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Implementing Relationship Based Care in an Emergency Department

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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Abstract

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MSN, University of North Carolina, Greensboro, 2001

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Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

When patients and families come to the emergency department seeking medical attention, they come in with many mixed emotions and thoughts. The fast paced, rapid turnover of patients and the chaotic atmosphere may leave patients who visit the emergency department with the perception that staff is uncaring. The purpose of this project was to implement a patient care delivery model, relationship-based care, in the emergency department. The model is comprised of several caring theories including Jean Watson's model of human care and Kristen Swanson's middle range theory of caring. The main goals of the project were to help staff enhance the patient and caregiver interaction, strengthen co-worker relationships, and gain appreciation of the importance of self-care. The intervention was an educational workshop about the relationship-based care model. Eight participants were consented, given a preassessment survey, educated about the model, and then given a postassessment survey. Prior to education, 83% of participants believed strongly that patients and families need to feel cared for during an emergency department visit; this increased to 100% posteducation. Perception about the importance of coworkers' relationships being trusting went from 38% to 50% and the importance of caring for one's self increased from 63% to 100%. It was recommended that the model be implemented in all emergency departments and all staff educated in its use as a way to promote social change through intentional focus on caring in every patient interaction.

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Dedication

This is dedicated to my mom, Annie Lawson Little, my hero. When I wanted to give up, she said, "You have come too far baby girl. What can I do to help you?" My response was always, "Just pray." She encouraged me, held my hand, and was a constant reminder for me to see my vision to improve the lives of anyone I encounter and to demonstrate caring physically, emotionally, and spiritually. Her heart for caring and loving others keeps me focused when I may desire to do otherwise. Because of you, I know that everyone has a back story and but for the grace of God, there go I. Thank you mom for showing me the love of Jesus and how to rise above any difficult trials life may bring my way. I love you so very much! Toni

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To my children, Tai, Ashley, and Robert thank you for asking me "How's school coming Mom?" on a consistent basis. I needed those reminders to push forward. Mr. Pompey, thank you for helping me make sense of the numbers. Last, but not least, my dear husband Danny. This has been a fast paced two years and now I can truly focus on our new life together. I love you dearly.

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Section 1: Overview of the Evidence-Based Project

Like any other industry, health care is a business driven by financial gains and losses. However, in contrast to other industries, the welfare and care of human beings is at stake. Just as general market consumers demand adequate service, patients expect to receive the appropriate service and quality care in health care organizations.

Problem Statement

In recent years, the main focus of hospitals and other health care organizations has been how to treat the patient using the latest and quickest technology and medicine; creating a disconnection between what the driving forces are and what matters most, the patient (Koloroutis, 2004). Nurses and other ancillary staff can be focused on completing required tasks and moving patients in and out as fast as possible. This type of nursing is especially prevalent in the emergency department (ED). The emergency department is constantly busy. The fast paced, rapid turnover of patients and the chaotic atmosphere can sometimes leave patients who visit the emergency department with the perception that staff is uncaring (Cameron et al., 2010). Because of these issues a project was developed to implement relationship-based care (RBC), a patient-centered care delivery model, in an emergency department.

Purpose Statement and Project Objectives

The purpose of this project was to plan the implementation of a new care delivery model, RBC, in a busy rural hospital's emergency department. The main goal of health care organizations is to improve the patients' health, which leads to better outcomes for

the patient and the organization. However, there is often a disconnection between how the organization wants to meet that goal and the customer or patient's expectations and perceptions of how it should be met (Koloroutis, 2004). While the organization as a whole has a goal of moving the patient through the system expeditiously, the patient often has a need and desire to feel cared for, to form a therapeutic relationship with providers, and to make connections with their caregivers (Glembocki & Dunn, 2010; Koloroutis, 2004; Mathes, 2011). Relationships with coworkers and caring for self are also key aspects to consider when providing effective nursing care to patients and their families (Felgen, 2003; Koloroutis, 2004). The objectives for implementing RBC in the emergency room were to: (a) enhance the patient and caregiver interaction, (b) strengthen coworker relationships, and (c) gain some appreciation of the importance of self-care.

Significance to Practice

More than any other area in the organization, the ED must maintain a steady flow or it will quickly become congested. Patients sometimes decide to take their business elsewhere or leave with a serious illness untreated. Patients' perception of the nurse can sometimes effect their willingness to share information or receive therapeutic interventions (Thomas et al., 2010). Ultimately, the measure of timely and cost-effective health care delivery must be met. Delivering nurturing health care in busy ED interactions can be challenging.

It is both morally and fundamentally necessary for nurses to establish connections and build relationships with (Brilowski & Wendler, 2005). Koloroutis and Trout (2012) posited that nursing is more than completing tasks and fulfilling work agendas, and that

the patients and their families invite nurses into their world to perform the important work of caring. The concept of caring must return to the patient/caregiver relationship and can be demonstrated in each patient interaction (Suliman, Welmann, Omer, & Thomas, 2009). Jean Watson's theory emphasizes the importance of the human and interpersonal connection between patients and their caregivers (Koloroutis, 2004). When caring is demonstrated, patients begin to heal. Waters (2010) also recognized the imperative for health care organizations to understand and act upon what patients perceive as caring behaviors. The central concept behind the RBC delivery model is to provide practical ways for staff to demonstrate caring in every interaction with the patient, their families, and coworkers (Koloroutis, 2004).

The five caring processes of nursing is a caring theory that uses practical ways to make interactions more caring (Jakobsen, 1998). This theory includes five caring processes that are the driving force behind the RBC care delivery model. In this proposal I suggest that integrating the principles of the RBC care delivery model in the Annie Penn emergency department would lead to an increased perception of caring behaviors from the members of the health care team and increase the patients' perception of feeling cared for during care delivery as demonstrated by the results from the Press Ganey patient satisfaction surveys.

An RBC training program was developed for the project and implemented to be used by the Annie Penn Hospital's emergency department nurses. The results of the project provided the nursing leadership with options to improve the patient experience,

team member interactions, and employee self-care within the department. Specifically, this project helped the emergency department leadership to implement RBC by:

1. Utilizing established teaching materials.
2. Developing an implementation plan.
3. Developing an evaluation plan.

Significance of Project

Many attributes of caring are described within the literature. Brilowski and Wendler (2005) cited relationship, action, attitude, acceptance, and variability as important attributes of caring. According to Finfgeld-Connett (2007), the attributes of caring include interpersonal sensitivity, personal respect, unconditional positive regard, and empathy. Establishing a relationship helps to build trust, intimacy, and empathy. The attribute of action is a constant in the work of nurses. The actionable part of caring is in doing for others what they would do for themselves if they were able (Swanson & Wojnar, 2004). Nursing actions include giving medications, bathing, feeding, or just being present.

Another vital part of caring is the attitude that nurses present during interactions with the patient and family. Attitude determines the depth of the interpersonal relationship that can be established. Nurses must be open and willing to communicate without judgment. Being willing to accept the patients is another important part of caring. The relationship cannot move forward if nurses judge patients, families, or their situations. Finally, the nurse must understand that caring is variable, not only from patient to patient, but also between coworkers and for oneself. The level of caring on

both sides of the patient-nurse relationship will change based on the nurse's level of experience and how long the relationship lasts (Brilowski & Wendler, 2005).

Implications for Social Change

Many people enter the field of nursing because they want to care for others, and they believe themselves to be caring individuals. Traditionally, the profession has been focused on completing tasks such as giving medications, changing bandages, or assisting with activities of daily living. In fact, according to Olsen (1993) as cited in Lea and Watson (1996), "the words 'caring' and 'nursing' were completely absent from the vocabulary of nurses in training and practice in at least one center in the United States between 1915 and 1937" (Lea & Watson, 1996, p. 72). However, the focus shifted with the 1995 American Nurses' Association's (ANA) social policy Statement (Koloroutis, 2004). Koloroutis (2004) noted that the ANA's social policy statement encouraged nurses to look at their profession as one dedicated to caring and healing individuals versus just completing tasks. The relationship-based care delivery model focuses on treating the whole patient, body, mind, and spirit as they work to create a caring and healing environment (Felgen, 2007; Koloroutis, 2004).

