figure.

[00:02:06] **Bridget:** I didn’t know that.

[00:02:08] **John:** We are here because we are just fascinated with the conversations that we have about the health care built environment and all the things that we do in the FGI *Guidelines* and the soon to be *FGI Facility Codes* to make them safe and supportive.

[00:02:21] **Bridget:** Today, we’re taking you back to the Health Care Facilities Innovation Conference where I had the pleasure of sitting down with Jeff O’Neill and Kathy Easter ahead of their presentation titled “Nine Hacks to Improve the Patient Experience.”

[00:02:34] **John:** And unfortunately, I was not there. I was doing a presentation of what’s new in the 2026 *FGI Facility Code* draft.

[00:02:43] **Bridget:** Yeah, and if you didn’t catch the previous episode, I highly recommend going back and listening to it. John, our own John Williams, and Leah Hummel, his copresenter go over quite a few things that are new in the draft.

[00:02:57] **John:** Kathy and Jeff did a great job doing the presentation, and the audience really responded to it, so I’m curious to hear what they have to say.

[00:03:04] **Bridget:** So, let’s travel back just a few short weeks to that conversation with Jeff and Kathy, and John, what do you say we hop on a motorcycle to go back in time?

[00:03:15] **John:** Awesome. Welcome to the world of reflection.

[00:03:19] Bridget: Put your helmet on.

[Sound of motorcycle starting and driving off]

[00:03:20] John: Here we go.

[00:03:21] Bridget: Hold on.

[00:03:24] John: Wee!

[Music fades.]

Guest introductions

[00:03:33] **Bridget:** With us today, we have Jeff O’Neill and Kathy Easter, and I’m super excited to have you in the same room. Jeff, you and I work together on *Guidelines* since you’re part of the HCRC, and Kathy, this is my first time meeting you, but together you’re both going to be presenting here at the HCFI conference. So, let us know a little bit about who you are and what you do [to] get started.

[00:03:55] **Kathy Easter:** Thank you. It’s a pleasure to meet you. I am a nurse by training, masters-prepared. I’ve been working in health care about 45 years. I’ve been at Robert Wood Johnson University Hospital in New Brunswick, New Jersey, for 41 years in a variety of roles. I started out as a staff nurse working in critical care, and the patient experience has always been near and dear to my heart.

In my current role, I serve as the assistant vice president for nursing excellence. I oversee the patient experience department, the Magnet Recognition Program, and also the volunteer department.

[Upbeat, jazzy music]

[00:04:34] **Bridget:** Just popping in to explain the Magnet Recognition Program. Magnet status has its root in a 1983 study from the American Academy of Nursing that identified qualities in a hospital that attract and maintain nursing staff. Side note: “Magnet” is not an acronym; it’s used to indicate this desired attract-and-maintain-nursing-staff quality. Today, Magnet is a designation that hospitals may earn from the American Nurses Credentialing Center, and as of July 2024, only 9.6 percent of hospitals in the U.S. have achieved this designation. There are currently 591 Magnet hospitals in the nation, as well as 17 international hospitals that include 11 countries.

[Music fades]

[00:05:21] **Kathy:** Robert Wood Johnson University Hospital is unique in that it is a Magnet-recognized organization six times; one of the original Magnet-recognized hospitals in the country and in the world, and we are currently writing our document for our seventh designation.

[00:05:37] **Bridget:** Kathy, thanks for joining us today, and Jeff, great to see you. Tell us about *your* role at Robert Wood Johnson University.

[00:05:44] **Jeff:** Bridget, thanks for having me here today. I’m vice president of facilities design and construction. My office is right below Kathy’s on the second floor. I’m an architect by training and licensure. I oversee both the capital projects, but also the operational aspects of the physical plant. So, we get into the regulatory issues, and we also get into the patient experience piece of it too, when we have to go into a room to correct the environment or do what we can to make the care environment the best we can make it.

