2015

The Design and Implementation of a Relationship-Based Care Delivery Model on a Medical- Surgical Unit

Paula Ann Rodney
Walden University

Walden University

College of Health Sciences

This is to certify that the doctoral study by

Paula Rodney

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Mirella Brooks, Committee Chairperson, Health Services Faculty
Dr. Donna Williams, Committee Member, Health Services Faculty
Dr. Mary Verklan, University Reviewer, Health Services Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2015

Abstract

The Design and Implementation of a Relationship-Based Care Delivery Model on a Medical- Surgical Unit

by

Paula A. Rodney

MSN, California University of Pennsylvania, 2011

BSN, University of Virginia, 1979

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

April 2015

Abstract

Patient satisfaction and clinical outcomes have become important issues in healthcare since the introduction of the Value Based Purchasing Program. Patient satisfaction, as measured by Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, was declining and hospital-acquired pressure ulcers (HAPU), falls, and catheter-associated urinary tract infections (CAUTI) were rising on the pilot unit. The purpose of this non-experimental correlational design quality improvement project was to combine information from focus groups, a content analysis of the literature on Kristen Swanson's theory of caring, and relationship-based care, to develop and implement a relationship-based care delivery model. An additional aim was to determine its impact on patient satisfaction and the reduction of HAPU, falls, and CAUTI. The model was designed and implemented by a team consisting of bedside care providers, leaders, an educator, and a student facilitator. The components of the model included scheduling for continuity of care, whiteboards, seated bedside report, hourly rounding, a nurse advocate, and 5 focused minutes of attention per shift. Descriptive statistics were used to determine the mean change in HCAHPS scores before and after implementation of the model, and revealed improvements in dimensions of communication with nursing by 13.2%, responsiveness by 12.5%, overall rating of care by 14.5%, and willingness to recommend by 8.7%. The result of audits of the pilot unit's medical records indicated a reduction in falls by 3, HAPU by 2, and CAUTI by 2 from August, the baseline month. As a result of these findings the model will be implemented on all inpatient nursing units. The target audience for this project includes nursing leaders, educators, and bedside providers with interest in patient-centered care and staff empowerment.

The Design and Implementation of a Relationship-Based Care Delivery Model on a Medical Surgical Unit

by

Paula A. Rodney

MSN, California University of Pennsylvania, 2011

BSN, University of Virginia, 1979

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

April 2015

Dedication

Caring is at the center of all we do as nurses and this project is dedicated to all the patients, educators, mentors and colleagues who taught me this. Nursing is an incredible career with many twist and turns, and every day I am thankful that it is my profession.

Acknowledgments

I would like to thank my professor, Dr. Mirella Brooks and my preceptor and mentor, Connie Stone for all the help and guidance provided throughout this project. I would also like to thank my husband, Eric, and my daughter, Lauren, for the support and love you provided during this journey. This project is the culmination of a love affair with nursing and the beginning of a future filled with evidence-based practice and lifelong learning.

Table of Contents

List of Tables

List of Figures

Section 1: Overview of the Evidence-Based Project

Introduction

Patient satisfaction, as well as, clinical and safety outcomes have become very important issues in healthcare since the introduction of the Value Based Purchasing Program in 2011 by the Centers for Medicare and Medicaid (CMS). Under this program CMS, (2011) will make value-based incentive payments to hospitals according to how well they perform on selected quality measures and patient satisfaction, or on the survey, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). As a result, reimbursement for care and competition for patients now depends more heavily on the results of publicly reported outcomes and the hospital's ability to meet the needs of the patients.

Over the last two years, strategies have been implemented at the hospital under study, such as collaborative governance, bedside shift report, and interdisciplinary rounding to enhance both patient and nurse satisfaction. Yet the hospital still struggled with patient satisfaction and quality outcomes. The development of a care delivery model that was patient-focused and relationship-based helped improve patient satisfaction and quality outcomes. The care model defined the decision-making authority and responsibilities of the nurse and others in the healthcare environment, as well as, work distribution, communication, and management. The model helped transition patient care from being task-oriented to patient-centered. The unit environment provided an optimal patient experience by focusing on a relationship-based approach.

This care delivery model included nursing assignments that promoted continuity of care. Focused care time, the intentional, uninterrupted communication intervention between the nurse and the patient or family on each shift. During those 5 focused minutes, the care provider sat at the patient's bedside in order to get to know the patient, and to determine both the patients' and providers' goals for care. This time was intended to support the patient and nurse in establishing and maintaining a therapeutic relationship. It enabled the nurse to learn what the patient or family was most concerned about and allowed the patient to participate in care planning. Other components were the use of whiteboards for communication, seated bedside hand-off and hourly rounding. The final component included the nurse advocate role. The nurse advocate led the team and was responsible for establishing the plan of care based on the patient's needs and goals. The nurse advocate coordinated the plan of care from admission through discharge, worked with the patient and family to evaluate their goals and revise the timeline as necessary.

Background

The literature suggests that nursing shortages and economic challenges have resulted in a restructuring of the nursing workforce, which, in turn, has impacted the effectiveness of the provision of care (Fernandez, Johnson, Tran, & Miranda, 2012). Three articles on relationship-based care (Allen & Vitale-Nolan, 2005; Gerrie & Nebel, 2010; Winsett & Hauck, 2011) described (a) increased patient satisfaction with care, (b) increased verbal and nonverbal caring behaviors,(c) improved quality of care and outcomes, (d) improved nursing satisfaction and (e) feelings of autonomy and a reduction in task-oriented care with a move toward relationship-based care.

During the development of a framework for person-centered nursing, McCormack and McCance (2006) identified a range of attributes that impacted on the implementation of relationship-based care. The most significant attributes were workplace culture, learning culture, and the physical environment. The models of care that result in greater nurse and patient satisfaction, as well as, improved outcomes were those which were patient-centered and promoted engagement with the patient and family and provided continuous well-coordinated care

Allen and Vitale-Nolan (2005), determined that the theory and process used to design the patient-centered process, contributed more to nurse and patient satisfaction than the chosen model of care. Allen and Vitale-Nolan surveyed 75 registered nurses using the Index of Work Satisfaction. The authors concluded that relationship-based care empowers nurses who know the patient best to decide how to provide care, thus creating an environment where the nurse feels empowered. The combination of the proper facilitator and the knowledge and practice skills of the bedside provider determined the success of the design and implementation of a model of care for this hospital. The successful design of this project required activities and educational approaches that fostered collaboration and empowerment, and included consideration of personal and professional values (Allen & Vitale-Nolen, 2005).

Finally, in a randomized controlled study, Wolf, Lehman, Quinlan, Zullo, and Hoffman (2008) determined that relationship-based care improved the patients' perception of level of satisfaction and quality of care received. Patient experience and level of satisfaction influence the decision to return to a hospital and the model of care

can impact that decision. The relationship-based model empowers nurses to take the time to know their patients, seek their input and priorities for care and involve them in all aspects of their care, resulting in increased satisfaction and improved outcomes for the patient. It is apparent that nursing leadership must work collaboratively with nurses to improve processes in nursing practice that could enhance nurses' job satisfaction and improve patient care delivery (Wells, Manuel, & Cunnings, 2011).

Problem Statement

In the current healthcare climate, the state and federal governments have increased the focus on patient satisfaction as an indicator of quality care and business success for healthcare institutions (Dingman, Williams, Fosbinder, & Warnick, 1999). The hospital engaged NRC Picker as the vendor for HCAHPS data collection. NRC Picker is a healthcare research and quality improvement firm. In 2001, National Research acquired Picker Institute to form NRC Picker (National Research Corporation, 2014). NRC Picker designs tools and surveys to measure what matters most to patients and also provides data to the client that can be used to improve patient satisfaction with care.

Each month NRC Picker calls a predetermined number of discharged patients and surveys them about their hospital stay. Each patient rates the hospital on a variety of topics based on a scale of one to ten, with ten being the highest score. The result of the patient satisfaction survey for overall care received by the patients at this hospital was 60%; this represents the percentage of patients who rated the care received with a score of 9 or 10. An overall care score of 60% is 2% lower than the national average for the NRC Picker database and 7.2% lower than the studied hospital's health system average.

The hospital under study ranks the lowest in overall patient satisfaction among the eight hospitals in the health system.

Patients identified the problem areas as nurse communication, timely response to requests for help, and pain management. The patient satisfaction scores for the pilot unit were the lowest overall for the hospital. Patients rated the overall care on the unit as a nine or ten only 45% of the time; this was 15% lower than the overall hospital score. This unit is a 36-bed medical-surgical unit caring for patients with an average age of 70 years. The patients were 55% female and 45% male. The two primary populations for this unit were post-operative patients and patients on dialysis. It is the largest unit in the hospital, and therefore, when the hospital census increases, this unit's census can increase from 20 patients to 36. There is also a concern for the number of hospital-acquired pressure ulcers, catheter-associated urinary tract infections and falls.

The staff includes registered nurses, nursing technicians, and unit clerks. The average age was 50 years old. There was a variety of experience levels on the unit, from novice to expert nurses. The nursing technicians and the unit clerks all had long tenure with the unit and functioned as its historians. The unit manager was fairly new to the unit with tenure of 3 years; she brought collaborative governance and teamwork to the unit and served as the inspiration for the focus on quality. The unit was in disrepair, which contributed to the appearance of uncleanliness. An upgrade was needed.

Project Questions and Hypothesis

The following two questions guided the project's design and implementation of a care delivery model with the goal of full hospital implementation and perhaps implementation across the health system.

1. Will the design and implementation of a relationship-based care delivery model improve patient satisfaction on a medical-surgical unit?
2. Will the relationship with the patient resulting from the new model of care decrease falls, hospital-acquired pressure ulcers and catheter-associated urinary tract infections?

The project hypothesis assisted in shaping the goals, objectives, and the design of the program and also the monitoring and advancement of the project. The hypothesis was as follows: a relationship-based care delivery model would result in a caring relationship with the patient and family and thus patient satisfaction and quality outcomes would improve. The improvement in patient satisfaction and outcomes would increase reimbursement from the CMS.