The core values of the rural hospital include providing care for the patients and their families as well as the community which it serves. There is even a focus of responsibility to the people you work with on a daily basis. Preventing illness and caring for the community has been the organization's mission for a long time and this is regardless of the patients' ability to pay for services. With the implementation of the RBC care delivery model in the ED, the social impact expected was the creation of

consistent acts and interactions that demonstrate true caring to all who may encounter the employees in the department, regardless of their socioeconomic status or cultural background. When a patient has to visit the ED it is a life marker for the individual(s), and an opportunity for pure human interaction. During those moments of interaction, there is a responsibility for health care professionals to connect with humanity when they are at their most vulnerable, less than their optimal state of health, and fearful of the unknown (Watson, 2003, 2005, & 2008).

For many patients, the ED visit may be their only interaction with the hospital. Since this interaction may be the only one with the organization, everyone who enters the ED in this rural hospital should expect and receive a quality, caring experience. Hussey (2012) acknowledge that patients have many different needs and there is no way to compare one patient's need for reassurance and comfort to that of another's. The RBC model states that all patients have the right to a caring interaction. Patients and families may not be able to readily articulate the medical diagnosis or recommendations that they received during their ED visit. However, "they do know-and it matters to them-whether someone provides them with gentle support…" (Hostutler, Taft, & Snider, 1999, p. 48). In the ED environment, it is important to maintain not only the physical side of care, but also to attend to the social and relational needs (Hostutler et al., 1999).

Definitions of Terms

Relationship Based Care (RBC) is a care delivery model that focuses on three key relationships: (a) the caregiver's relationship with patients and their families, (b) the

caregiver's relationship with colleagues, and (c) the caregiver's relationship with self. The model has seven dimensions as follows:

- Caring and healing environment is demonstrated when caregivers seek to meet the needs of the whole patient-body, mind, and spirit, while maintaining the patient's dignity.
- Leadership is recognized throughout the entire organization no matter what your job title is; anyone can be a leader. Leaders have vision and work with purpose to ensure removing barriers as needed to provide quality care.
- Teamwork speaks of healthy teams with members who have functional trust, interdisciplinary collaboration, and mutual respect.
- Professional practice means that all members of the team show compassion, especially the nurses demonstrating an understanding of human condition.
- Patient care delivery is about the way that care is delivered to patients. The RBC model supports the primary nursing model.
- Primary nursing is a way of delivery nursing care to the patient and family. There are four design elements of primary nursing:
    - Responsibility for decision-making is allocated to and accepted by to one nurse.
    - Assignments of daily care are made by case method.
    - Communication is given directly person-to-person .

  - Responsibility for the quality of care administered to patients on a unit twenty-four hours a day, seven days a week is operationally given to one designated nurse.
  - Other key elements of primary nursing are that the nurse develops a therapeutic relationship with the patient and/or family member(s). The nurse and other members of the health care team include the patient and family in the development of the patient's plan of care.
- Resource usage is driven by determining the most effective manner of distribution. The staff and leadership work together to think critically and reflect about delegation, skill mix, schedules, patient assignments, and basic common sense decisions.
- Outcome measurements look at the evidence by collecting meaningful data to consider and make improvements in patient care and interactions.
- I2E2 is a formula for leading change during the implementation of RBC within a given area. In the formula, the first "I" is for inspiration, the second "I" is for infrastructure, the first "E" is for education, and the second "E" is for evidence.
- Therapeutic relationship is one in which nurse has the responsibility, is accountable, and has the authority to work with the patient and his or her family to create a plan of care.
- Caring is defined by Kristen Swanson, nurse theorist and Dean of the University of North Carolina's nursing school, as "a nurturing way of relating to a valued

other toward whom one feels a personal sense of commitment and responsibility" (Swanson & Wojnar, 2004, p. 46).

- Leininger (2002), as cited in Suliman, Welman, Omer, and Thomas (2009), defined caring as "a universal phenomenon where perceptions of caring may vary with one's cultural background, which contributes culturally learned behaviors, actions, techniques, process, and patterns" (Suliman et al., 2009).
- Jean Watson's theory of caring expounds that, "caring is a way of being human, present, attentive, conscious, and intentional" (Suliman et al., 2009, p. 293).

The main focus of this project was to implement RBC to make caring clear and visible to patients and carers. Meeting the needs of the whole person, body, mind, and spirit is important to promote healing, and healthy work relationships (Koloroutis, 2004). According to the principles of RBC, nurses should demonstrate caring in all interactions with patients/families, with each other, and with self.

Assumptions and Limitations

Successful implementation of the RBC model relied on several assumptions. These twelve basic assumptions are the drivers for the transformational change that leads others to deliver relational, nurturing care. In her foreword, Jean Watson in Koloroutis (2004) wrote that the assumptions for the RBC model are that (a) human connection is pivotal to the essence of caring, (b) connecting with another individual helps with healing, but isolation can destroy ones spirit, (c) it does not matter where you work in an organization you can contribute to the patient's care, (d) the caregiver/patient relationship is the heart of the interaction, (e) care and understanding of self is critical (f) healthy colleague

relationships help inspire quality patient care, (g) when people are inspired and share a common goal, change occurs, and (h) transformation of the individual happens one relationship at a time.

Limitations for the implementation of the RBC model included the amount of time provided for in-servicing staff about the model and the number of staff who attended the workshop. Another limitation was that only one workshop was given with eight participants. There were only 3 hours allotted to present materials; however, a minimum of 4 hours were needed. Because of the short window of time, some materials were combined or shortened. Another limitation was that the physician groups, physician assistants, or other key team members that frequently care for the patients in the rural hospital's ED were not able to attend any of the in-service education presentation. This is significant because there is a section on the patient satisfaction survey dedicated to feedback related to physicians and other members of the health care team's interaction with the patient and/or family.

Section 2: Review of Scholarly Evidence

Specific Literature

A systematic review of the electronic databases of Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, OVID, and PUBMED was conducted using the keywords: (a) relationship-based care, (b) nurse satisfaction, (c) patient satisfaction, (d) patient-centered care, (e) patient safety, (f) retention, and (g) work environment. The literature search and other references also included books, reports, and personal communication with leaders from the Creative Health Care Management group.

Caring, quality care, and customer satisfaction are key with every patient encounter, especially in the emergency department as that is often the first interaction many patients have with a health care organization. Winman and Wikblad (2004) studied trauma patients' perceptions of caring and uncaring behaviors by nurses in an emergency department in Sweden were measured. The interactions between patients and nurses were videotaped and results showed that nurses' interactions, verbal and nonverbal, were mostly uncaring (Winman & Wikblad, 2004). Another study looking at the perception of caring by nurses in an emergency department in Iceland showed the importance of staff demonstrating caring behaviors. The staff members were taught nursing care standards based on Jean Watson's theory of caring. Caring behaviors and patient satisfaction scores increased by 6.6% after the education (Baldursdottir & Jonsdottir, 2002). In a descriptive study conducted by Hayes& Tyler-Ball (2007), 70 participants seen in a level

one trauma center were surveyed using the Caring Behaviors Inventory (CBI). The CBI is a 42-item questionnaire used to assess the patient's perception of caring by the nurses. While the study results revealed an overall positive perception of caring, there was still noted room for improvement in some areas including touching and spending time with the patient (Hayes& Tyler-Ball, 2007).

Other literature reviewed about caring and patient perceptions about caring included Finfgeld-Connett (2008), a meta-synthesis of forty-nine qualitative studies and 6 concept analyses about caring. There were key connections noted between the attitudes of caregivers, how they demonstrated caring/uncaring behaviors, and the patients' perception of caring. Andershed & Olsson (2009) conducted a systematic review of one hundred twenty studies and twenty-three analyzed where Swanson's caring theory was used. The key concepts were that nurses' attitudes are an important part in the care of vulnerable persons/families, and there is a need for further discussion related to caring, nursing, and the nursing process (Andershed & Olsson, 2009). Another study in which thirty-two cancer patients and thirty nurses were given the Caring Assessment Instrument (CARE-Q) survey, there was a difference between what actions demonstrated caring from the nurses point of view versus the patients'; implying that staff need to ask patients about the care they desire instead of providing what they belief to demonstrate caring (Widmark-Petersson, Essen, & Sjoden, 1998). Finally, a study was conducted to evaluate patients' and nurses' perception of caring in a Person-Centered Nursing (PCN) model of care. Surveys were completed by nurses and patients across 8 different wards or departments in a tertiary hospital. The study findings showed that while nurses

consistently understood (PCN) and were able to articulate it, patients' perception of the nurses' caring was inconsistent; suggesting nurses need to be more attuned to what patients consider caring (McCance, Slater, & McCormack, 2009).