[00:06:20] **Bridget:** I’m so looking forward to talking to you both today because the presentation that you’re doing here is “Nine Facility Hacks to Improve Patient Experience.” As we were talking about a little bit before we started recording, the *Guidelines* documents are about the built environment, and they’re not an operational document. We often have that kind of push and pull and clarity around the boundaries of our documents, so I really want to explore with you how the patient experience and the codes intersect.

[00:06:52] **Jeff:** So I’ll start by saying the “HCAHP” surveys, and Kathy can talk more about how they came to be, but they very narrowly touch on the built environment. There’s [sic] only 2 questions that really go after that.

[00:07:08] **Kathy:** During this hospital stay how often were your rooms and bathrooms kept clean? During this hospital stay how often was the area around your room quiet at night?

[00:07:24] **Bridget:** Before we get going, for those that don’t know what HCAHP is, do you mind?

[00:07:29] **Jeff:** Go ahead. What does HCAHP stand for, Kathy?

[00:07:30] **Kathy:** Yes, it’s my pleasure to explain that. It is a mouthful. So, it’s the Hospital Consumer Assessment of Healthcare Providers and Systems, “HCAHPS,” and it’s a national standardized publicly reported survey of our patient’s perspective of hospital care. There are 32 items on the survey. The surveys are submitted to the Centers for Medicare & Medicaid Services. There are eight domains, two global measures, six composite measures. The connection and why it’s important, it really impacts our reputation, but there’s also financial disincentives or incentives. If you fall below the 50th percentile, money is taken away, withheld, from CMS. If you achieve more than the 50th percentile, then you are incentivized.

[00:08:26] **Bridget:** That HCAHP score, as far as the, the questionnaire, how is that administered? Who gets it? How many folks?

[00:08:34] **Kathy:** There’s a survey sent, and right now CMS only looks at mailed paper surveys. They haven’t transitioned to electronic surveys yet, but that’s on the horizon. We can’t send the surveys; an outside vendor has to send the surveys, and annually there are about, I believe, 2.8 million surveys returned and about 7,700 surveys daily that are returned.

[00:09:05] **Bridget:** And who does it go out to?

[00:09:07] **Kathy:** Adult inpatients over the age of 18 who were discharged home.

[00:09:12] **Jeff:** And the way they track it is from the unit you were discharged from, so you can break down all that data per unit, wherever that patient was last [before] they were discharged to home. What that means is they could be reacting to something that happened in the emergency department or in the imaging department. They weren’t discharged from there, but if I had an issue in the built environment in the ED, that could influence the score of where they released.

[00:09:41] **Bridget:** So because the HCAHP scores are for patients that are 18 and over, what kind of feedback can you receive or do you receive for pediatric patients?

[00:09:51] **Kathy:** Thank you for that question. So even though the HCAHPS survey is the one that’s for patients 18 and above, we also send surveys through our vendor. There are surveys for pediatric populations, ambulatory populations, outpatient medical practices, NICU-specific surveys, etcetera, so, there are surveys virtually for every population that we serve.

[00:10:17] **Jeff:** The other part too, there’s the Press Ganey survey, where there’s comments.

[Upbeat, jazzy music]

[00:10:23] **Bridget:** You didn’t think I’d leave you possibly not knowing what Press Ganey is, did you? OK, so remember the HCAHP scores? Those measure how often a service was performed, as in “How often was the area around your room kept quiet at night?” HCAHP scores are used for public reporting. Press Ganey measures quality; how well a service was performed, and these patient comments are used internally as an improvement tool.

[Music fades]

[00:10:51] **Jeff:** And we, in the facilities department, we live in the comments section because that’s where they said, “My room is too hot,” or “My neighbor’s TV was on, it kept me up all night because they had it blaring.” So those give us the indication, “Where do I need to fix that air handler?” Or “Where do I catch that in real time?” Or “Where do I get the headphones out so they can plug them into the side of the pillow speaker so they’re not out there full volume without headphones and disturbing their neighbor?” Because we do have our share of two-bedded rooms still out there. We need the beds, as we all know. So that becomes a problem when you have that room, and even with hot and cold, the one might be hot, the other might be cold, so I kinda can’t win in that situation, but the best I could do is make it comfortable.