Purpose Statement and Project Objectives

The purpose of this project was to combine (a) information from patients and nurses on what they perceive as caring, (b) Kristen Swanson's five caring principles, and (c) the elements of relationship-based care, to design and implement a care delivery model. This model was expected to enhance patient satisfaction, as well as improve quality outcomes. The mission of this project was to promote quality outcomes and patient satisfaction through caring relationships. The goal was to ensure a positive patient

hospital experience through the development of a care delivery model that outlined the structure and process of care, facilitated the nurses' contribution to patient outcomes and the environment, enhanced patient satisfaction and improved quality outcomes.

The five project objectives for this project were as follows:

1. Perform a needs assessment.
2. Design a relationship-based care delivery model.
3. Train the bedside care providers about the new care delivery model.
4. Implement the model of care.
5. Evaluate the effectiveness of the model and make modifications.

These objectives were achieved through the collaborative effort of the student facilitator, the unit manager, three unit nurses, one nursing technician, one unit clerk, and an educator. The membership on the design team was voluntary. The needs assessment included focus groups with bedside caregivers and patients and families in order to establish a baseline understanding of caring.

Framework of the Project

The theoretical framework for this project was Kristen Swanson's theory of caring (1991) in conjunction with the principles of relationship-based care created by Mary Koloroutis (2004). Swanson was influence by Jean Watson, who served as her dissertation chair. Jean Watson's work explored how nurses express care to their patients. Watson theorized that caring can promote health and is central to nursing practice (Watson, 2008). Watson contends that caring is transmitted by the culture of the nursing profession as a way of coping with its environment (Jean Watson, 2013). A caring

environment accepts a person as they are and looks toward what they can become. There are ten carative factors:

1. Forming humanistic-altruistic value systems
2. Instilling faith and hope
3. Cultivating a sensitivity to self and others
4. Developing a helping-trust relationship
5. Promoting an expression of feelings
6. Using problem-solving for decision-making
7. Promoting teaching and learning
8. Promoting a supportive environment
9. Assisting with the gratification of human needs and
10. Allowing for existential-phenomenological forces (Watson, 2008, p.30).

Watson's theory provides a framework for nursing that can be generalized to a variety of patients and situations. The patient is the focus of the care, not the technology. Jean Watson's theory served as a theoretical foundation for the work of Kristen Swanson with mothers experiencing miscarriage.

Through her work with post-miscarriage mothers, Swanson (1991) defined the structure of caring as five interrelated processes; maintaining belief, knowing, being with, doing for and enabling. Relationship-based care is based on three caring processes: the relationship with the patient and family, the relationship with self and the relationship with colleagues. The choice of this theory and framework was a result of a reported decline in patient satisfaction scores and nursing satisfaction. Swanson's theory provided

a clear explanation of the links between caring process and patient well-being. Swanson's five caring processes provide a foundation for actions by the nurse that can establish a relationship that puts the patient at the center and improves patient satisfaction, clinical/quality outcomes and nursing satisfaction. The principles of relationship-based care provided guiding principles that transformed care on this medical-surgical unit from task-oriented care to relationship-based care. The primary vision was to provide care that was personal for patients, rewarding for nurses, and provided in an environment that was safe and nurturing.

Project Description

This project was a non-experimental, correlational, quality-improvement project. Its goal was to examine the correlation between the newly created model of care and patient satisfaction and quality outcomes. This design facilitated the identification of many interrelationships in a situation, in a short amount of time (Burns & Grove, 2010). The design was applicable for the project because there was no intervention, patient satisfaction data were obtained from the HCAHPS survey, and the quality outcome data were from unit-based quality measures collected on a monthly basis. In the project, the interest was (a) the impact of the care delivery model on both patient satisfaction and quality outcomes and (b) test the hypothesis that establishing a relationship with a patient results in better outcomes and satisfaction. There was also an interest in establishing a framework "for exploring the relationship between variables that cannot be inherently manipulated" (LoBiondo-Wood & Haber, 2009, p. 201) that will be explored in the section on method. Correlational design is a very useful design for clinical research

because many of the phenomena of clinical interest are beyond the ability to manipulate, control, or randomize.

Significance and Relevance to Practice

Caring is a complex process that is perceived differently by patients and nurses. The significance of this project was to combine the perceptions of patients with that of nurses and develop a shared definition of caring and then translate that definition into practice. With the advent of information technology, nursing has become more task oriented, resulting in a decreased presence in the therapeutic relationship. Patients cannot readily identify if a nurse has provided competent care, yet, they can identify behaviors that represent caring. These behaviors include communicating, respect, informing, aiding, comforting, empathizing and being seen (Issel & Kahn, 1998). Incorporating these behaviors into a care delivery model will help to clarify the concept of caring in the hospital under study and help improve patient satisfaction.

This project was the beginning of a cultural transformation for the hospital under study. From senior leadership to the bedside provider, a commitment to relationship-based care changed how the hospital functions. This commitment is expected to have far-reaching consequences for many areas of hospital operations, such as the incorporation of patient-centeredness in hiring practices, reworking the performance evaluation process to place emphasis on relationship-based principles, and fostering environments by leaders and managers that allow for a strong relationship between nurse and patient. The goal for the patient and family was to be active participants in their care to the extent allowed by their culture and comfort. To help understand and respect cultural and religious beliefs,

bedside providers had access to a software program, *Culture Vision.* The relationship-based care delivery model was an opportunity to create a strong bond with patients and to work collaboratively with colleagues to meet the patients' needs.

Implications for Social Change in Practice

The design and implementation of a relationship-based care delivery model on the pilot unit transformed nursing at the hospital under study from task oriented and disorganized to a model of care that is patient-focused and coordinated. The components of relationship-based care helped put the patient and family at the center of care; it provided a way for patient and family to communicate their preferences and it reduced the incidence of unneeded or unwanted care. This medical-surgical unit was the first unit to design and implement the care delivery model in this hospital. And due to its successful implementation, the model will be rolled out to additional units and departments with the ultimate goal of changing the hospital culture to one of patient-centeredness.

This hospital was the first hospital to institute relationship-based care in the healthcare system and also in Montgomery County, Maryland. The implications for social change are significant. The largest hospital system in the state would be the first to put patients at the center of care and to promote the establishment of relationships between care givers, patients and families. This care delivery model empowers nurses to be a patient advocates through the implementation of a nurse advocate. The nurse advocate for the patient, in conjunction with the care team, decided the course of treatment while the patient was in the hospital. The nurse advocate (a) established a

therapeutic relationship with the patient, (b) developed an individualized plan of care, (c) made decisions about nursing care, (c) communicated the decisions to the other members of the health care team and(d) made sure that patient assignments maintained relationships and continuity of care.

The 5 focused care minutes was the means used to establish a therapeutic relationship between the patient, nurse and nurse technician. This time was used to (a) get to know the patient and their family as individuals and (b) talk about the patient's wishes and fears during hospitalization. An uninterrupted time to provide any needed explanations or to provide comfort during a stressful time could transform the relationship between caregivers, patients and families. The 5 focused minutes also provided the design team members the opportunity to role model and mentor staff on techniques for establishing a therapeutic relationship during hospitalization. The therapeutic relationship required the unit to work more effectively as a team to meet the goals of care and fulfill the patients' needs.

Definition of Terms

Operational definitions for this care delivery model project were as follows:

Caring is "the nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (Swanson, 1991, p. 162).

Care delivery system is a way of organizing care delivery to meet the needs of the patient. It defines how work will be assigned and how the staff will function. The organizing principles cover decision making, work allocation, communication channels and management responsibilities (Koloroutis, 2004).

Design team includes the student facilitator, nurse manager, four registered nurses, one nursing technician, one unit clerk, one educator and one industrial engineer for the purpose of designing, educating, implementing and evaluating the care delivery model.

Five focused care minutes is the time taken by nurses and nurse technicians to sit down at the bedside and connect with their patients. No other care or information is happening at this time, just an opportunity for the staff to form a relationship with patients.

Healing environment is therapeutic surroundings in which the primary goal is to provide compassionate care to the whole patient both body and spirit. The environment is designed to provide for privacy, quiet, and rest.

Normative data helps to compare the outcomes of a project to the defined goals and objectives. There is normative outcome, treatment, implementation, and environment

data. All can be used to identify the intended and unintended results of a project. (Kettner, Moroney, & Martin, 2013).

Nurse advocate is "a care delivery system in which a registered nurse accepts responsibility, authority and accountability for establishing and maintaining a therapeutic relationship and an individualized plan or care for the patient and family. The primary nurse is responsible for coordinating the care with other members of the care team" (Koloroutis, 2004, p. 172).

*Relationship-based care (*Figure 1) is "an overarching philosophy, model and system that focuses on three crucial relationships for the provision of humane and compassionate care. Relationships with the patient and family, with colleagues and with self are the three crucial relationships" (Koloroutis, 2004, p. 15).

Structure of caring (Figure 2) is defined by Kristen Swanson and based on the five caring principles; knowing, being with, doing for, enabling and maintaining belief (Swanson, 1993).

Figure 1. Pictorial representation of the components of relationship-based care. From "Implementing a Relationship-Based Care Model on a Large Orthopedic/Neurosurgical Hospital Unit," by M. A. Schneider and P. Fake, 2010,Orthopedic Nursing, 29, p.376. Copyright by National Association of Orthopedic Nurses.

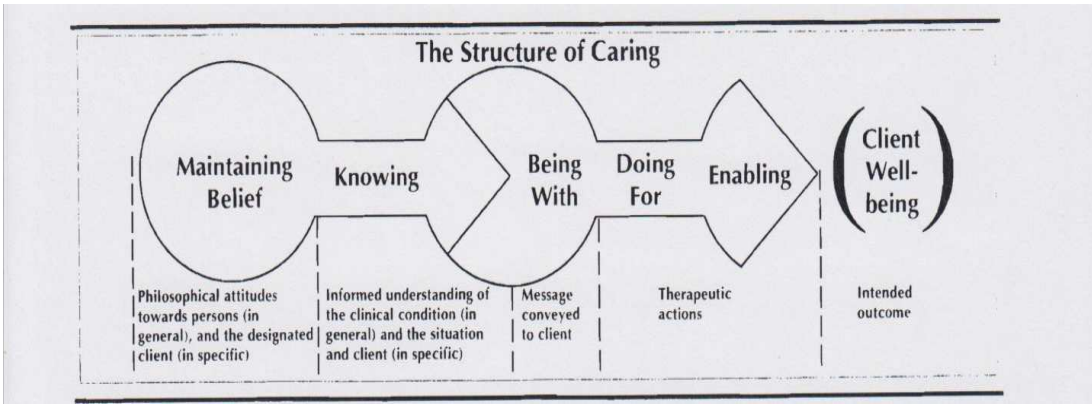


Figure 2. The structure of caring as linked to the nurses' philosophical attitude, informed understanding, message conveyed, therapeutic actions, and intended outcome. Reproduced from "Nursing as informed caring for the well-being of others" by Kristen Swanson,1993, *IMAGE: Journal of Nursing Scholars, 25,* p. 355

Assumptions of the Project

The assumptions for this project included statements that were considered true but could not be empirically verified. These assumptions were important to the design of the care model because they provided a basis on which to conduct the project. For the purpose of this project, the following assumptions were made:

- Patients and families will provide accurate and honest feedback to the questions.
- Nurses and nurse technicians will provide accurate and honest feedback to questions.
- The data collected by NRC Picker on patient satisfaction was obtained in a professional and non-biased way.
- The quality outcome data collected by the performance improvement department were accurate and timely.
- The pilot unit's satisfaction scores after implementation reflected patients' experience of the relationship-based model of care.
- An increase in satisfaction scores was an accurate reflection of the model of care.