General Literature

Intensive focus on increasing consumer knowledge of health care treatment options and the rising costs of health care exemplify the need to support patient-centered care (Committee on Quality Health Care in America, 2001). According to Persky, Nelson, Watson, and Bent (2008), the relationship between the patient and their caregiver is pivotal and is an integral part of the healing process. The central focus of the RBC care delivery model is demonstrating caring in every interaction. The nurse works to establish a therapeutic relationship with the patient and family, every member of the health care team seeks to understand what is most important to the patient/family, and then everyone makes every effort to meet that need in every interaction (Koloroutis, 2004). Relationship-based care is a care delivery model with seven dimensions that guide the focus of providing patients and families with caring and healing relationships. The seven dimensions are professional practice, leadership, teamwork, outcomes, care delivery, resources, and caring and healing environment (Koloroutis, 2004).

Theory/Conceptual Model

The RBC model is based on the concept of caring. The model is a culmination of theories and frameworks related to caring. Jean Watson's model of human care, Madeline Leininger's theory of cultural care diversity and universality, and Sharon

Dingman's caring model have all influenced the development of the RBC model. However, the theory that is most practical and helps nurses to put caring into action is Kristin Swanson's middle range theory of caring (Koloroutis, 2004). Swanson's theory was developed with contributions from five other theories including Jean Watson's theory of human caring, Patricia Benner's novice to expert, Florence Nightingale's environmental theory, Virginia Henderson's needs theory, and Dorothea Orem's self-deficit care theory (Swanson, 1993). The major concepts of the Swanson theory are being with, doing for, and enabling, which are three action processes. The final two concepts, maintaining belief and knowing, are internal processes (McEwen & Wills, 2011). When these concepts are applied to nursing practice, *maintaining belief* is believing that people have the capacity to make it through events, *knowing* is striving to understand the effect of the event on this person's life, *being with* is being authentically present in the moment, *doing for* means doing for others what they would do for themselves if they were able, and *enabling* means helping to facilitate the other's transition through an unfamiliar event (Koloroutis et al., 2009; & Koloroutis, 2004). For the purposes of this proposal and because of time constraints, the workshop focused on three of the five caring processes, *maintaining belief, being with, and knowing*.

The science behind the materials used for RBC implementation was based upon Peter Senge's learning principles. These principles included personal mastery, mental models, and systems thinking. In personal mastery, participants are taught to (a) reach for a vision even if it seems impossible, (b) see reality even if it makes us uncomfortable,

(c) maintain consciousness/awareness, (d) choose the results and actions that will determine our destiny, (e) authentically express who we are, (f) encourage ourselves and each other, and (g) act with courage and integrity (Koloroutis, 2010). The mental models help us to take a deeper look at the world around us, our perceptions, assumptions, and life experiences (Senge, 1990). We take in the aspects of our mental models and personal mastery into our work environment, the hospital. Hospitals are complex organizations with multiple parts and many different individuals dealing with patients and families who are often in crisis. Senge stated, "If the human body is what we eat, then our organizations become the stories we tell ourselves" (Senge, 1990, p. 90).

The materials used for the inservice included sections chosen from materials from various resources. Some included worksheets taken from the *Re-igniting the Spirit of Caring* (RSC) workbook. RSC was initially introduced to the organization in 2007 as a three-day workshop that focused on engaging, grounding, renewing, and uniting the staff from various disciplines across the organization (CHCM.com, 2013). For the purposes of the workshop, specific materials from the RSC manual were selected to help the attendees focus on options and choices and how their choices may affect others. Some of the specific worksheets used in the workshop included: the *Mind, Body, Spirit, Perception/Diversity, Choice-making: Tools for Success*, *Thriving Scale*, *Commitment to my Co-workers,* and *Way of Being*.

Other materials used for the workshops included PowerPoint presentations developed using information from several books including *Relationship-based Care: A Model for Transforming Practice, See Me as a Person: Creating Therapeutic*

Relationships with Patients and their Families, and *Radical Loving Care: Building the Healing Hospital in America.* These materials were readily available, organized and taught specifically for this group of ED nurses. The ultimate goal was to increase the participants' awareness about who they were, who they were being in the work environment, the importance of relationships, how all these pieces affect the work they did on a daily basis, and how they show up in evaluations of their caring.

Measurement of patient satisfaction in many hospitals is based on results from Press Ganey surveys. Press Ganey is company with over 25 years of experience using various survey tools to evaluate and analyze patients' perceptions of quality and caring (Press Ganey, 2012). Patients are randomly selected to receive surveys about their visit to the emergency department. The Press Ganey assessments of patient satisfaction are divided into fourteen different sections that allow the patient to rate their visit from the emergency room visit all the way through to the discharge process. The rating scale ranges from 1 to 5, where 1 is very poor, 2 is poor, 3 is fair, 4 is good, and 5 is very good. For the purposes of this project, the focus was only on the emergency department section of the survey. The Press Ganey Associates' survey included questions about the patient's experience in the emergency room. Some of the specific questions addressed with patients were: (a) nurses kept me informed, (b) nursing staff was friendly, (c) timeliness of responses to call light, and (d) the amount of wait time to see a practitioner (Press Ganey, 2012).

Press Ganey survey results have been used in some studies to assess patient

satisfaction results related to ED crowding. Tekwani, Kerem, Mistry, Sayger, and Kulstad (2013) suggest that there is a negative impact on patient satisfaction scores when the ED was crowded. Data from Press Ganey surveys completed from August 1, 2007 through March 31, 2008 by patients who had visited the ED were collected for a total of 1591 surveys, and data from the emergency department work index (EDWIN) and the hospital's diversion status were utilized (Tekwani et al, 2013). Emergency department leadership had established a mean satisfaction score of 85 as the department goal; however, the mean score was only 77.6 (Tekwani et al., 2013).

Locke, Stefano, Koster, Taylor, and Greenspan (2011) completed a study that evaluated patient/caregiver satisfaction in a pediatric emergency department. Press Ganey survey results from June to December 2009 were evaluated specifically for keeping the patient informed about delays, overall physician ratings, nurses' attention to patient needs, pain control, and the discharge callback (Locke et al., 2011). The results suggest that quality interpersonal interaction and communication between the patient and caregiver helps to achieve optimal satisfaction scores (Locke et al., 2011).

The Caring Factor Survey (CFS) is a tool used to measure the concept of caring (Nelson & Watson, 2012). The CFS tools have been used in multiple research studies nationally and internationally and has been validated as a way of measuring the perception of caring in the patient-caregiver relationship (DiNapoli, Nelson, Turkel, & Watson, 2010). In a study in Macao, China, the CFS was used to evaluate the patient's perception of nurses' caring in the hospital setting. A total of 261 patients' caregivers, a

98% response rate, participated in the study and the Cronbach's alpha was 0.87 with the Content Validity Index (CVI) of 0.86 (Nelson & Watson, 2012). The study indicated that the patients' perception of nurses was that they demonstrated satisfactory caring behaviors (Nelson & Watson, 2012).

In another study, done at Inova Health System (IHS) in Fairfax, Virginia, the CFS Care Provider Version (CFS-CPV) was used to assess the staffs' perception of self and the health care team in caring for patients (Nelson & Watson, 2012). The reliability and validity of the tool was found to be satisfactory with a "Cronbach's alpha score of at least 0.70 pre- and post-intervention with one subscale of 'Allow Miracles' at 0.83 and 0.78 respectively" (Nelson & Watson, 2012, p. 179).

Summary

Health care organizations not only strive to provide effective clinical care that is acceptable and beneficial to the patient, but they also try to ensure that quality care is delivered (Jenknison, Coulter, Bruster, Richards, & Chandola, 2002). However, in providing that quality care, true effectual caring must be demonstrated. Making caring visible is an essential element of delivering care to patients and families, and it has a direct impact on the patient's perception about the quality of care they receive. Glembocki and Dunn (2010), noted that the framework of the RBC model contains both the philosophical foundation and practical infrastructure that can be utilized throughout an organization as a way to transform how patients and their families are cared for and to improve services that are provided during that stay. Meaningful changes such as focusing on building a therapeutic relationship with the patient can make a difference in

the patient's perception of feeling truly cared for with every interaction. Section 3 of the paper will provide an overview of the project design and methods.