[00:11:38] **Bridget:** Temperature control is not something we would address in the *Guidelines*. Right? But help me see where that intersection [with the codes] is.

[00:11:45] **Jeff:** I’ll be happy to. So, to pick up on the notion of going in and making a repair because somebody is not comfortable, particularly on the HVAC system, I could not go into that room and say, “Well, you know, your room meets the code minimum.” Codes are set around the parameters on which to design. Yes, I need to keep it within that parameter, but I need to make that patient comfortable within those parameters, and if I can’t do that, that’s the extension of the code.

[00:12:14] **Bridget:** Right. You know, it’s always good to remember that when we’re talking about the FGI codes, we’re talking about minimum standards, and it goes back to that functional program to make determinations that may be above code minimum.

[00:12:27] **Jeff:** Sure. A vinyl composition tile is A-OK from a code minimum, but over time, there’s only so much I can do with that tile and keep it looking clean. We have areas where it’s been cleaned so much, it’s next to impossible to get it to look clean. So that’s when we go in and make a modification that way. Then we look to the code. What can we put in there? What can’t we put in there? I’m not gonna put shag carpet into a patient toilet room, right?

[00:12:57] **Bridget:** Oh, thank you.

[00:12:58] **Jeff:** You’re welcome. But I have my parameters. What looks good? What can I get done quickly? What do I have on hand and make it look that much better and service the patient better and what will make it easier on our environmental services.

[Jazzy 3 note interlude]

[00:13:15] **Bridget:** Another area where I can see the overlap between the code and the patient experience, I think about, you know, I just kind of go through my mind, what’s in the *Guidelines* that addresses pediatric patients? Well, we make sure that there’s space for the family to be there. We make sure that there’s sleeping space when it’s needed, that the visitor lounge is big enough to be able to handle the family that will be in with them, you know?

[00:13:38] **Jeff:** And talk about a group that needs a pleasing environment.

[00:13:40] **Bridget:** Absolutely.

[00:13:41] **Jeff:** They’re such emotional times with a youngster in the NICU.

[00:13:47] **Bridget:** All populations are responsive to their environment, right? Another one that comes to mind, patients that are looking for a crisis intervention with behavioral health and the difference between the patient experience seeking help for a behavioral mental health crisis in an emergency department with all the literal bells and whistles that come along with the emergency department, and compare that to a crisis unit of the type that Dr. Scott Zeller talks about and having that, space to treat.

[00:14:17] **Jeff:** Sure.

[Bossa nova music]

[00:14:19] **Bridget:** If you’re not familiar with behavioral health crisis units, or you want to hear more about them, I encourage you to go back to *Between the Lines* season one. In episode five, Scott Zeller talks to us all about behavioral health crisis units.

[Music fades]

[00:14:31] **Jeff:** That type of environment is so challenging. On one hand, you want it to be the safest it can be. You want it to be safe for the patient against self-harm, that’s obvious, but you also want the staff to be safe, like the nature of that patient, there’s an element of risk that’s very big that is, you know, part of the condition of the patient coming in. So where do you make that separation? That environment needs to be as calming, pleasing as possible, yet, you’re trying to deliver care to a certain patient population that has extraordinary needs within the environment. How do you set it up for the safety of everybody? So that is particularly challenging when you talk about the environment score especially if they’re discharged from that crisis center.

[00:15:21] **Bridget:** I’m really curious to know the input that both of you would have on the new chapter in the outpatient document that’s about crisis units. I would love to see your lens on the patient experience, go through that chapter and see what feels good and what gives you the heebie jeebies, you know?