Limitations of the Project

The limitations of this project may include:

- The study has limited generalizability. The results can only be generalized to the same population in a like facility
- The design team was all female, however, there was ethnic and age variation, this could contribute to gender bias.

- The presence of the manager on the design team could alter the team members' assessment of current patient care and conditions on the unit.
- Patients and families may not want to participate in care decisions and planning.

Summary

The increased involvement of state and federal government in hospital reimbursement has put a new focus on patient satisfaction and quality outcomes. The hospital under study has struggled in these areas over the past two years. This non-experimental, quality-improvement project was undertaken to answer two questions: Will the design and implementation of a relationship-based care delivery model improve patient satisfaction on a medical-surgical unit and will the relationship with the patient resulting from the new model of care decrease falls, hospital-acquired pressure ulcers and catheter-associated urinary tract infections? The theory of caring and the concept of relationship-based care provided the framework for the design of the model of care. The model includes (a) continuity of care, (b) seated bedside hand-off, (c) hourly rounding, (d) the nurse advocate, (e) whiteboards and (f) 5 focused care minutes. After implementation, patient satisfaction and quality outcomes improved. Nursing care was transformed from task-oriented to patient-focused.

Section 2 reviews the theoretical and conceptual framework for this project. The review of the literature identified available research and existing scholarship to support this project.

Section 2: Review of Literature and Theoretical and Conceptual Framework

Introduction

The purpose of this literature review was to identify components of a successful relationship-based model of care and to determine the results of implementation of such a model on patient satisfaction and clinical outcomes. Although there was no one universal definition or concept of caring, this review focused on the principles of Kristen Swanson's Theory of Caring for the development of a care delivery model, for patients' perceptions of caring for inclusion in the model, an overview of relationship-based care and the impact of relationship-based care on patient satisfaction and clinical outcomes. This information was to be used by the researcher and the design group as a foundation for developing the model of care for the pilot unit.

Nursing shortages and financial challenges have resulted in a restructuring of the nursing workforce, which has impacted the effectiveness of the provision of care (Fernandez, Johnson, Tran & Miranda, 2012). For the hospital under study, the introduction of assistive personnel resulted in a nursing staff that focused on the tasks of care and less on relationships with patients. This task-focused nursing care resulted in a poor showing on patient satisfaction (HCAHPS) surveys; quality and safety measures were below expectations. In addition, the Accountable Care Act, and the CMS imposed pay for performance have challenged the hospital under study to review its financial results, patient quality, safety outcomes and patient satisfaction and then to design and implement strategies that enhance outcomes and assure continued reimbursement.

Nurses play one of the most important roles in influencing patients' perception of care. Patients' ratings of nursing care have the most direct impact on ratings of overall quality of care and service (Otani, 2010). Nursing engagement is important for better patient outcomes. However, one of the barriers to engagement is getting nurses to accept and implement specific types of personal interactions with patients (Small & Small, 2011). Patient-centered moments, such as those between one nurse and one patient, need to be increased; they need to become an everyday cultural norm. The practice attributes that impact the implementation of relationship-based care; include workplace culture, the learning culture and the physical environment (McCormack, Dewing, & McCance, 2011). The current focus on relationship-based care is the result of the need to move away from medically dominated, disease oriented, and fragmented care toward care that is collaborative, relationship focused and considers the whole patient (McCance, McCormack, & Dewing, 2011). The successful design and implementation of relationship-based care over the years has resulted in improved patient satisfaction, nurse satisfaction and improved quality outcomes.

Literature Search Strategy

This project, sought to design and implement a relationship-based care-delivery model on a medical-surgical unit. The following two databases were used in the searches, covering the years 1999 to the present: MEDLINE and CINDAHL. The following keywords were used: *nursing, caring, models, perception, partnership, outcomes, theory, Swanson, Watson, patient satisfaction, relationship-based care, and patient-centered care*. Most of the articles were qualitative and one systematic review was found. Twenty-

five articles and six books met the criteria for inclusion in the literature review. The articles were included to provide support for the implementation of a care delivery model. The books provided comprehensive overviews of the conceptual and theoretical literature, as well as assistance with project design and nursing research.

Theoretical Framework Literature

Kristen Swanson and Caring

Swanson and other nurse theorists have provided theoretical frameworks for investigating caring or the healing relationship in nursing. Swanson's theory of caring was derived from phenomenological inquiry into the needs for caring by women who had recently experienced miscarriage (Swanson, 1991). The purpose of Swanson's studies was to describe the inductive development of a middle range theory that provided a definition of caring and five essential processes that characterize caring. Swanson's initial research was the result of three studies; study one involved the women who miscarried, study two neonatal intensive care unit (NICU) caregivers and study three at-risk mothers (Swanson, 1991). The definition of caring derived from this research is: caring is a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility (Swanson, 1991). Also developed were the five caring processes; knowing, being with, doing for, enabling and maintaining belief. Although there are five different processes they all overlap to result in client well-being. Each process is defined with its own set of behaviors (Table 1).

Table 1

Kristen Swanson's Five Caring Processes Definitions and Associated Behaviors

Process Definition	Associated Behaviors
Knowing understands the care event as it has meaning in the life of the patient.	Avoiding assumptions, focusing on the one being cared for
Being With involves presence or being emotionally available for the patient.	Sharing feelings, not being rushed or dismissive, conveying ability
Doing For is doing for the patient what they would do for themselves if they were capable.	Competent, anticipatory and skillful care that is protective of the patient's needs
Enabling is facilitating the patient's passage through life transitions and unfamiliar events.	Explaining, supporting, validating feelings, generating alternatives, thinking things through, providing alternatives
Maintaining Belief is sustaining faith in the patient's capacity to get through an event or transition and face a future with meaning.	Assist to attain, maintain or regain meaning in their experiences with a positive attitude, being there for the patient

Jean Watson was Kristen Swanson's dissertation chair and mentor and as a result Watson's Theory of Transpersonal Care had an impact on Swanson and the development of her Theory of Caring. Jean Watson's Theory of Transpersonal Caring was developed in 1979 and has been revised over the years; however, the basic concepts remain the same. The theory combines scientific knowledge with the elements of human caring and presence. It was designed to bring meaning and focus to nursing as a distinct health profession.

> Interactions or caring moments result when the nurse and patient make contact, the nurse enters the patient's room, and when a feeling of expectation is created, these moments transform both the patient and nurse and link them together in a patient-centered relationship. (Jesse, 2010, p. 93)

The nurse's role is to establish a caring relationship with patients and treat patients as holistic beings; through the nurse's attitude and competence, a patient's world can be influenced. According to Watson (1981), the nurse must be knowledgeable, spend time with the patient, be accepting and treat the patient well. These behaviors display unconditional acceptance for the patient and their care.

In two articles (Nelson-Peterson & Leppa, 2007, Tonges & Ray, 2011), the middle range theory of caring was used as the theoretical basis for studies involving development of a care delivery model. Virginia Mason Medical Center in Seattle, Washington combined Swanson's theory of caring with Lean principles to cut costs, increase efficiencies and improve the care they provided to their patients. The telemetry unit at medical center is a twenty seven bed unit that experiences daily inefficiencies such as nurses and nursing technicians engaged in parallel patient care as opposed to collaborative care, lack of communication, assignments based on location not patient acuity, supplies not located at the point of care and inconsistent and unfocused rounding that missed changes in patient status. Through the combination of Lean principles, such as, just-in-time, standard work and Kanban, and the education of the staff to Swanson's five caring principles, the nurses' work has been refocused to the bedside which allows for caring acts to occur (Nelson-Peterson & Leppa, 2007). The results of the study were an increase in nursing time at the bedside, resulting in a reduction in patient falls and skin breakdown, an 85% reduction in the distance a nurse walked in a shift, hours per patient day below budget, a decrease in overtime and an improvement in patient satisfaction (Nelson-Peterson & Leppa, 2007).

Tonges and Ray (2011) used the theory of caring as a conceptual framework for the development of the professional practice model at the University of North Carolina Hospitals. The Carolina Care model is a consistent set of behaviors based on Swanson's five caring process that increase patient satisfaction. The behaviors include staff rounding, nurses and nurse technicians rounds on alternate hours, a moment of caring (a 3 to 5 minute seated conversation with each patient each shift), no pass zone (no one passes a patient call light without responding), and blameless apology (Tonges & Ray, 2011). Two acute care units were used to develop Carolina Care and patients' descriptions of caring behaviors were used as the foundation of the model. The teams that designed the model of care consisted of bedside providers and the nurse manager. The results of this development of the model of care were an increase in patient satisfaction scores as reported by Press Gainey, and nosocomial pressure ulcers were reduced by 50%.

Swanson (1999) performed an in-depth review of the literature based on caring. Through this meta-analysis of caring Swanson identified the top five caring behaviors valued by the patient and the top five valued by the nurse. The top five behaviors valued by the patient were that the nurse instilled confidence in care, was knowledgeable about equipment and treatments, treated the patient as a person, and always put the patient first (Swanson, 1999). Caring behaviors valued by the nurse were listening, allowing time for the patients to express feelings, touch, being receptive to the patient's needs and realizes the patient knows himself/herself the best (Swanson, 1999). The next section of the review of literature will be perceptions of caring by patients.