Section 3: Approach and Project Design/Methods

Project Development

The RBC program has been in existence for over 30 years and is a product of Creative Health Care Management, Incorporated in 2007 (CHCM.com, 2013). Although the RBC model for caring was readily implemented on the inpatient departments, there was no push to implement it in the emergency department areas. However, as patient satisfaction scores gradually improved in most of the inpatient areas, the emergency departments continued to see a decrease in patient satisfaction numbers. Some reporting scores as low as the single digits.

Historically, the study ED's patient satisfaction scores have ranked in the 80th percentile when compared nationally to other hospital emergency departments of comparable size (D. Green, personal communication, August 6, 2012). Since the recent implementation of an electronic medical record system, the Electronic Privacy Information Center (EPIC), patient satisfaction scores have plummeted to the 20th percentile (D. Green, personal communication, August, 6, 2012).

Working with the ED's nursing leadership team as part of the DNP internship, the DNP student was invited to develop an in service education program and a plan for implementation of the RBC care delivery model. Carrying out the project and the outcomes was dependent on those involved. The steps completed during the project were as follows:

1. Assembled an interdisciplinary project team
2. Lead the project team in reviewing relevant literature

3. Defined project goals and objectives
4. Developed the educational program
5. Validated the content/delivery of project
6. Developed the implementation plan
7. Developed the evaluation plan
8. Presented the educational materials and the implementation plan to the ED interdisciplinary team

Steps 1 through 3 were completed during the DNP clinical internship. The interdisciplinary team for the RBC project consists of various members of the health care team. The members of the emergency department leadership include the ED department director, assistant director, and the registered nurse level four (RN 4). The patient advocates (one worked the day shift and was a nutritional services worker, while the other worked the evening shift and was a health care technician), the vice president of nursing, a physician assistant (PA), and the project leader. Other members invited to be a part of the team included the department director for the two main nursing departments in the facility because of the high volume of patients received from the ED and representatives from the radiology and lab departments. The campus president, who was very engaged and focused on patient satisfaction, was an ad hoc member of the team.

A systematic review of the electronic databases of the Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, OVID, and PUBMED was conducted as detailed in Section 2 of the paper. The interdisciplinary team determined

that the project should look at patient and staff satisfaction scores before and after the implementation of the new care delivery model, relationship-based care, in the emergency department at the study hospital. The goal was an improved perception of caring by patients and members in the health care team after implementation of the RBC model. Objectives related to the project included an increase in patient satisfaction scores as noted by Press Ganey monthly results, an increase in staff satisfaction and colleagueship, and verbalization of an increase in self-awareness and self-care.

Steps 4 through 8 were completed for the DNP project.

The Implementation Plan

The original version of the RBC program involved staff attending a series of classes that include: shared governance education (8-hours), *Re-igniting the Spirit of Caring* (32-hours), RBC introduction (4-hours), *Responsibility/Authority/Accountability* (RAA) (4-hours), and a series of *Get Smart* sessions, which can range from (12-24 hours). Due to time and cost constraints, the program was be streamlined to be delivered in twelve workshops that consisted of education about the RBC model's 7 dimensions related to caring for patients, colleagues, and self (Felgen, 2007). While all 7 of the dimensions were presented briefly, only 2 dimensions of the model were addressed in detail, teamwork and caring and healing environment. There was only 1 workshop and total education time lasted 3 hours plus there were 15 minutes allotted at the beginning and end of the workshop for completion of a pre and post assessment. Prior to the need to implement fiscal constraints and budget cuts, the nursing leadership team had agreed to

make the workshops mandatory for all of the staff in the emergency department and to have a total of twelve workshops.

Implementing Relationship Based Care (RBC) in the emergency department involved four key steps:

1. Reviewed workshop format, tools, and expected outcomes
2. Observed and coached
3. Provided review and support
4. Discussed implications with leadership

First, there was a meeting with the leadership and project team members and any key stakeholders in the emergency department. During this meeting, the materials for the workshops were reviewed. The expected outcomes were reviewed to ensure that tools were in place for proper data collection. Once the participants had attended the workshop, the project leader observed and coached staff once during various interactions with ED patients. Thirdly, the nursing survey and Press Ganey results were not reviewed with the leadership team because of time and budget constraints. Press Ganey data results that include the period of time after the workshop was presented have yet to be collected by the Press Ganey Associates, Incorporated. The pending results will be sent to the study hospital's Patient Experience Department and reviewed mid-late December 2014. S. Rabbani, Patient Experience and Data Manager, organizes the data by campus and department specific results and then places the information into folders on the company's Intranet.

The nursing staff survey, included statements related to perception of teamwork, perception about the care they provide to patients/families in the ED, and self-care, data was collected prior to the presentation of workshop and again immediately after completion of the workshop about the RBC program. The staff survey is a series of 14 statements taken from the Caring Factor Survey (CFS) series (Nelson & Watson, 2012).

Support will be given for low scores including additional workshops or periodic review of materials in departmental meetings, and assistance with action plans to help improve patient satisfaction as needed. Finally, follow up with leadership, stakeholders, and any other designees will be necessary to ensure project success.

Development of Evaluation Plan

Choosing the appropriate evaluation plan of any program was important. The evaluation plan will assist the team in determining the effectiveness of the program's workshops, tools, and interventions. However, it is salient to consider that despite the best efforts of the team the outcomes may not be favorable. White and Dudley-Brown (2012) noted negative outcomes may happen even when proper steps are followed and positive outcomes may happen when improper steps are followed.

According to Grol, Hulscher, and Laurant (2003), process evaluation is either used to: (a) "describe the quality improvement intervention, (b) explore actual exposure to the intervention, or (c) describe the experience of those exposed (the participants)" (White & Dudley-Brown, 2012, p. 237). Process evaluation was the most appropriate form of evaluation for the implementation of RBC in the emergency department program. Process evaluation involves assessment of "fidelity, completeness of program delivery,

continued use of the program, participant satisfaction, and environmental monitoring" (Hodges & Videto, 2011, p. 208). Using this evaluation method will allow the project team to evaluate the effectiveness of the workshop on a continuous basis. On-going assessment enables the team to review effects of the project on the target population, assess barriers, make adjustments as needed, and possibly have an impact on the outcomes immediately (Hodges & Videto, 2011).

Summary

Patients who present to the ED with illness and/or injury are in a vulnerable state. They trust the nurses and other staff to be competent, and to demonstrate caring during their interactions with them. Another very important aspect of the patients' care is the relationships between team members. They must support each other during difficult situations and crises. However, neither of the previously mentioned relationships will be productive and healthy if the individual does not practice good self-care. Implementing the RBC model in the emergency department was expected to lead to improved patient satisfaction, employee satisfaction, and an increased awareness of self.

Section 4: Findings and Discussion

I posit that nurses who work in the emergency department and practice using relationship-based caring during their interactions with patients and each other will demonstrate visible caring behaviors. The patients and coworkers will perceive the individual's behaviors as caring.

Sample and Data Collection

A small group of emergency academy nurses who worked in various departments across a large multi-campus health system participated in the project. One workshop was presented on September 15, 2014, in the Nursing Education Center on one of the study hospital's campuses. There were a total of 8 participants, all of whom have been registered nurses for at least 1year to thirty plus years. All participants worked in 1 of 4 EDs with the exception of one nurse who had system-wide responsibilities.

Data were collected via a preassessment tool at the beginning of the workshop prior to education about the RBC model. Immediately after the workshop was completed a postassessment tool was given. Participation was voluntary and confidentiality was guaranteed.

Findings

Table 1 shows the results of the pre education responses and Table 2 shows the post education responses (see Appendix 1 for the survey). It is notable that 83% of the participants strongly agreed that patients and families needed to feel cared for during a visit to the emergency department prior to education about the RBC care delivery model and 100% agreed post education. Thirty-eight percent of the participants strongly agreed

and 50% agreed that they provided care and demonstrated loving kindness towards patients before the education and 75% of participants strongly agreed after the education. Yet, 75% responded with strong agreement, on both pre and post assessments, that they work to meet physical and emotional needs of patients. Providing a caring and healing environment as well as building a therapeutic relationship, are significant components of the RBC model. *Maintaining belief* for patients, one of the five caring processes shared with participants, increased from 63% to 75% of participants who strongly agreed that this concept was important while 13% neither agreed nor disagreed.