[00:15:37] **Jeff:** Well, having been involved with that chapter, as that subcommittee chair there, I was trying to bring that lens into it, that, you know, what can we do that way for safety? And it was very interesting, the debate around that and where the document landed.

[00:15:55] **Bridget:** Yeah, has that been a difficult adjustment to shift your lens from so patient experience focused to the limitations that a code document gives, which is that minimum standard?

[00:16:08] **Jeff:** Well, what’s helpful to me personally is that I’m involved with the ICC model codes and have been for a long time with John Williams, so that gets you into a certain mindset of “Here are my minimums. Here’s what I’m doing to meet [them]. How do I get that in the code properly to set what I know are things we need to do in these environments” So, the ICC experience helped me when coming into the *Guidelines* that way. A little bit of a different setup in terms of the way it’s developed and debated, and [I] really enjoyed it, particularly in those behavioral health discussions, both with the group that I work with on the outpatient document and the overall topic group with behavioral health. It was interesting to come up with one thing in our outpatient [group], bring it to the topic group, and see how that got moved around a little bit. So, it’s been very rewarding that way.

[Jazzy 3-bass note interlude plays.]

[00:17:07] **Bridget:** I have a question about the functional program process. What happens in the discussions before a facility is built? Who would be good to include in the room to be an advocate for the patient side and the patient experience?

[00:17:21] **Jeff:** Well, without question, a patient experience department. We’re fortunate to have one at RWJ led by Kathy, but there’s also other avenues there, too: patient family advisory councils are really a group we look to to provide us with those insights on how best to make that patient experience. That’s a key engagement.

[00:17:45] **Kathy:** I would also say to include the frontline staff, nurses, and other health care providers, because they’re the ones who hear from our patients and families, and they can provide insight that we hear from our patients and families.

[00:18:00] **Bridget:** We interviewed Tony...

[Upbeat, jazzy music]

[00:18:03] **Bridget:** That’s Tony Ruebsam, an owner’s representative from Northstar Management Company who joined us on the podcast in season one, episode three, to talk about the functional program.

[Music fades]

[00:18:14] **Bridget:** ...and he was talking about when he designs the first thing he does is go and walk the space. He wants to be walked through to see what is this to be like for, someone who’s working there, a caregiver or a patient, you know, and what do you run into that you wouldn’t otherwise realize?

[Jazzy 3-bass note interlude plays.]

[00:18:33] **Bridget:** Are there any times that you see a code that gets in the way of providing a good patient experience?

[00:18:40] **Jeff:** You know, there’s really not, like I said, everything’s basically a minimum and we’re pretty good at hitting the minimums. The trick is to mix it all together to make it a pleasing environment for everybody. Like, you know, when you think about everything we do with the codes with fire and with fire prevention, you know, even the eight-foot corridor, that actually helps us. If I can throw on a layer of corridor clutter, which is why in the *Guidelines* we have more for storage alcoves and percentage storages, if I bring in a patient experience effort to that, that helps make it click with a unit like I come up on the floor and I point out the quarter clutter. “Here he comes again. He’s going to make us move the stuff that we need.” But if I can hold up [the survey results] saying, “Hey, your patients are saying your unit looks disorganized or it’s showing up in the environmental score,” and I get that comment that there was junk everywhere, that’s when they really snap to it, and that actually helps me enforce what we’re trying to do with the codes as well. So, in many ways, they’re supplemental to each other. We’re all in it for the same purpose. We’re all in it for the safest environment to provide the best care we can, so I think that’s where they all can converge.

[Jazzy 3-bass note interlude plays.]

[00:20:00] **Bridget:** I really enjoyed seeing the development of the new outpatient chapter for sleep disorder centers that you were a part of. In this chapter development, I watched somebody submit a proposal, and then I watched the outpatient document group of the HCRC take that proposal and work so hard to break that chapter apart and make sure that it was comprehensive. And it was very interesting to see how concerned people were with making sure that minimum standards got in that chapter, which is now a draft chapter, but got in the chapter that address the patient experience, still being in code language. So, for example, there was interest in making sure that the lighting was appropriate and that the lighting was dimmable, and I see that existing lighting in the hospital document, it talks about lighting in corridors being able to be dimmed at night, and where we have patient control of lighting or nightlights, and you don’t want to have, you know, things flipping on or off when they’re not meaning to, but it’s, that interests me to watch that in action with you guys.