Patients' Perception of Caring

Swanson's contributions are invaluable in providing direction on how to design and implement caring strategies that result in patient participation and ultimately their well-being. However, in the literature there is some conflict between what nurses perceive as caring and what patients do. Jennings, Heiner, Loan, Hemman, and Swanson (2005), in a descriptive phenomenological study were able to determine what military beneficiaries wanted in their healthcare. The six resulting features were; treating me as I matter, competence, making the patient the first priority, providing information, an efficient care process and an insurance plan that is simple. The findings of this study suggest that patients' requirements are not beyond reach and that nurses can use these findings to shape the development of a care delivery model that includes caring in all interactions (Jennings, Heiner, Loan, Hemman, & Swanson, 2005).

Fosbinder (1994), through the use of a qualitative ethnographic approach found that when patients were asked what happened when the nurse was taking care of them they primarily focused on the nurses' interactive style. As a result of this four processes were identified that were used to devise a framework for interpersonal competence; translating, getting to know me, establishing trust and going the extra mile. The identification of these processes has important implications for the development of a care delivery model. These skills must be incorporated into daily patient care by both the nurse and the nurse technician through education and practice. The need to establish rapport with the patient quickly is important because of the shortened length of stay for patients and the twelve hour shifts worked by the nurses. The value of the patient's

perspective in this study resulted in suggestions for interpersonal competencies for all healthcare providers but most importantly the nurse.

Ferguson, Ward, Card, Sheppard, and McMurtry (2013), conducted an interpretive descriptive qualitative study to find out how patients describe their experiences on an acute care medical inpatient units. Similar themes emerged from the data; patients want to feel valued and respected, trust is essential for an effective relationship, communication of information relevant to their situation was extremely important, and patient's perception of teamwork specifically with the physicians was important. Patients were also asked what advice would they give to healthcare students and the advice fell into three categories; common courtesy, communication and relationships/commitment (Ferguson, Ward, Card, Sheppard, & McMurtry, 2013). The most common advice was; ask permission, thank patients, be polite and respectful of patient opinions, commit to the patient's well-being and respond to their concerns. Based on these results, the incorporation of these behaviors in a care delivery model was of significant importance and healthcare providers and students recognize the importance of effectively including the patient in their own care.

Three other studies (Dewar & Nolan, 2013; Henderson, et al., 2007; Yeakel, Maljanian, Bohannon, & Colombe., 2003), provided insight on subject areas for inclusion in a relationship-based care delivery model. Formal education, staff identification of goals, reinforcement from peers, incorporation of goals into performance review, and posting of examples of caring behaviors or moments to serve as guidelines and reminders to the staff (Yeakel, Maljanian, Bohannon, & Colombe, 2003). These studies found that

nursing caring behaviors can be influenced by multiple focused interventions with resulting improvement in patient satisfaction. Henderson et al. (2007) combined observational data and post discharge survey data to conclude patients focus more on the nurse's ability to respond to their specific request than the closeness to the nurse, when nurses are readily available to care for the patient correlated to the patient feeling cared about and strategies to address issues should be implemented. Nurses should introduce themselves at the beginning of the shift and together with the patient set a plan for the duration of the shift. Inform the patient when the nurse will be unavailable, such as lunch break, and who will assume the care during that time. Also, the nurse needs to effectively prioritize and delegate care to meet the expectations of the patient. Dewar and Nolan (2013), determined that the knowledge, skills and values required for relationship-based care are willingness to negotiate and compromise, the ability to see someone else's perspective, promoting and accepting others emotions, sharing personal information, openness to new ideas, sharing insight and recognizing what others are good at.

In order to be successful in creating an environment that is therapeutic and relationship based there must be an exploration of relationships from both the patient and the nurse perspective. There must also be a focus on relational practices and the skills and activities necessary to create an environment for the patient that has connection and collaboration as central characteristics. The use of relationship-based care as a framework for this project will help to bring together patients and nurses to outline essential behaviors and activities to improve the effectiveness and quality of care on the pilot medical-surgical unit.

Conceptual Framework

Relationship-Based Care

Caring is the essence of nursing, however, with the increase in technology and federally mandated documentation it appears that the nurse is spending more time meeting requirements than establishing rapport with patients. Relationship-based care is designed to take nursing care from task focused to relationship focused. This framework provides a proposed structure for how things are done with the focus on improving quality of care, enhancing teamwork among caregivers, improving work environment, providing continuity, but most importantly, establishing a relationship with the patient and family that puts them at the center and encourages active participation in their care. As stated before in this paper, relationship-based care is composed of three important relationships; relationship with patient and family, relationship with self and relationship with colleagues. The goal of relationship-based care is a caring and healing environment that supports the other dimensions of leadership, teamwork, care delivery, professional nursing practice, resources and outcomes (Campbell, 2009).

The relationship-based care concepts provide the framework for every department to plan their own model design. The essential values of relationship-based care are embedded in these principles; caring and healing environment, responsibility for individualized relationship and plan of care, work allocation, schedules and assignments, communication, leadership and process improvement. The heart of relationship-based care is that the registered nurse has full authority for determining the kind and amount of nursing care a patient will receive, the work that care requires, how much of that work

requires the attention and time of the registered nurse and how much can be delegated to other caregivers (Wessel & Person, 2004). Patient assignments are based on continuity of relationships, complexity of care required, and the skills and knowledge of the care giver (Wessel & Person, 2004). The manager creates an environment supportive of professional nursing practice where registered nurses are autonomous decision makers and creative problem solvers (Wessel & Person, 2004). The relationship-based model operationalizes the concepts of responsibility, authority and accountability through the identification of the six essential dimensions, with the patient as the center of the activity (Cropley, 2012). Through patient focused work based on common vision, mission, values and goals excellence in health care can be delivered. The flexibility of relationship-based care is that it emulates the culture and priorities of the unit or the hospital.

Some identified components of relationship-based care are shift huddles for the purpose of information sharing, seated meaningful bedside shift hand-off that includes the patient, hourly rounding for the purposes of anticipating the patient's needs in regard to positioning, pain, elimination and presence, instituting the tenets of primary nursing/nurse advocate where one nurse is the primary nurse/nurse advocate from admission through discharge and serves as the advocate and care coordinator for the patient, use of white boards in the patient rooms for communication, interdisciplinary rounds for collaboration and continuity of care, and having the nurse and nurse technician sit with each patient for five focused care minutes during the shift for the purpose of sharing information and forming a relationship (Campbell, 2009, Cropley, 2012, Dingman, 1999, Schneider & Fake, 2010, Woolley et al., 2012).

A clinical manager that fosters an environment that encourages reciprocal care between the nurse and patient is necessary for the outcomes of relationship-based care to be met. The ability to engage in a partnership with patients requires mentorship to develop insight and interpersonal skills to work with patients who are fully participating in their care. Patients will need to know what is expected of them and what their role in the model of care entails. To become partners in care will help to increase satisfaction and outcomes of care. The next section explores reported outcomes after implementation of relationship-based care on a variety of units in several states and Canada.

Outcomes of Caring and Relationship-Based Care

Woolley et al. (2012) implemented a relationship-based care delivery model at Surgical Medical Care Center on a 61-bed surgical unit in the Midwest. The main components of the care delivery model were white boards in each patient room, hourly rounding focused on pain, potty, PO, position, pump and pickup, education of staff on team building and effective communication with colleagues. The elements of this care model were monitored using a green sheet completed during hourly rounding and chart review. The goal was to create a caring healing environment for patients and a safe and healthy environment for the staff where they could work as a team with accountability (Woolley, 2012). By inspiring staff, establishing practices and processes, educating the new staff, providing continuing education to the current staff, celebrating and rewarding those with the greatest adherence during implementation and providing the necessary tools the relationship-based care model was instituted. As a result, an increase in patient satisfaction was demonstrated by HCAHPS scores showing an upward trend to 100% of

the time nurses treated me with courtesy and respect, 86% of the time nurses listened to me carefully, 86% of the time nurses explained care in a way that was understandable and 90% of the time communication with nurses was good. Other positive outcomes were a decrease in falls and hospital acquired pressure ulcers and an improved staff efficiency due to a decrease in call light usage resulting in nursing having more time at the bedside.

Hedges, Nichols, & Filoteo (2012), implemented relationship-based care on a fifty two bed combined postpartum and antepartum unit in California. The design team consisted of staff nurses, managers and clinical specialists. The team developed five guiding principles and seven practices. The five guiding principles were coordination, communication and collaboration, clinical decision making: knowing the patient, work allocation and patient assignment, leadership and team approach, professionalism and self-care (Hedges, Nichols, & Filoteo, 2012). The seven principles of the model implemented on this unit were team briefing and debriefing, standardized nurse handoff at change of shift, focus time the intentional uninterrupted period of time spent by the nurse communicating with the patient and family each shift, assignments based on continuity of care, participation of the nurse in rounds for the purpose of managing the patient's plan of care and coordination of care. After implementation, the compliance with practices was met 80-90% of the time. If compliance dropped off, one-on-one coaching and reinforcement was provided. Patient satisfaction was monitored through the response to three HCHAPS survey indicators; addressed emotional needs, kept patient informed and treated patient with respect. Although the changes in patient satisfaction were small, a positive upward trend was noted.

Relationship-based care was implemented at a small hospital in Texas (Cropley, 2012). The model of care was designed and implemented using the collaborative governance professional development team. The staff was engaged through the use of in-services, staff meetings, question-and-answer sessions, and use of key tools such as rounding and care collaboration (Cropley, 2012). The three indicators used to evaluate the implementation were patient satisfaction, length of stay and readmission rates. Pre-implementation data was compared to post implementation using descriptive statistics. Moderate correlation was found between the relationship-based care model and readmission ($P = .05$) and weak correlation between relationship-based care and patient satisfaction ($P > .05$) and length of stay ($P > .05$). The conclusion in this study was relationship-based care supports a patient-centered collaborative environment that improves patient satisfaction and potential reimbursement (Cropley, 2012).

In their study of patient-centered care in Canada, Poochikian-Sarkissian, Sidani, Ferguson-Pare, and Doran (2010), examined the extent to which nurses engage in patient centered care as perceived by both patient and nurse. They also correlated the relationship between patient-centered care and patient outcomes. Their findings indicated that patient-centered care (individualized care and involving patients in decision making about their care) contributed to an increase in self-care ability and patient satisfaction with care. Overall, patients and nurses reported implementation of patient-centered care, to a moderate extent, resulted in high levels of patient self-care. Based on their descriptive correlational study, they concluded that implementation of patient-centered care

improved patient outcomes by increasing patient self-care ability and improving satisfaction with care and quality of life.