Another dimension of the RBC model addressed teamwork and colleagueship. It is extremely difficult to deliver quality, compassionate care without the support of a cohesive team. Statements 2 to 5 and 8 speak specifically to this aspect of the work environment. Responses varied with 50% to 88% of participants in agreement that they maintain dignity, respect, and the best intentions with colleagues and work well together solving problems in a creative manner prior to education about the model. However, only 38% of the participants believed that they had trusting relationships with co-workers. On post assessment, the numbers changed with 50% strongly agreeing, 38% agreeing, and 13% neither agreeing nor disagreeing regarding trusting colleague relationships.

Another very important relationship for implementing the RBC model successfully is taking care of self. While participants seemed to understand the significance of taking care of one's self prior to the workshop, only 63% strongly agreed that it was important to care for self in order to provide the best care to patients and co-

workers. After the workshop, 100% of participants strongly agreed that was important to care for one's self. Self-knowing and appreciation for self also increased from 63% to 75% and 38% to 63%, respectively.

Table 1
Relationship Based Care Data- Pre Assessment

	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly Disagree
Caring for patients & families	88%	13%	0%	0%	0%
Problem solving	13%	88%	0%	0%	0%
Dignity & respect	13%	63%	13%	13%	0%
Best of intentions-team	38%	50%	13%	0%	0%
Trusting relationships-team	38%	38%	25%	0%	0%
Loving kindness	38%	50%	13%	0%	0%
Physical & emotional needs of patients	75%	25%	0%	0%	0%
Creative problem solving	38%	50%	0%	13%	0%
Self-care	63%	38%	0%	0%	0%
Maintaining belief/hope & faith	63%	38%	0%	0%	0%
Care for the whole patient	25%	63%	13%	0%	0%
Value increasing knowledge of self	63%	38%	0%	0%	0%
Appreciate myself	38%	50%	13%	0%	0%

Table 2
Relationship Based Care Data- Post Assessment

	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly Disagree
Caring for patients & families	100%	0%	0%	0%	0%
Problem solving	25%	63%	0%	13%	0%
Dignity & respect	13%	63%	25%	0%	0%
Best of intentions-team	50%	50%	0%	0%	0%
Trusting relationships-team	50%	38%	13%	0%	0%
Loving kindness	75%	25%	0%	0%	0%
Physical & emotional needs of patients	75%	0%	25%	0%	0%
Creative problem solving	25%	50%	25%	0%	0%
Self-care	100%	0%	0%	0%	0%
Maintaining belief/hope & faith	75%	13%	13%	0%	0%
Care for the whole patient	50%	25%	13%	13%	0%
Value increasing knowledge of self	75%	25%	0%	0%	0%
Appreciate myself	63%	25%	13%	0%	0%

Discussion

Although the sample size was small and statistical analysis to determine significance of the changes between the pre and post assessments was not justified, these findings indicate that participants had an increase in knowledge and understanding about the importance of taking time to know the patient and to be intentional in demonstrating caring interactions. There was focused discussion about avoiding assumptions, seeking cues, and truly seeing the patient as a person. Tools such as perception/diversity and choice making were explained in great detail and participants shared stories that helped to connect the knowledge to experience (see Appendixes C and D). In response to

statement number 6 on the pre assessment, "*The care I give is provided with loving-kindness,"* one participant described how it is *"Sometimes hard for me to 'love' my patients either because of disrespect to me or the way they care about their condition…they don't care for themselves or their stories are too sad."* In spite of this statement, this participant responded that she agreed that she treated the whole patient. On the post assessment, this participant marked the same statement, number 6 on the survey, as neither agree nor disagree, perhaps acknowledging that there is room for improvement in the care delivered.

Responses on the pre and post assessment did indicate that self-knowing is an important part of demonstrating caring to our patients and colleagues. This was especially noticeable in another of the responses to statement 14. As one participant stated, *"I feel if you cannot care for you, how can you care for someone else efficiently? If you don't love yourself how can you love someone else?"* There was extensive discussion about caring for self, especially during times of perceived busyness within the department and outside of work. Some of the self-care tools introduced during this discussion were the mind/body/spirit diagram, which helped participants to see the connection between these three parts of self; the choice making diagram, a visual reference to remind participants that there is always a choice no matter the situation; and the thriving scale, a scale used to measure wellbeing on a continuum (see Appendixes B, C, and E). Other tools discussed during this part of the workshop were reflection and journaling. According to Koloroutis and Trout (2012), the individual's ability to be vulnerable plays a major role in how he/she might reflect about a given situation.

Vulnerability is *"A sticky subject when you work in the ED. The pace really doesn't allow you time to get involved or attached"* (Workshop participant, personal communication, September 15, 2014). Some of the participants shared that they do journal, but not as much as they would like.

Limitations and Strength

The first limitation of the project was the sample size of only 8 participants. The workshops were initially planned to be presented to all emergency department staff including nurses, nursing assistants, secretaries, and other ancillary staff for a total of twelve workshops. However, because of financial constraints, the organization did a substantial amount of downsizing of staff and several projects were cut with educational offerings being at the top of the list. While there had been agreement early on in the process with leadership for the need to implement RBC in the emergency department, the project was placed on hold. After almost 6 months, permission was given to present 1 workshop to a cohort of 8 participants.

Another limitation was the amount of time that lapsed between the original proposal and the actual delivery of the workshop. The buzz and excitement of implementing a new care delivery model was quieted by all of the budget cuts and staff members began to focus on keeping their jobs and not necessarily on the importance of improving patient satisfaction or building the therapeutic relationships with patients and each other. The issue almost became oxymoronic. At the beginning of the workshop, 1 participant was heard saying, "*I want to spend more time with my patients, but I was told*

'We need to focus on moving them upstairs, not holding their hands,' that made me feel like I was wasting time." The participant felt the need to be "*more productive*."

Finally, the findings of this project are not generalizable due to the small size of the cohort and the fact that only one workshop was presented. Many individuals who touch patients in the ED did not received this education. Another issue of concern was that those who did attend the workshop worked on 3 different campuses across the health system. The ability of these participants to effect change in their various departments is limited. Regardless, the importance of 1 person being the spark to ignite the flame for change was stressed throughout the content in the workshop that was delivered.

A strength of the project implementation was also the size of the group. While it would have been nice to have a larger cohort, the size of the group allowed time for more intimate conversation and interaction. The group engaged in reflection and storytelling quickly and seemed comfortable sharing early, within the first hour of the workshop. The atmosphere was inviting and even 2 of the quieter participants were engaging in discussion before the break.

Implications for Practice

Putting the RBC model into practice really should be an easy implementation. After all, nurses, doctors, and other health care providers are caregivers by virtue of their job descriptions. True caring, however, is demonstrated by our actions, both verbal and nonverbal. Given this, it would be important for nurses and all health care providers to always be mindful of every interaction with patients and their family members.

Because the ED is fast paced and often chaotic, every interaction becomes an opportunity to change perceptions. The leadership in the ED will need to be strategic about questions asked of the staff, helping them to focus on what is working right and how to do more of those things instead of what is wrong in the department. Another area of focus will be educating all other members of the team in the ED. New employees will need to attend workshops and be placed with preceptors who are champions for the change and demonstrate intentional efforts to role model the behaviors of relationship-based caring in their practice.

Next, there will need to be concentrated effort on placing reminders of RBC tools around the department. Examples of these reminders include an appreciation board to post cards/letters from previous patients commending the staff on the excellent care they received, staff appreciations or caught caring notes when someone has gone the extra mile to help a coworker, and perhaps a thermometer centrally located in the department so that the rising patient satisfaction scores are seen. These visual reminders will help to keep staff motivated to continue the journey to improve care for the patients and families, as well as to improve relationships with each other.

Finally, there can never be too much emphasis on celebrating successes. Small, medium, or large, the size is not important. The main thing is to celebrate the success because it builds momentum and helps others to embody the change.

Implications for Social Change

With the implementation of the RBC model in the ED, it is expected that patients and families will feel that there has been a caring interaction during their visit. There will

be an emphasis on curing the patient and connecting with the patient. Demonstrating caring is the responsibility of all clinicians who encounter patients and that caring relationship helps us to minister to one another (Kolorutis & Trout, 2012). When the RBC model is implemented entirely, job title or duties will not matter; all staff members will demonstrate caring behaviors, both verbally and nonverbally, during every patient/family interaction and with co-workers. Providing safe, quality technical patient care is essential to the healing process and likewise it is essential to offer a caring and nurturing relationship to facilitate the healing process as well (Koloroutis & Trout, 2012).