[00:21:04] **Jeff:** Sure, so, I think what you were touching on there, too, is we were careful not to be too prescriptive and tell people exactly what to do because when you think about all the people that are coming with you, the nursing staff, the provider staff, the patient inputs, all those people give an input to the design, they know what works, so we want to allow room for that, but we also know when we’re setting that minimum what works and what doesn’t, and you want to keep it away from what we know just doesn’t work, but get in there that wisdom, and that’s the great part of the development process of the codes. Reaching consensus is a huge process, we know, it can be ugly, but at the end of the day, you come out with consensus, and that’s really where you appreciate what went into that minimum [code]—building that consensus on what provides for the best environment is so key.

[Jazzy 3-bass note interlude plays.]

[00:22:07] **Bridget:** Is there anything that didn’t make it into the draft that you felt particularly passionate about?

[00:22:13] **Jeff:** Uh, well, you know, having worked at facilities that have very robust behavioral health [services], knowing that there’s some minimums we should be employing, there’s some just things around protections in the outpatient environment that there’s always the public comment process, right? That we can get into that way, which is it’s out for now. What that taught me though, nothing against those opinions, is that that’s where the minimums come in. That’s where we all set and agree to, what we believe the minimum should be. Do I think there should be more minimums? Yeah. But then this process allows for that to be fully vetted out and tested, and if it, and the other big thing I learned in the ICC department, if you don’t get exactly what you want, that’s OK, you just move on, and you do what you need to do.

[00:23:01] **Bridget:** It’s one of my favorite things about witnessing the process of the *Guidelines* revision cycle is I have been on the sidelines of some very, very heated calls and discussions, and then, you know, not five minutes after that call is over, everybody’s smiling, shaking hands because everybody has the same goal in mind, you know, and the process is trusted.

[Jazzy 3-bass note interlude plays.]

[00:23:24] **Bridget:** I thought we could play just a little game called “code or no code.”

[Dramatic tympany/orchestral interlude plays.]

[00:23:30] **Bridget:** I’d love to know from you, Kathy, some of the things that, you’re going to talk about in your presentation here. And then Jeff, I’d love for you to be able to respond whether what she mentions would be a code item or not a code item and why we would or wouldn’t find something like that in the *Guidelines*.

[00:23:45] **Kathy:** One thing that that I’m going to talk about is really the stress response and what happens to our patients with the stress hormones. Those stress hormones released, um, negatively impact. The patient and the things that happen to them might make them more predisposed to a fall, for example, so we’ll talk about some of those items in, the presentation.

[00:24:09] **Bridget:** I have a code connection I’m thinking about, but Jeff, I want to hear from you first.

[00:24:13] **Jeff:** The stress response piece, nearly impossible to quantify in the code. Very subjective, but we know it when we see it. As far as the flooring example, there are the slip coefficients that we need to be mindful of that do appear in, you know, the accessibility standards referenced in the *Guidelines* and everything that way.

So that’s where we need to be careful when we are replacing that flooring, that we’re mindful of that, particularly in a patient room where falls are a particular concern. So, little bit of code in there that we have to be mindful of when we’re making selections, but boy, stress response. How do you put code around that? I’m not sure.

[00:24:55] **Bridget:** Right. Exactly so. I was thinking about, you know, the flooring, all the language we have in the *Guidelines* around flooring and how if you have a really busy pattern, some folks can have a hard time understanding where they’re going or where the steps are. I’m thinking also about aging populations, and if they don’t see contrast in colors, then a lot of times it looks like a step or not a step, so that’s interesting. OK. Another one, Kathy.