Summary and Conclusion

This review of literature demonstrated that relationship-based care is just a framework used to change the culture on a unit or a hospital. How it looks in each facility will vary and reflect the mission, vision, values and culture of the organization. The presence of strong leadership support and clear goals are two of the main ingredients for success in the implementation of care model based on relationships. Each hospital in these studies implemented the model with focus on different elements; however each experienced improved patient satisfaction and quality outcomes. These studies help to provide the evidence and underpinning for this project and will help to inform the design and implementation.

The lack of studies where all four components (a) development of a nurse advocate role, (b) seated bedside shift hand-off, (c) 5 minute focused care and (d) continuity of care was the gap that structured this project. The formation of a design group consisting of bedside providers, leaders, an educator, and the student facilitator combined the elements of evidence derived from Kristen Swanson, patients' perceptions, and the relationship-based care framework into an effective care delivery model. The approach to this project was informed by those who have successfully implemented a relationship-based care delivery model and the identified benefit of a collaborative approach that provided those closest to the care of the patient to design, train on, implement, and evaluate the relationship-based care delivery model.

Section 3 will detail the project design and methods, as well as, the plan for population sampling, data collection and analysis, and evaluation.

Section 3: Method

Introduction

The change in healthcare over the last two decades has led to task-oriented depersonalized care, focused more on checking boxes and performing interventions on time, than on having a relationship with the patient. The idea of the patient as an active participant in their care is no longer a notion but a requirement. The era of physician-driven care without regard to patient preference is not only ineffective; it is unrealistic. A relationship-based care model furthers the tenet that no decisions should be made about a patient without the patient's involvement. Important to the mission and goals of a care delivery project are the care providers, patients, and families. During the focus groups, the stakeholders provided needed information and feedback to support and motivate those designing this project. This project used stakeholder feedback and the literature to answer the questions (a) will the design and implementation of a relationship-based care delivery model improve patient satisfaction and (b) will the therapeutic relationship improve quality outcomes?

This section will explain the approach and design for the care delivery model. It will also lay out the plan for data collection and analysis, population sampling, and evaluation.

Project Design and Methods

The three steps to project design to be detailed in this section are mission statement, program goals and objectives, and estimated time needed for the program (Hodges & Videto, 2011). The mission statement provided the parameters around which

goals and objectives were designed (Kettner, Moroney & Martin, 2013). The mission statement provided a look toward the future for the target population and the organization. Goals were the statement of expected outcomes for the project. A goal flows from the mission statement and serves as a reference point for the progress of the project and a motivator for those involved in the production of results. Objectives outline the results to be achieved and the manner in which the results will be achieved. This project had five objectives: needs assessment, design, education, implementation, and evaluation. Each objective had a time frame, a target for change, a process, and a designated responsibility. The final step of structuring a project plan was to breakdown each objective into specific tasks that were completed in order for the objective to be met. Appendix A, illustrates the mission, goal, objectives, and activities that were developed for this project.

In order to complete the project on time and assure that all objectives and tasks were accomplished a Gantt chart was used. The Gantt chart (Appendix B) is a visual representation of the project, objectives and activities, the projected timeframes and completion percentage of each. The team was easily able to see the organization of the project and the progress made.

Population and Sampling

In project planning, the development of a mission statement helps to create the foundation for planning, implementation and evaluation (Hodges & Videto, 2011). The goals for the project were general and set the expectations for the outcome. The objectives were specific, measurable and used to evaluate the project. The target

populations in the development of a relationship-based care delivery model were the bedside care providers, patients and families. In order to create a meaningful mission statement, goals and objectives it was important to understand the baseline knowledge of bedside providers, patients, and families perception as caring. This knowledge helped to develop a mission statement that answered the questions what do we want in terms of care and how do we want it delivered. The inclusion of bedside care providers and patients helped to determine the elements of relationship-based care that currently exist and also those that needed to be developed. This aided the design team in developing a shared vision of relationship-based care. Participation by the target population helped to develop an ownership and pride in the project and targets areas where change was needed (Kettner, Moroney, & Martin, 2013), as well as, areas that were established and effective.

Quality and safety of health care rises, costs decrease and satisfaction increases when health care administrators, providers and patients/families work in partnership (Institute for Patient and Family Centered Care, n.d.). The Patient Family Advisory Council at the hospital was of help with the development of the care delivery model by providing important perspectives about the experience of care. They brought a connection with the community and served as a sounding board for the design team. This group was valuable when establishing the components of care because they were able to identify their wants and needs as patients. Another component of a care delivery model is the physical environment for both patients and staff, to this end the Women's Board and the Hospital Foundation facilitated the improvement of the physical environment by donating money to the pilot unit for paint, furnishings and décor. These two groups had

been very instrumental in many past change projects through fundraising and donations that the regular operating budget could not provide.

The strategy for facilitating the involvement of the bedside care givers was to hold the design meetings on a time and date that ensured the bedside providers coverage for their patients. The manager arranged adequate staffing to cover the time the bedside providers were in the meeting. Having their patients covered by another nurse or nursing assistant helped to decrease the distraction and worry about whether the patients were receiving required care. The Patient Family Advisory Council already had established meeting times and was very motivated to contribute to the establishment of a care delivery model that put patients and families in the center. A monthly progress update and solicitation of feedback and suggestions by the design team student facilitator helped to motivate this council to assist with this project, as well as, gave them a stronger commitment to the improvement of patient satisfaction through an improve care delivery model.

Data Collection

The precede-proceed model (Hodges & Videto, 2011) of needs assessment was the basis for the needs assessment for the development of the relationship-based care model. This model outlined the type of data that should be collected and delineated a means of interpreting that data for both the implementation and evaluation of a project. The premise of the model is health behavior is the result of multiple factors and that voluntary behavior change is more successful than non-voluntary change. The two groups assessed during this project were the bedside care providers and patients and their

families. The interaction of predisposing, reinforcing and enabling factors helped determine the type of behaviors to be focused on when developing the model of care (Hodges & Videto, 2011). The use of both primary and secondary data was of importance to this project. The use of normative data, perceived need and expressed need helped to define and evaluate the model for care (Kettner, Moroney, & Martin, 2008). These approaches helped define what providers and patients perceived as caring based on actual care given or received and personal beliefs. A systematic review found there is considerable evidence to support the idea that there is little similarity between the perceptions of patients and nurses in regard to which behaviors are considered caring and that intentional caring behaviors are not always perceived as such by patients (Papastvrou, Efstathiou, & Charalambous, 2011).

The secondary data collection came from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey provided by NRC Picker to the hospital on a monthly basis. This survey is a phone survey given to discharged patients in an effort to rate their satisfaction with their hospital stay. There is an overall hospital rating as well as rating for each individual inpatient nursing unit. This survey provided valuable information through the ratings and patient comments to begin to design a care model. The HCAHPS survey was also used to evaluate the success of the model. The hospital also compiles quality outcome data on a monthly basis that was used to assess the effectiveness of care. The primary data was collected using focus groups composed of nurses and nurse technicians in one group and patients and their families in another. Two questions were asked of the care providers to elicit their ideas; what did the patient want

from you while they were in the hospital and how often those needs were met. The same questions were asked of patients and their family members and the answers were recorded, transcribed and assessed for commonality and themes.

The challenge with the nurse/nurse technician focus group was arranging a meeting time that facilitated their participation. Another identified potential challenge was no one would participate and the time required to conduct these focus group would be prohibitive. Solutions to these problems were to use already established meetings such as the collaborative governance meeting and the Patient Family Advisor Council to serve as the focus groups. Also the use of the marketing department and the director of organizational development to facilitate these groups helped to enhance conversation and not introduce any potential bias. Even with these challenges, the information collected from these groups provided a good foundation. This data was also valuable for the evaluation of the effectiveness of the model. The goal of this project was to improve patient satisfaction and quality outcomes as a result of an improved therapeutic relationship.

Data Analysis

The normative data used for this project was readily available to managers and staff on a weekly, monthly, quarterly, and yearly basis. This data was used to compare goals and objectives to outcomes. The hospital under study was very transparent with data relative to patient satisfaction, and quality outcomes. There was no special permission needed for access to the data required for the evaluation of this project. The data was located on a shared drive on the hospital intranet and all staff has access. A

request for access to the hospital network was completed during hospital orientation. The data from the focus groups was collected by a marketing employee using voice recording and supplemental written notes. After the recordings were completed, they were transcribed verbatim and provided to the author for review and analysis. The hospital under study requested that the verbatim transcripts not be included in the project report due to sensitivity and concern for confidentiality. The only interaction the author had with the Patient and Family Advisory Committee or the nursing staff was to introduce the project and thank the attendees for their participation. The transcripts were analyzed for recurring themes and responses. A categorized list of care components identified by patients and nurses was generated.

The patient satisfaction data or HCHAPS was provided to the hospital from NRC Picker a government approved vendor for the collection and analysis of data from patients discharged from the hospital. The vendor calls a random predetermined number of patients discharged from all units of the hospital to home. The survey consisted of 28 questions about the patient's experience of care while hospitalized. Some questions are judged on a Likert scale and others are yes or no questions. At the completion of the survey, the data are collated and assessed on a hospital level and also the unit level. The results were compared to a national NRC Picker database benchmark, as well as, the hospital under study's corporate health system benchmark. This data was provided via the NRC Picker website on a weekly basis with the calculation of a rolling twelve month average.

The data for quality outcomes was collected by an administrative assistant in the performance improvement and risk management department. This administrative assistant has been trained to review the chart for approved criteria on falls, pressure ulcers, catheter-associated central line infections, and catheter-associated urinary tract infections. The training provided was very specific because these are publicly reported data and the need for standardization is imperative. The data extraction was audited on a quarterly basis by a state provided auditor, and it met strict standards to ensure accuracy. The administrative assistant consistently has high rating for accuracy of data collection. The clinical outcome data was available for all employees to see on the hospital intranet and was also included each unit's balanced scorecard. This information was used for informational and evaluative purposes by leadership and employees on a regular basis.