Self-Assessment

During my time in the Doctor of Nursing Practice (DNP) program at Walden University, I have grown so much. My critical thinking skills and my view of life have evolved. I am more aware of how the decisions I make may possibly effect change in someone's life. Asking the hard questions such as what are the social implications for this decision and how does it affect others, has become the norm. While completing this project, being able to "see the person" was an important part of the process. Developing a sense of who people were and understanding that everyone has a back story gave me clarity about the importance of the work that needed to be done.

As a scholar, I have gained knowledge about the process of leading a project and conducting research. My knowledge about the RBC model and caring theories has increased. I have learned how to conduct a study from the beginning, navigate the Investigational Review Board (IRB), and conduct a thorough literature review. Managing a project from beginning to end has been interesting, challenging, and joyous.

The importance of having all stakeholders at the table was quite clear and at sometimes most challenging because of work schedules and project buy-in or the lack there of. As a practitioner, this work has prepared me for my current position in academia. I will be in the lead faculty role this spring and in charge of revamping a course. Understanding that everyone plays a role in caring for the patient, in this case the student, will guide my decision-making for assignment of duties and the overall process of the course development.

One issue that occurred during this project was having to change jobs after 23 years of working with the same company, and that was not an easy task. Maintaining a scholarly mindset, and having to share the importance of caring for others when I was not feeling cared for was challenging to say the least. In my previous role, I was the educator for the health system whose job it was to help staff and leadership understand the importance of RBC. While presenting the education for RBC to the cohort, it became abundantly clear that I was speaking to myself. I had to teach the information and listen to the information from a different perspective. Caring for your co-workers had a new meaning for me. During the completion the DNP program and the capstone project, I have grown; however, I have done much more than that. I have matured and embraced a different way of thinking….scholarly.

Summary

Koloroutis and colleagues (2007) cited ten critical elements that are needed for a successful implementation of the RBC model of caring. These elements included the need for appreciative inquiry becoming the standard way of thinking, working, and interacting within the organization; commitment and excitement for RBC being built in at the executive level from the beginning; relationship-based care integrated into all of the organization's strategic planning; leaders exhibiting constancy of purpose for implementing and sustaining RBC; and staff inspired to deliver professional, compassionate care to all patients during any interaction (Koloroutis et al., 2007). Some of these elements were discussed during the presentation of materials in the workshop with an emphasis on the individual and how she can effect change in practice on a daily basis.

While this workshop was the starting point for change, there is still much work to be done if a lasting transformation is to become noticeable. It was evident by the changes in responses on the post assessment that participants initially tended to think favorably about their communication skills and ability to connect with others. However, once strategies and concepts about the RBC model were shared, eyes were opened. The possibilities for improvement became more apparent and the transformation began with that small spark of insight.

Section 5: Scholarly Project

Executive Summary

Health care has changed over the past several years. The art of caring seems to have been lost in the hustle and bustle of the modern health care organization. Nurses and other ancillary staff are focused on completing required tasks and moving patients in and out as fast as possible. This type of nursing care delivery is especially prevalent in the emergency department (ED). The emergency department is constantly busy. In an article by Cameron and colleagues (2010), the focus was on effecting change in the ED given that this environment exists and patients perceive it to be uncaring. The fast paced, rapid turnover of patients and the chaotic atmosphere can sometimes leave patients who visit the emergency department with the perception that staff members are uncaring (Cameron et al., 2010). Because of these issues, a project was developed to implement relationship-based care (RBC), a patient-centered care delivery model, in an emergency department.

A team of key stakeholders was assembled that included the leadership team in the ED, the vice president of nursing for the campus, staff nurses, a member of the service excellence department, other patient care support staff, and the DNP student. The president of the campus was an ad hoc member. After discussion about key issues within the ED and reviewing patient satisfaction scores and data, a project was developed to educate a team of nurses and other staff who worked in the emergency department about the RBC care delivery model. This hospital was one of six in a multi-campus health system. During the development of the project, plans were changed due to budget

constraints and the project was not fully implemented across the health system; however, the nurses who were educated did work in 4 of the 6 EDs in the health system.

The objectives for implementing RBC in the emergency room were to: (a) enhance the patient and caregiver interaction, (b) strengthen coworker relationships, and (c) gain some appreciation of the importance of self-care. There were 8 participants for the workshop. A preassessment was administered to each participant, education about the RBC model was presented, and then a postassessment was administered. Prior to education about the RBC delivery model, 83% of the participants agreed that patients and their families needed to feel cared for during a visit to the ED and 100% agreed post education. Thirty-eight percent of the participants strongly agreed and 50% agreed that they provided care and demonstrated loving kindness towards patients before the education and 75% of participants strongly agreed after the education. Yet, 75% responded with strong agreement, on both pre and post assessments, that they work to meet physical and emotional needs of patients. Providing a caring and healing environment as well as building a therapeutic relationship, are significant components of the RBC model. *Maintaining belief* for patients, one of the 5 caring processes shared with participants, increased from 63% to 75% of participants who strongly agreed that this concept was important while 13% neither agreed nor disagreed.

Another dimension of the RBC model addressed teamwork and colleagueship. It is extremely difficult to deliver quality, compassionate care without the support of a cohesive team. Statements 2 to 5 and 8 on the assessment tool spoke specifically to this aspect of the work environment. Responses varied with 50% to 88% of participants in

agreement that they maintain dignity, respect, and the best intentions with colleagues and work well together solving problems in a creative manner prior to education about the model. However, only 38% of the participants believed that they had trusting relationships with co-workers. On postassessment, the numbers changed with 50% strongly agreeing, 38% agreeing, and 13% neither agreeing nor disagreeing regarding trusting colleague relationships.

Another very important relationship for implementing the RBC model successfully is taking care of self. While participants seemed to understand the significance of taking care of one's self prior to the workshop, only 63% strongly agreed that it was important to care for self in order to provide the best care to patients and co-workers. After the workshop, 100% of participants strongly agreed that was important to care for one's self. Self-knowing and appreciation for self also increased from 63% to 75% and 38% to 63% respectively.

Although this was a small cohort of participants, there are some recommendations for change that may help improve patient satisfaction results, strengthen coworker relationships, and increase employees' self-knowing within the ED. It will be important for nurses and all health care providers to always be mindful of every interaction with patients and their family members. As previously mentioned, the ED is fast paced and often chaotic; therefore, every interaction becomes an opportunity to change perceptions. The leadership in the ED will need to be strategic about questions asked of the staff, helping them to focus on what is working right and how to do more of those things instead of what is wrong in the department. Focusing on educating all other members of

the team in the ED with the RBC care delivery model will need to be a priority. New employees will need to attend workshops and be placed with preceptors who are champions for the change and demonstrate intentional efforts to role model the behaviors of relationship-based caring in their practice.

Next, there will need to be concentrated effort on placing reminders of RBC tools around the department. Examples of these reminders include an appreciation board to post cards/letters from previous patients commending the staff on the excellent care they received, staff appreciations or caught caring notes when someone has gone the extra mile to help a coworker, and perhaps a thermometer centrally located in the department so that the rising patient satisfaction scores are seen. These visual reminders will help to keep staff motivated to continue the journey to improve care for the patients and their families, as well as to improve relationships with each other.

Finally, there can never be too much emphasis on celebrating successes. Small, medium, or large, the size is not important. The main thing is to celebrate any success or improvements and share the stories across the health system as this may help other departments improve their outcomes.

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Appendix A: Staff Survey Relationship-based Care

Please answer respond to the following statements by marking an "X" beside the choices that most closely reflect your opinion. This survey does not contain any identifiable markers; therefore it is anonymous and will remain as such.

1. Overall, the care I give is provided with loving-kindness.

___ Strongly agree

___ Agree

___ Neither agree nor disagree

___ Disagree

___ Strongly disagree

2. I work to meet the physical and emotional needs of my patients.

___ Strongly agree

___ Agree

___ Neither agree nor disagree

___ Disagree

___ Strongly disagree

3. I believe that the health care team that I currently work with solves unexpected problems really well.

___ Strongly agree

___ Agree

___ Neither agree nor disagree

___ Disagree

___ Strongly disagree

4. As a team, my colleagues and I are good at creative problem solving to meet the individual needs and requests of our patients.