[00:25:20] **Kathy:** So, things to consider are how far can that cardiac patient walk, how far can that oncology patient walk, what reasonable accommodations do we have to make in ambulatory centers as patients are traversing the organization, not just from an inpatient setting, but from that outpatient environment? We know what we need on an inpatient setting, but what do you need for that outpatient setting, that outpatient environment, to keep our aging population safe?

[00:25:53] **Jeff:** And from a life safety perspective, that outpatient, not as heavily regulated that way as it is in the hospital setting but when you get into the surgery centers, they are regulated that way, and a lot of that stuff gets replicated. It goes beyond the code. It’s sort of what I was talking about what I felt was missing from the outpatient document, but you could always exceed the code. You could always go ahead and do what you know is right, so we wind up replicating a lot of stuff in a business occupancy. We don’t need to do it because of code, but we know our clientele wants it, so we go through, and we add it in any way.

[00:26:32] **Bridget:** Hmm. Another item, Kathy?

[00:26:35] **Kathy:** So even things like hearing, what do we respond to in the aging population? Can we hear directions as well, especially if there’s an emergency situation?

[00:26:46] **Bridget:** Where do you sniff code in there, Jeff?

[00:26:49] **Jeff:** So, it’s a great topic in terms of life safety and alarms, on one hand, because we’re dealing with the noise and frankly, an alarm fatigue. It’s not just fire alarms, it’s the alarms on the pumps, alarms on the monitors, the one coming in for the pneumatic tube. There is a very serious issue with alarm fatigue that way, so in both the life safety code and the fire code, you’re allowed what’s known as silent mode alarms. That was a direct effect of these patients can’t respond to an audible alarm like they could in a movie theater or in an office building where you’ll be expected to pick up and evacuate, so that was very much influenced by not only patient experience, but staff experience.

[00:27:37] **Kathy:** I would also say wayfinding, signage, helping the patients and families and their caregivers navigate the environment, how to get to places, how easy is it for them to navigate the environment.

[00:27:50] **Jeff:** It’s key because it starts on your phone the day before when you’re planning for your appointment or your admission. It’s imperative that what you see online actually gets manifested in the site there. I have a specific example I’m tracking now, over time, names on units change, but the signage didn’t, so when you’re trying to get to it, you can even come from the front door, get up on the floor. None of the signs match, so it’s imperative it matches what’s out there in the market.

[00:28:21] **Bridget:** We have specific codes about wayfinding, but we wouldn’t say something in the *Guidelines* about how often you need to check to make sure that your signage is current. That would be operational, an example of operational.

[00:28:34] **Jeff:** Yeah, the codes say you have to have it, but it’s up to us to make it match.

[00:28:39] **Bridget:** There’s language in the draft, the 2026 draft, I don’t know if you saw this, Jeff, about emergency department signage, what it has to say, where it has to be located, how it has to be separate from the ambulance entrance, so I’m thinking about that in response to Laura’s Law. I wonder how many times codes develop out of a patient experience, either positive or negative.

[00:29:04] **Jeff:** Well, with that specific change, and I am familiar with it, you have to make sure that people can get into the building and that you know what’s happening outside your entry. Tragic situation there in Massachusetts where, you know, they didn’t even know she was there, and she passed away. I think that incident really demonstrated that when you’re in that situation seeking care emergently, you can’t be reading complicated signs or looking for things that are written small, even in red or something. It needs to be absolutely clear where you’re going, and I think it’s a good change to know that there’s maybe get a little standard around it, so you know what to look for. The road signs out here in California read just the same way as they read on the East Coast. It’s a familiar format, so this change, I think, gets us one step closer to almost a universal way to understand where’s an emergency department.

[Jazzy 3-bass note interlude plays.]

[00:30:07] **Bridget:** As far as future code writing and these four-year revision cycles that we’re on with FGI, where do you see future need of codes that can support patient experience?