Evaluation

Evaluation Methods

The discussion of evaluation methods is based on the work of Kettner, Moroney, & Martin (2013). Performance measurement, monitoring and evaluation are important aspects to be considered when planning a project. The project must identify the target population and data to be collected in order to progress through the planning, to implementation, and finally evaluation. Performance measurement has its' roots in finance and management. It provides feedback on performance of the project to external stakeholders and possibly government agencies. Performance measurement is only concerned with the collection and reporting of performance data. Effort, cost-efficiency, results, cost effectiveness and impact data are the types of data collected and assessed for

performance management. The target population for this project was the pilot medical surgical unit's patients and bedside caregivers. The data used to develop performance measurement was the patient satisfaction data and clinical outcomes data; these are publicly reported and have an impact on reimbursement and the reputation of the hospital.

Process and outcomes monitoring has roots in management and is concerned with the assessment of program operations. The monitoring focus involves, was the project implemented as designed and did it meet the expectations of the target population. Both performance measurement and monitoring are concerned with quality, outcomes and meeting the goals and objectives of the design during implementation. The type of program data appropriate for monitoring is coverage, equity, process, effort, cost-efficiency, results and cost-effectiveness. Performance measurement reports outcomes to external stakeholders. Internal monitoring is used to make sure the project is implemented as planned. If the data indicates the project has gone off course, then the design team is provided the opportunity to correct or refine the design. Both these processes also look at cost effectiveness and cost efficiency. The creation and adherence to a budget and the collection of outcomes data served the purpose of monitoring for this project. Observation, mentoring and auditing of bedside handoff, five minute focused time, hourly rounding and assignment of a nursing advocate for the patient assisted the design group with assessment of the care delivery model implementation and function.

The program evaluation component is rooted in policy and planning and the primary purpose is program and policy improvement. Although program evaluation is

interested in the cause and effect of the project, it is most interested in how these impact policies and planning. Program evaluation is also concerned with both intended and unintended consequences of the project and how they impacted the overall project. Program evaluation was useful during both the implementation stage and the after the project was completed. The data collected for program evaluation included coverage, equity, process, results, cost-effectiveness and impact. The source of the data for program evaluation was the patient satisfaction data, the unit-based scorecard, and clinical outcomes and quality outcomes. The overall plan for evaluation was of prime importance. This plan determined data needs and design elements to meet the needs of the target population.

Evaluation Plan

All four types of evaluation, formative, process, impact, and outcome were appropriate for this project A formative evaluation generally takes place before or during a project's implementation with the aim of improving the project's design and performance. Formative evaluation was used during the needs assessment and the design and planning phase of the project. The goal for the needs assessment evaluation was to determine if the data collected during the focus groups with patients and nurses and the interpretation of the data reflected what the patients and nurses actually said and meant. After the completion of the needs assessment the data was collated and put in to presentation form and presented to the Patient Family Advisory Council and the nursing staff. This presentation verified the key factors that each identified as caring for the purpose of information and assessment of accuracy and relevance. The goal for the

formative evaluation during design and planning was to determine if educational materials were appropriate and also to test potential new behaviors to see if they are appropriate for inclusion in the project. The activities included in this evaluation were a review and assessment of the educational materials for appropriate reading level and clarity. The education video was previewed to assure it was acceptable and conveyed the new information appropriately. Observations and assessments of the newly proposed caring behaviors were performed. These observations determined if a connection between caregiver and patient had been established.

During implementation, the goal of process evaluation was to determine if the project was implemented as planned. The key areas of focus were education, training, the appropriateness of goals, objectives, and the target population. Ultimately the purpose of this evaluation was to assess whether the target population, caregivers and design members were satisfied with the results. Multiple types of data were needed for the process evaluation; observation, test data from training, patient satisfaction data, clinical outcome data and budget data. The activities included observation, chart review, forms review for continuity of care, hourly rounding, and the consistent assignment of lunch breaks. This evaluation provided information that determined if the care delivery model flowed in a logical way and the need for modifications or deletions.

Impact evaluation reviews improvement in behavioral, environmental and other factors to determine the extent the project has caused the intended change (Hodges & Videto, 2011) in the short term. Impact evaluation can be used at three month intervals after implementation of the model of care This evaluation helped determine if there has

been an improvement in patient satisfaction and clinical outcomes and if not what are the needed adjustments to the project. Again the same data sources were used to assess improvement or decline. Patient satisfaction will be compared to the months before implementation with focus on satisfaction with overall care, responsiveness and the question during this hospital stay did the staff take your preferences and those of your family into account in deciding what your healthcare needs were.

Lastly outcome evaluation determines the extent of accomplishment of the project's long term goals. Outcome evaluation would be appropriate at one year post implementation to determine if the anticipated cultural change from fragmented task-oriented patient care to accountable and relationship-based care has occurred. This would be determined from patient satisfaction survey data, clinical and safety outcome reports and the results of the employee opinion survey. Also the review of the publicly reported data would also help to provide feedback to the success or failure of the care delivery model. For sustainability the need to review budgets, productivity and the impact on supplies and equipment would also be needed.

The importance of evaluating a project from design through implementation and then at regular intervals after the project is established cannot be overstated. Each step of the process is improved by the use of data for evaluation. A thorough evaluation plan identifies performance data that is required to perform the evaluation function. The risk of planning for evaluation after implementation is the data is not available or does not exist. For this project all the data needed exists and is readily available to the student and design team members. The importance of this project rests upon correctly identifying and

providing for the needs of the patients on the pilot unit and this evaluation plan is the key to achieving this goal.

Summary

The design, implementation and evaluation of a relationship-based care delivery model are the first steps in making the patient a partner in care. This care delivery model is a starting point that provides guidelines for decision making, care provision, culture change and eventually practice changes that can be implement hospital and potentially corporate-wide. Patient satisfaction and quality outcomes are the incentive for caregivers to make the change to relationship-based care and to abandon historical task-oriented care. Charts, tables and graphs helped the team visually identify the progress of the project and maintain motivation and clarity. The combination of these elements resulted in a well-planned and organized project that improved patient satisfaction and quality outcomes.

Section 4 will review the results, findings, and recommendations for the future of the relationship-based care delivery model.

Section 4: Results, Findings, and Implications

Introduction

The design and implementation of a care delivery model was undertaken as a result of declining patient satisfaction scores and concern for clinical outcomes on a pilot unit at the practicum hospital. The aim of the project was to incorporate feedback from two focus groups, one with patients and families and one with nurses and nurse technicians, Kristen Swanson's five caring principles and the concepts of relationship-based care in order to develop a care delivery model that would encourage continuity of care and engagement with the patient. The goal was to ensure a positive hospital experience for the patient by developing of a care delivery model that facilitated the nurses' contribution to patient outcomes, and improved clinical outcomes. This non-experimental, quality-improvement project answered these two questions: (a) Will the design and implementation of a relationship-based care delivery model improve patient satisfaction on a medical-surgical unit? and (b) Will the nurses' relationship with the patient resulting from the new model of care decrease falls, hospital acquired pressure ulcers and catheter-associated urinary tract infections? The project brought together a group of bedside care givers, the unit manager, an educator, a unit clerk and a student facilitator to design, train on, implement, and evaluate a relationship-based care delivery model.

Walden's Institutional Review Board approved the project components and methodologies (08-28-14-0340894). The resulting components of a care delivery model that were most important to the focus groups were

- Attention,
- Information,
- Kindness
- Knowledge.

The care delivery model was designed with these key components:

- Scheduling and assignments for continuity
- Meaningful, seated, bedside hand-off
- 5 focused care minutes,
- Whiteboards
- Hourly rounding
- Development of a nurse advocate for each patient.

Three months after implementation, patient satisfaction and clinical outcomes showed improvement. Other inpatient nursing units reviewed the model and then the next unit for implementation was selected.

Results

The results of this project are grouped by phases: assessment, design, training on, and implementation. Each phase built upon the previous work and culminated in a care delivery model that enhanced care for both the patient and family.

Assessment

Focus groups convened with patients and families in one group and nurses, nursing technicians and unit clerks in the other. Each member was given a consent form to sign . The same questions were posed to both groups and the answers were recorded

and transcribed by a member of the marketing department. Members of the Patient and Family Advisory Council participated in the patient and family focus group. The bedside provider group was a convenience sample of nursing staff from each inpatient unit.

The questions posed to each group were as follows:

1. What did caring mean to you and or the patient while you or the patient were in the hospital?
2. What percentage of the time during your hospital stay or shift did you receive or provide the care you wanted?

The literature suggests that patients' and nurses' perceptions of care are quite different (Jennings, Heiner, Loan, Hemman, & Swanson, 2005). However, this did not hold true with these focus groups. After reviewing the transcripts of the focus groups and grouping the responses, both groups' caring behaviors fell into four categories; attention, information, kindness/empathy and knowledge. Elements under attention included timely response, listening, follow through, someone to depend on, quiet and a private room. Information included keeping patient/family informed such as plan of care and when discharge will occur, when tests will occur and reason for any delays. Kindness/empathy included don't leave me, talk to me, teach me, sit down, treat me with respect and dignity and act with compassion. Knowledge included providing competent care, using plain English instead of medical jargon, and continuity of caregivers. Both the focus groups believed that only 50% of the time they did the patient receive or the nurse provide the care they wanted. The main reason for this response was identified as staffing and increased census. Patients did not want to hear about how busy the unit was or how many

other patients the nurses had, they wanted the focus to be on them when the nurse was in the room. With the conclusions from the focus groups and the theoretical framework of Swanson's theory of caring and relationship-based care the design planning began.

Design

The design group consisted of the student facilitator, nurse manager, two clinical team coordinators, three nurses, two nursing technicians, and one clinical educator. This group met once a week for six months to review current literature, theoretical framework and conceptual framework to formulate the model of care for the pilot unit. The team created a team charter and ground rules (Appendix D) for the purpose of clarifying the purpose of the group and the requirements for each member. The care model emerged from focus group information, literature review, Kristen Swanson's theory of caring and the concepts of relationship-based care. The resulting model of care (Figure 3) included the following components; staff scheduling and assignments to enhance continuity of care, sitting at the patient bedside for meaningful bedside shift report, use of white boards for communication, 5 focused minutes a shift for the development of a therapeutic relationship with the patient, hourly rounding by the nurse and nurse technician, and the development of the advocate nurse role.