___ Strongly agree

___ Agree

___ Neither agree nor disagree

___ Disagree

___ Strongly disagree

5. Patients and families need to feel cared for when they visit our emergency department.

___ Strongly agree

___ Agree

___ Neither agree nor disagree

___ Disagree

___ Strongly disagree

6. It is important for me to take care of myself so that I can give my patients and team members the best care.

___ Strongly agree

___ Agree

___ Neither agree nor disagree

___ Disagree

___ Strongly disagree

7. Members of my work group treat one another with dignity and respect.

___ Strongly agree

___ Agree

___ Neither agree nor disagree

___ Disagree

___ Strongly disagree

8. I support hope and faith in the patients I care for.

___ Strongly agree

___ Agree

___ Neither agree nor disagree

___ Disagree

___ Strongly disagree

9. I respond to each patient as a whole person, helping to take care of his/her needs and concerns.

___ Strongly agree

___ Agree

___ Neither agree nor disagree

___ Disagree

___ Strongly disagree

10. I believe the best of intentions when interacting with my team members.

___ Strongly agree

___ Agree

___ Neither agree nor disagree

___ Disagree

___ Strongly disagree

11. I have established helping, trusting relationships at work.

___ Strongly agree

___ Agree

___ Neither agree nor disagree

___ Disagree

___ Strongly disagree

12. I value opportunities that allow me to increase knowledge about myself.

___ Strongly agree

___ Agree

___ Neither agree nor disagree

___ Disagree

___ Strongly disagree

13. I appreciate myself as a whole person and seek to take care of all my needs and concerns.

___ Strongly agree

___ Agree

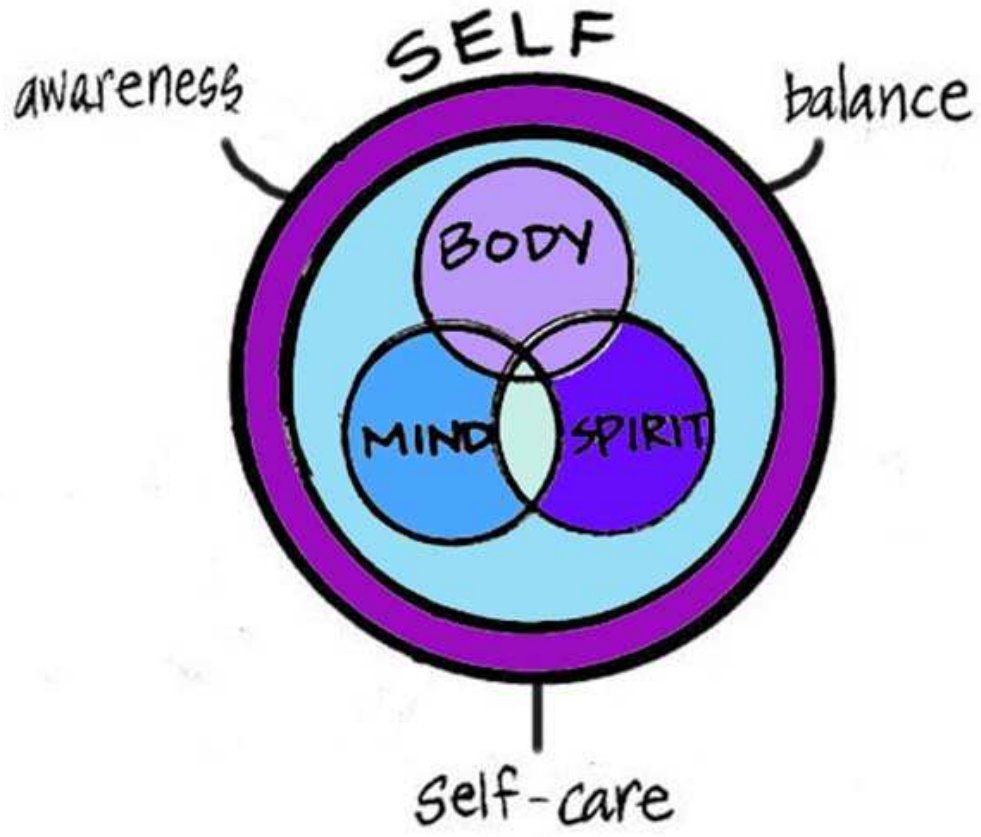
___ Neither agree nor disagree

___ Disagree

___ Strongly disagree

14. Please describe any specific attitudes, behaviors, or actions that led to any of the answers above.

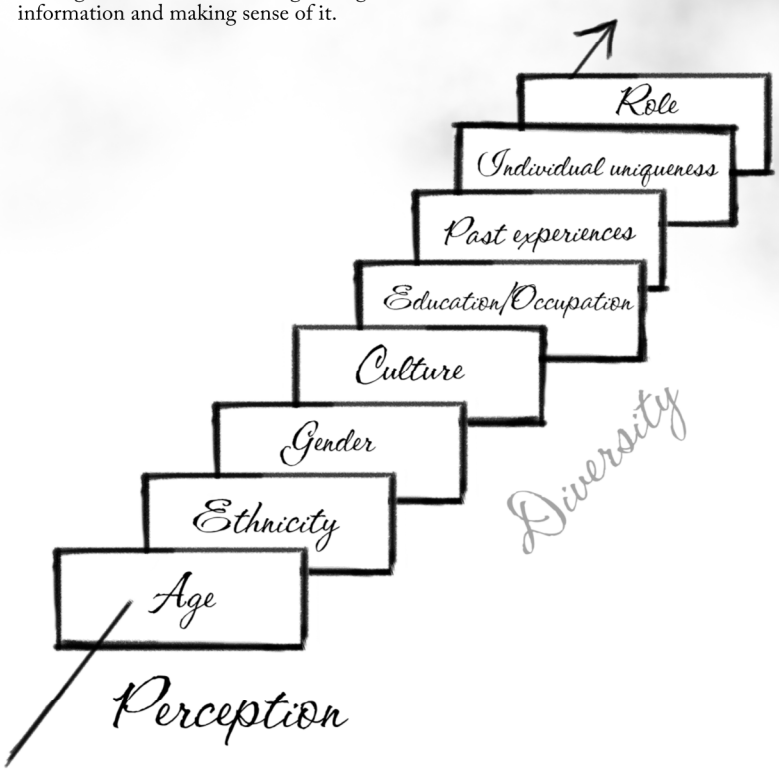
Appendix B: Mind/Body/Spirit



Creative Health Care Management, Inc. 2009

Appendix C: Perception/Diversity

Perception: the process of taking in information through our five senses (sight, hearing, smell, touch, taste); organizing the information and making sense of it.



Creative Health Care Management, Inc. 2011

Appendix D: Choice-making: Tools for Success

Choice-making: Tools for success

I am able to manage my energy and cope with stress when I recognize that I have a choice in any situation.

While I cannot always control the situation, I can always choose how I respond.

The ability to claim and make choices is directly related to personal ownership, respect and self-worth.

Creative Health Care Management, Inc. 2011

Appendix E: Thriving Scale

Thriving scale

Where am I on the Thriving Scale below?

1	2	3	4	5	6	7	8	9	10
Compassion Fatigue				*Surviving*					*Thriving*

Compassion Fatigue: A chronic clouding of caring and concern for others; a physical, emotional and spiritual fatigue or exhaustion that takes over a person and causes a decline in his or her ability to experience joy or to feel for and care for others

Surviving: Endure, live through, persist, pull through, breathe, continue, do, endure, go on, prevail, stay

Thriving: Do well, flourish, grow, shine, radiate, develop, get ahead, be abundant

List two circumstances that contribute to my feeling a healthier balance and an ability to thrive (e.g. relationships, self-care, spiritual practices, etc.).

1.

2.