[00:30:19] **Kathy:** I would say it’s about what and it’s about how. The patient will always remember how we cared for them. They expect that we’re going to have a safe environment, but then it’s that how piece. Is the signage easier to read for them? Is it easier to get from one place to another? Is it easy for them to rest at night because we’re maintaining a quiet environment?

[00:30:46] **Bridget:** That one, right there, so important, the quiet environment. The *Guidelines* do have minimum standards around acoustic requirements, but where do those codes bump up against the patient experience?

[00:30:59] **Jeff:** So, we have those minimums, but it’s set up around if the door is closed and if I don’t have a TV blaring in the room. We were doing a renovation, this is at an institution I worked at before, where we were directly above a postpartum unit. We knew that was trouble, so we did a lot of communication. We bought stacks of baby blankets to give away as service recovery, but we also came up with quiet hours, and what we found was we had a better quietness score than other units in the hospital because it was expected because they knew what was coming. “OK, there’s the jackhammer, but I know it’s going to be done in 20 minutes,” so a nurse going into the room isn’t going to say when asked by the parent or the mom, “When is this going to end?” You don’t want her to be in the position to say, “Oh no, I don’t know. They don’t tell us anything. This really stinks. This is a nightmare. Isn’t it awful?” Instead, it was just, “Give us 20 minutes. They’re going to stop. They’re going to give us two hours for quiet time and then they’ll resume this afternoon. So maybe we’ll do something different this afternoon.” Having that knowledge with the care staff in tune with what’s going on with the construction is so key.

[“Skip to My Lou” by Neal Caine Trio plays.]

I hope I’m providing a good takeaway for folks to bring back, but I’m also hoping it’ll spur other ideas. It’s a score, but it’s also a reflection of your environment, so if it’s low, something’s going on in your environment that you need to fix. So hopefully this provides some concrete examples to help that out.

[Music continues.]

# Outro

[00:32:38] **Bridget:** Thanks for joining us for another episode of *Between the Lines with FGI*. Do you have an idea for an episode or a question that you’d like us to answer? You can get in touch with us by sending an email to podcast@fgiguidelines.org.

[00:32:52] **John:** Also, did you know that your company can sponsor one or a series of episodes? We’ll give you a shout out at the beginning and mention you on our social media. If you’re interested, you can reach out to us at podcast@fgiguidelines.org.

[00:33:07] **Bridget:** Many thanks to Neal Caine and the Neal Caine Trio for the use of his song “Skip to My Lou.” Man, I got a chance to hear Neal play live with his jazz quartet a few weeks ago, and let me tell you, if you’re in New York City, do not miss an opportunity to go hear him play. You can find him playing in various clubs when he’s not touring with Harry Connick, Jr.

[00:33:26] **John:** Oh, he’s Harry Connick Jr.’s bassist?

[00:33:29] **Bridget:** He is!

[00:33:29] **John:** Nice. All right. Well, join us next time as we go between the lines with FGI. Bye, everybody.

[00:33:35] **Bridget:** See you next time! I keep thinking we should have some kind of tagline here, like, I don’t know, every day is a winding code.

[00:33:43] **John:** Hmm. Take me home country code.

[00:33:46] **Bridget:** Hit the code, Jack.

[00:33:47] **John:** We’re on the code to nowhere.

[00:33:50] **Bridget:** Goodbye, yellow brick code.

[00:33:52] **John:** The long and winding code. I like yellow brick code. That’s good.

[00:33:55] **Bridget:** I think the code to nowhere probably hits home sometimes.

[00:33:56] **John:** Yeah, that’s nice. I like, you know, I can identify with that.

[Conversation trails off and fades out as music continues.]

[00:33:59] **Bridget:** Not the FGI code, of course. Those all go somewhere.

[00:34:01] **John:** No, no, all the...I don’t want to throw any shade. Those codes in other countries. Yeah, that’s it.

[Music continues and fades out completely at 00:34:24.]