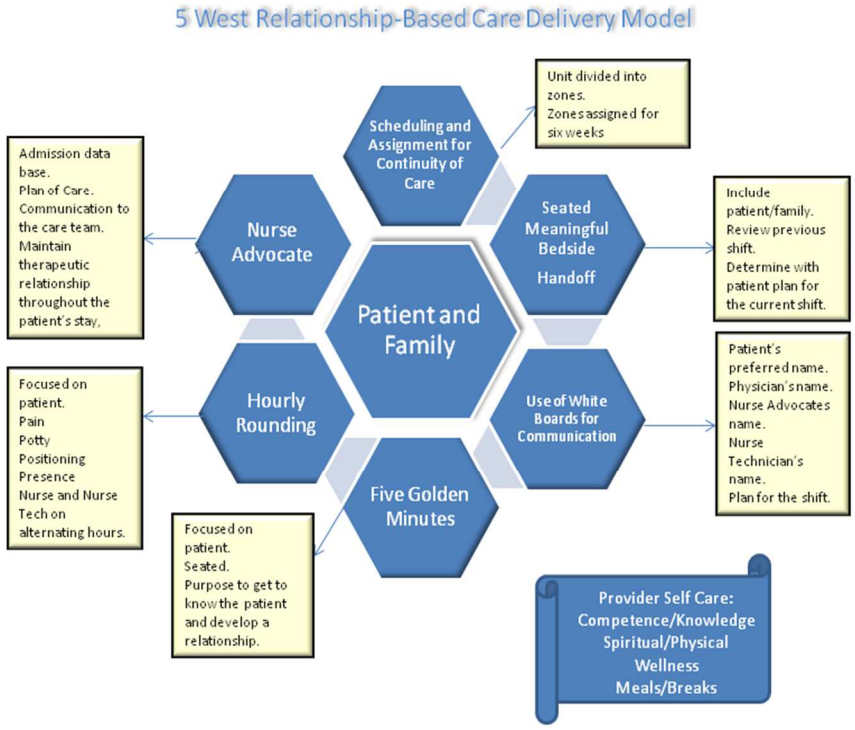


Figure 3. Pictorial representation of the components of relationship-based care for the pilot unit.

Staff scheduling and assignment to enhance continuity of care involved the division of the unit into zones of care, each zone contained five rooms. A day nurse and nurse technician paired with a night nurse and nurse technician for each zone for the duration of a 6-week scheduling period. This day/night pairing not only enhanced continuity of care but also encouraged teamwork between the caregivers. The average length of stay on the pilot unit is less than 3 days, therefore, having paired assignments assisted in meeting the patients' desire for consistency.

Meaningful seated bedside report provided the first opportunity to establish an intentional and therapeutic relationship with the patient. Patients were included in the

shift change plan of care and review of goals. This communication was instrumental in safe, effective handoff between nurses. Meaningful bedside report resulted in a thoughtful exchange of information between two caregivers. This exchange provided a well-informed and supported nursing team, and a patient whose needs are met. The patient's trust in the care team is solidified because of the transparent and inclusive conversation about their health and plan of care.

Whiteboards are used as a tool for communication between the care team and the patient and family. The boards identified the nurse, nursing technician and physician for the shift, as well as, the goal for the day and the plan for the hospital admission. The whiteboard also indicated what name the patient preferred to be called and what if any safe lifting equipment was needed for the patient's ambulation. Whiteboards were standardized for all the patient rooms and positioned on the wall so the patient and caregivers could easily see the information contained on the board.

The 5 focused minutes were the opportunity for the nurse to make a personal connection with the patient. It was the time to talk with the patient about patient, family or care concerns and to demonstrate an interest in the patient as an individual. It was an opportunity for the nurse to show compassion and to establish a therapeutic presence with the patient. This time created a bond between the nurse and the patient. The nurse conveyed respect for and interest in the patient beyond their diagnosis. Taking the time to find out what is important to the patient and family saved time. The patients' needs were met and trust in the care team established. Call bell usage decreased and the nurse had all

the information needed to effectively convey the patient's goals to the rest of the care team.

Hourly rounding was the only component of the model that already existed on the unit. Each nurse and nurse technician rounded on assigned patients each hour during their twelve hour work shift. The nurse and the nurse technician alternated these rounds so that every hour the patient would be checked on. The modification to this process was the addition of therapeutic presence. It was no longer enough just to enter the room. The objective of the rounds became assessment and relief of pain, positioning, and toileting.

The nurse advocate role was determined by the assignment for the day. The advocate nurse and the nursing technician formed the care team for a group of patients. The advocate nurse led the team and was responsible for establishing the plan of care, based on the patient's needs and personal goals. The advocate nurse coordinated the plan of care from admission through discharge and worked with the care team and patient and family to evaluate goals and timelines and revise as necessary. The communication from the advocate nurse to the other caregivers and physicians was a crucial responsibility of this role. Through the use of whiteboards and the patient care communication note in the electronic medical record the advocate ensured all members of the care team were collaborating. This method of communication aided in meeting the patient's needs and keeping the patient at the center of care. To maintain the therapeutic relationship and to keep the patient informed of progress toward meeting personal goals, the advocate also communicated information from the team back to the patient and family. The advocate nurse also had the responsibility of supporting a learning environment for the associate

nurse. This included effective communication of the plan of care during meaningful bedside rounds and connecting the physician's orders to the patient's plan and goals.

Education

During the introduction of the concepts of relationship-based care, articles and lectures were used for the bedside providers. The team created a relationship-based care bulletin board and all education announcements and updates were kept on that board. The board was located in the staff lounge in plain view so that all staff could see and be kept up to date. Staff meetings, daily huddles, and email were also used to keep the unit staff informed of progress and the timeline for implementation. As the model took shape, new behaviors were practiced for two weeks. The observations and feedback from the providers were used to modify the model of care if needed.

Once the model was finalized an instructional video was written and produced by the team (Appendix E). Before the video was presented a pretest (Appendix F) was given to assess the knowledge of relationship based care. After education and viewing of the video, a post test was used as a tool to assess knowledge of the model of care. Most behaviors associated with the model were easily understood by the bedside providers, with the exception of the nurse advocate role. The team reconvened, modified the role and developed a coaching tool to be used to clarify the role (Appendix G). Once the education was complete and there was strong baseline knowledge of the relationship-based care delivery model it was decided that implementation would begin.

Implementation

To create a sense of excitement, and to emphasize the importance of the model of care, there was a kickoff celebration. Food and decorations were available in the staff lounge throughout the day. The author used the morning huddle to review the components of the model and to answer any remaining questions. This model of care was designed to meet the needs identified by both patients and bedside providers and the team members reassured the staff that perfection was not required. The aspects of patient care that were important to the success of this project were open communication and therapeutic presence.

Throughout the first two weeks each team member volunteered partial or full shifts to serve as coach and mentor to the staff. The design team continued to meet on a biweekly basis to discuss the progress of the implementation and any areas of concern. At each meeting the available patient satisfaction and quality data was reviewed. After the first month it became apparent that there needed to be an identified resource or expert on the unit. This person was needed to answer questions and provide encouragement for the consistent focus on the patient and the care delivery model. One of the charge nurses was very dedicated to the success of the model and volunteered to be the resource and to facilitate the post implementation meetings. All the team members continued to role model and encourage the compliance with the relationship-based behaviors. Communication of the information obtained from patients needed to be documented and the team developed a patient communication note (Appendix H).

Reward and recognition for the staff was also the responsibility of the team. They developed a recognition strategy known as "You got caught caring." It was a ballot system (Appendix I). The care team members could submit a ballot when a fellow team member exhibited relationship-based care behaviors. The ballots were placed in a box located in the staff lounge. At the end of the month, the winners were chosen at random and provided a grocery store gift card. All ballots were counted and the nurse and nurse technician receiving the most recognition were featured on the relationship-based care bulletin board. This recognition was very popular and helped to hardwire the care model.

Evaluation and Findings

Using 3 months of data, an initial evaluation was performed. The findings from the evaluation were based on two parameters: patient satisfaction (Figure 4) and quality outcomes (Figure 5). The fiscal year at the hospital under study runs from July to June. The project was implemented in August of fiscal year 2015. Therefore, August data were used as baseline. As depicted in Figure 4, patient satisfaction scores have demonstrated a steady improvement in three dimensions; communication with nursing, responsiveness and overall rating. The willingness to recommend score, however had variable results. The HCHAPS dimension of communication with nursing improved by 13.2%, responsiveness by 12.5%, and overall rating of care by 14.5%. Willingness to recommend declined initially however by Month 3 had increased by 8.7%.

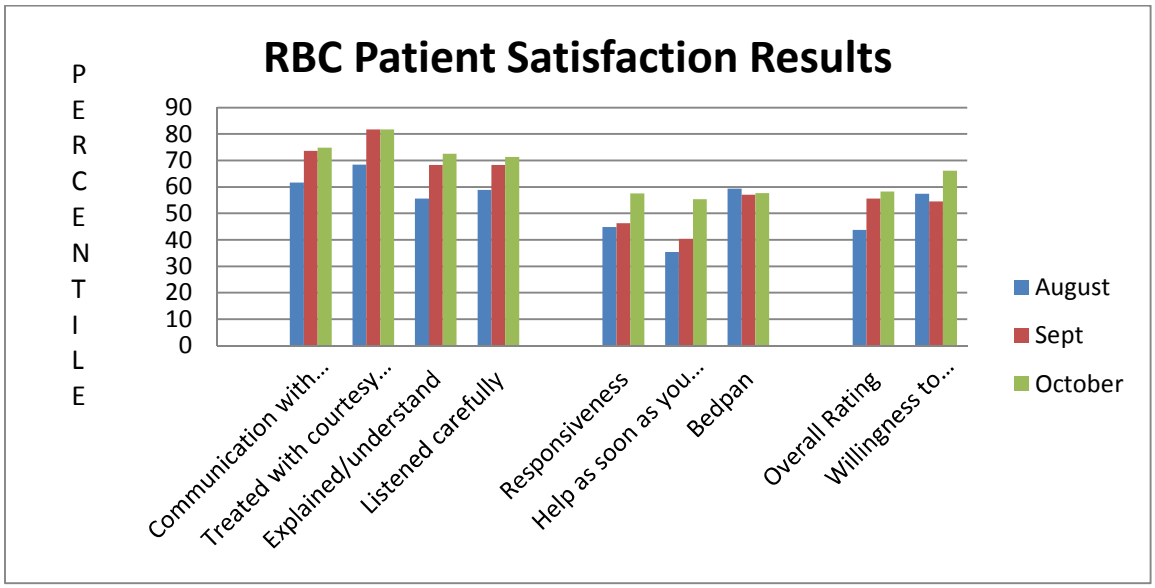


Figure 4. Graph of change in patient satisfaction scores as a result of design and implementation of the relationship-based care delivery model.