Appendix F: Commitment to my Co-worker

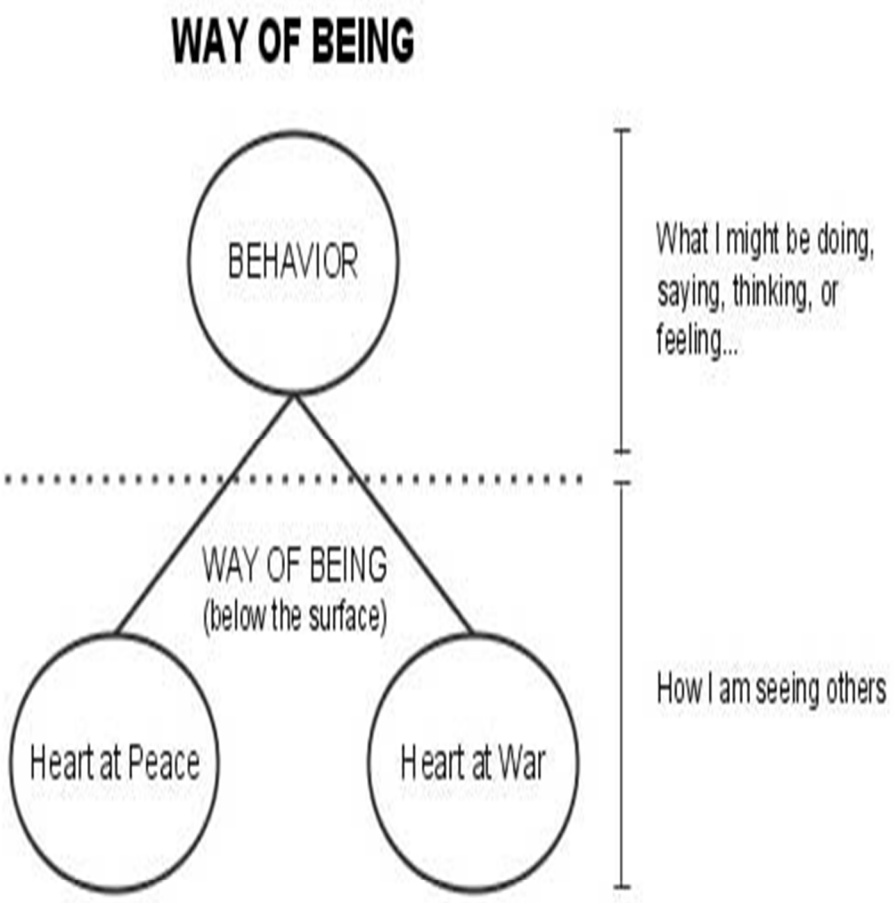
Commitment to my Co-workers©

As your co-worker and with our shared goal of excellent patient care, I commit to the following:

- I will accept responsibility for establishing and maintaining healthy interpersonal relationships with you and every member of this team.
- I will talk to you promptly if I am having a problem with you. The only time I will discuss it with another person is when I need advice or help in deciding how to communicate with you appropriately.
- I will establish and maintain a relationship of functional trust with you and every member of this team. My relationship with each of you will be equally respectful, regardless of job title, level of educational preparation, or any other differences that may exist.
- I will not engage in the "3Bs" (Bickering, Backbiting and Blaming). I will practice the "3Cs" (Caring, Commitment and Collaboration) in my relationship with you, and ask you to do the same with me.
- I will not complain about another team member and ask you not to as well. If I hear you doing so, I will ask you to talk to that person.
- I will accept you as you are today, forgiving past problems, and ask you to do the same with me.
- I will be committed to finding solutions to problems rather than complaining about them or blaming someone for them, and ask you to do the same.
- I will affirm your contribution to the quality of our work.
- I will remember that neither of us is perfect and that human errors are opportunities, not for shame or guilt, but for forgiveness and growth.

—Compiled by Marie Manthey

Appendix G: Way of Being



I see others as **objects**.	I see others as **people**.
They appear **less real** to me than I do to myself.	They appear **just as real** to me as I do to myself.
Their cares and concerns matter **less** to me than my own.	Their cares and concerns matter the **same** to me as my own.
I actively **resist** their humanity.	I actively **respond** to their humanity.

Curriculum Vitae

Name: Ruthie Waters Rogers
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Email Address: rwrogers@ncat.edu

Licensure: NC License # 112160
Compact License # Primary State: North Carolina

Certifications: Nurse Executive-Advanced (NEA-BC)
HIV Educator
Reigniting Caring Spirit Coach & Facilitator

Education:

Dates	Degree	Institution/Location	Major
2014	DNP(c)	Walden University	Doctor of Nursing Practice
2001	Masters	University of North Carolina-Greensboro	Nursing Administration
1997	BS	Winston-Salem State University	Nursing
1990	AS	Guilford Technical Community College	Nursing

Post-Doctoral Training or Special Experience:
Doctor of Nursing Practice-Candidate at Walden University

Academic Appointments:

Dates	Rank/Title	Institution	Location
January 2014	Clinical Instructor	NCA&T State University	Greensboro
August 2013	Adjunct Clinical Faculty	NCA&T State University	Greensboro

Other Employment:

Dates	Position Title	Institution	Location
2010-present	Adjunct Faculty	Creative Health Care	Minneapolis, MN
2009-2013	RBC Project Coordinator	Cone Health Network	Greensboro, NC
2001-2008	Department Director Medical Surgical Telemetry	Cone Health Network	Greensboro, NC
2001	Staff Nurse	Cone Health Network	Greensboro, NC
1997-2000	Assistant Director	Cone Health Network	Greensboro, NC
1990-1997	Staff Nurse	Cone Health Network	Greensboro, NC

Special Awards, Fellowships and Other Honors:

Awards and Recognitions

Great 100 Nurses of North Carolina (2013)

Memberships and Positions Held - (Scientific, Honorary and Professional Societies)

Date(s)	Name of Agency/ Organization/Society	Position Held
2012-present	North Carolina Organization of Nurse Leaders	Member
2007-2013	Nursing Beat, Editorial Board (Cone Health)	Member
2004-2013	American Organization of Nurse Executives	Member
2004-present	North Carolina Nurses Association	Member
2001-present	Sigma Theta Tau (Mu Tau)	Member
2014-	Sigma Theta Tau (Mu Tau)	Secretary

Memberships and Positions held in Community Organizations

Date(s)	Name of Agency/ Organization	Position Held
2009-present	Love & Faith Christian Fellowship	Member
	HIV Ministry	Educator
	Love & Care Ministry	Greeter
	Membership Deaconess	Deaconess

Continuing Education (Since 2012-present)

October 2014	Shifting the Healthcare Paradigm: Reshaping Interprofessional Partnerships Through Nursing Research
June 2014	Excellence in Teaching for Nurse Educator
April 2013	Breaking Barriers Through Breakthrough Leadership
March 2013	The Nurse Manager's Role in Reigniting the Spirit of Caring
March 2013	Understanding our Latino Community Training
September 2012	Cone Health's Nursing Research and EBP Symposium: Building Blocks for Quality Care: Making the Pieces Fit
June 2012	North Carolina HIV Counseling, Testing & Referral Training
May 2012	Stepping Into the Stream: Engaging the Bedside Nurse in Research
April 2012	Rockingham County 3rd Annual Nursing Symposium
February 2012	Diversity & Inclusion: A Courageous Dialogue

Presentations:

"Relationship Based Care: The Role of Nursing Faculty and Students" (2010)
Progressive Orientation Model (P20) (2007)
Rule Out Myocardial Infarction Observation (2001)

Refereed Poster Presentations:

Progressive Orientation Model (P2O) (2007)
Early Ambulation Study for Post Cardiac Catheterization Patients (1997)

Consultations/Training Offered:

Management/Leadership- Guilford Technical Community College Senior Nurses
Women/Heart Health-Beta Iota Chapter, Alpha Kappa Alpha Sorority, Inc.
Primary Nursing in Today's Nursing Environment-Ohio Nurses Association

Major Committees:

Schools/Colleges of Nursing

Community Engagement
Student Affairs
Admissions/Progression/Retention (Chair)

Teaching Assignments:

University

Course Number Level	Course Title	Role	Semester/Year Taught
NURS 464	Synthesis	Lead Faculty	Fall 2014
NURS 458	Bridge to Prof. Practice	Lead Faculty	Fall 2014
NURS 458	Bridge to Prof. Practice	Clinical Faculty	Spring 2014
NURS 455	Adult Health II Practicum	Clinical Faculty	Spring 2014
NURS 356	Adult Health I Practicum	Clinical Faculty	Spring 2014
NURS 355	Adult Health I Practicum	Clinical Faculty	Fall 2013
NURS 514	Adult Health III Practicum	Clinical Faculty	Fall 2013

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10/20/14