As a result of improved hourly rounding and the inclusion of the patient in their care, the quality outcomes for the unit have also improved. This improvement is not as positive as the patient satisfaction scores however it is moving in a right direction and overtime should demonstrate as significant an improvement as patient experience. The quality outcomes focused on during this project were falls, hospital acquired pressure ulcers and catheter associated urinary tract infections. The August baseline for each measure was as follows: falls 6, HAPU 4, and CAUTI 3. By the end of October each category had improved as indicated by the downward trend in Figure 5.

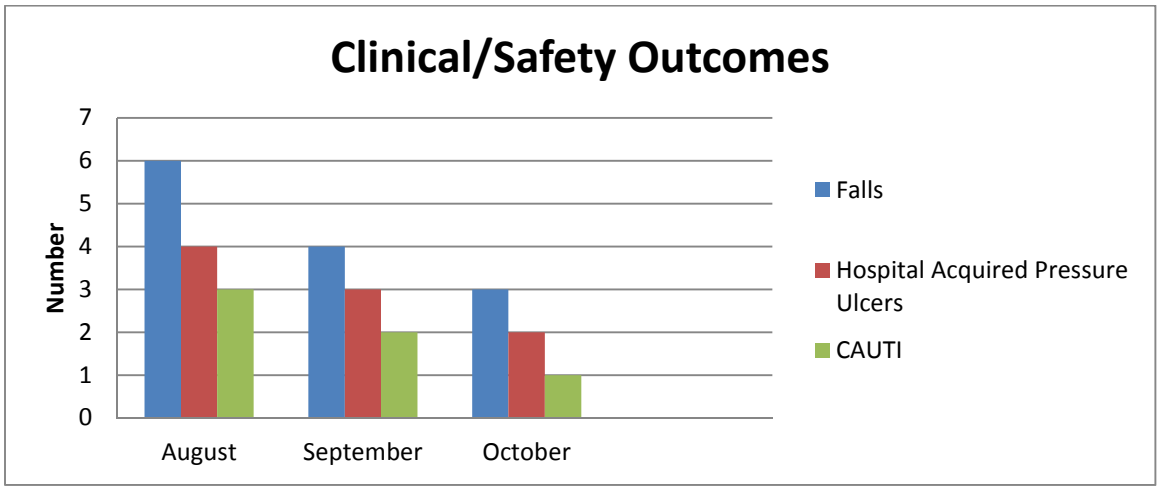


Figure 5. Incidence of falls, pressure ulcers and CAUTI post-relationship-based care implementation.

Findings in the Context of the Literature

As stated before, the review of literature demonstrated that caring and relationship-based care is just a framework used to change the culture on a unit or an entire hospital. What it will look like in each facility will vary and reflect the mission, vision, values and culture of the organization. The presence of strong leadership support and clear goals are two of the main ingredients for success in the implementation of care model based on relationships. Overall the findings for this project were consistent with those found in the literature with the single deviation being the closely aligned definition of caring behaviors by both the patients and families and the nurses. Each group described the same behaviors as caring and therefore they were incorporated into the care model design. The design components were also a combination of several suggested by research but seemed to fit well within the culture of the unit. The pilot units in the literature struggled with the concept of primary nursing and this was also an issue for this project. Initially the decision was to have one specific nurse advocate for each patient

based on the completion of the admission database. This nurse would serve as the nurse advocate for the entire hospital stay and be the coordinator of planning and delivering care. However due to the length of stay and the nurses working twelve hour shifts, the actual final model of care included a primary nurse for the shift with the focus on continuity of care. The implementation of a relationship-based care delivery model also had outcomes that were consistent with the literature. The pilot unit had an increase in patient satisfaction and a decrease in falls and hospital acquired pressure ulcers.

Implications

Policy

The implications of this project impact the organizational culture, patients, families, and the bedside care providers. The implications of the successful design and implementation of a relationship-based care delivery model are many. Due to the success of the project, the decision was to continue the model throughout the hospital to include the inpatient nursing units, as well as, departments that come in contact with patients and families. Many departments have all expressed the desire to learn more about relationship-based care and how it can be implemented in their departments. It is the goal to spread the model to the entire practicum hospital and eventually to present it and facilitate the development throughout the health system.

Also the principles of relationship-based care can be used to redesign the policies for hiring, orienting, and evaluating staff throughout the facility. A structured program based on relationship-based care will have impact on all aspects of employment at the practicum facility. Policies for teamwork, therapeutic presence, engagement and

interdisciplinary relations will need to be developed and implemented. As a result of all this focus on relationship-based care, not only will patient satisfaction and outcomes improve, care of oneself, effective communication, and interactions will also be enhanced. The department isolationism will need to be removed down so everyone can work together for the good of the patient, self, and colleagues.

Practice

The increased patient satisfaction and nurse engagement will help to improve the reputation of the hospital. Both public reporting and word of mouth will serve to attract more patients to choose the facility for their healthcare needs. In this volatile healthcare climate full of uncertainty in regard to reimbursement; quality and reputation will help the hospital differentiate itself to payers, patients and physicians. Enhanced nurse engagement will contribute to retention, as well as, reduce the costs of recruiting and orienting new nursing staff. Although the facility is not Magnet certified, a reputation for nurse engagement could influence nurses to seek employment with the hospital. Competition for nurses in the area is significant because there are five hospitals in a twenty mile radius so any advantage will be a benefit. Relationship-based care is an opportunity for this hospital to be a role model for others in the community.

Relationship-based practice is more than just patient focused. There can be no proper care if there is no communication, teamwork and care for the caregiver. Establishing a culture of caring that includes the patient will take time and patience. Continued support, practice, and positive reinforcement by those who lead will assure the success of this project. As the project continues, the care provided to the patient will be

more collaborative and based in teamwork. The team will work toward mutually agreed upon outcomes and provide the patient with care that will meet their cultural and personal needs, as well as, care that supports the needs of the caregiver.

Research

With the advent of population health and accountable care organizations, the need to continue research on patient-centered care will be paramount. Strategies for involving and sustaining patients' in their care will be an important aspect of future care. The need to replicate this study and expand to all departments in the hospital will be important. Competition for patients and the link between reimbursement and patient satisfaction and clinical outcomes will generate the need to explore new methods of delivering care. Patient involvement in their care will be the key focus of future research for the purposes of adherence to the plan of care and the reduction in readmissions to the hospital. Physicians and physician extenders will need to know and care for their patients in ways that match both the culture and wishes of the patient and family. This change is needed as physicians will manage patients throughout their lives. Also with the predicted nursing shortage and the widening opportunities for nurses outside the inpatient arena any research for developing nursing satisfaction and retention is timely. Relationship-based care has been proven to have a positive impact on nursing satisfaction through improved teamwork and a more fulfilling relationship with the patient. Organizations that continue to implement and monitor the effectiveness of relationship-based care for both the patient and nurse are making an investment in a successful future with improved quality outcomes, as well as, enhanced patient and nurse satisfaction.

Social Change

Relationship-based or patient-centered care shifts the focus of care from a medically dominated effort to a collaborative effort between provider and patient. The shift from episodic healthcare to a continuum of care will necessitate the ability to establish and maintain a relationship with the patient and family. The plan of care will have to be based upon those treatments or modalities that the patient is willing and able to accept. This shift will be significant for all caregivers involved. In order to know what a patient wants in terms of care, the practitioners will also need to know and understand how to develop and maintain a relationship with their patients.

The design team members, at the practicum facility, were given the opportunity to mentor and coach other healthcare providers in both the design and execution of this model. They are now looked upon as leaders and innovators and this has increased their job satisfaction and self-esteem. The hospital has embraced the concepts of relationship-based care and has begun the culture change. This culture change brings increased satisfaction for all involved and improvements in many outcomes that can only help to secure the viability of hospital and the program.

Projects Strengths

The project was evidence, literature, and research based. With the enactment of the Affordable Care Act in 2010, the country has an opportunity to transform health care to be more affordable and accessible. One recommendation by the Institute of Medicine (IOM) was that health care organizations support and help nurses in the development of innovative, patient-centered care models. Senior leadership at the practicum site

embraced this project for its potential to change the culture of the organization and also meet the challenges of the new health care environment. The design team was very engaged throughout the entire project and able to be flexible enough to meet the challenges that faced them and suggest meaningful changes. The bedside care providers were the major force in the design and implementation of this model of care and therefore the ultimate strength of this project. They believed in the concept of relationship-based care and did everything possible to make the care model successful.

Project Limitations

One limitation of this project was the lack of focus on bedside caregiver engagement as a formal evaluation criterion. The hospital under study performs a yearly employee satisfaction/engagement survey that was out of scope of this project. However, nurse engagement has been determined to be a key factor in patient satisfaction, as well as, retention and recruitment. The true value of relationship-based care is the inclusion of all caregivers in the team, therefore, another limitation of this project was the singular focus on nursing bedside providers. In order to establish true patient-centered care, future work will be required to include all other disciplines involved in the care of the patient. This project was designed for nursing as a pilot to determine feasibility for other disciplines and due to the positive results will now be considered for the other care team members.

Recommendations for Remediation of Limitations in Future Work

The vision of relationship-based care involves engaging everyone from the boardroom to the bedside. The strategies for remediating the limitations of this project are

to include all bedside caregivers for the next unit for implementation. This quality improvement project was focused primarily on the nursing staff. As the project moves forward to other units, all caregivers will be included in the design group. The other practitioners will include physical therapists, social workers, case managers, dieticians, and physicians. In order to make the concept truly effective the patient must be in the center of all these practitioners' practice.

Practitioner engagement is another key outcome of relationship-based care. For the remainder of the implementation, the results of the yearly employee satisfaction survey will be used as a criterion for success. Each year every employee of the hospital participates in the standardized employee satisfaction survey. The pre-implementation survey results can be compared to post-survey results for the effects of relationship-based care delivery model on teamwork and engagement. Although there will be a delay in the results, because they are only collected yearly, it will be important to ascertain the effect on engagement and teamwork the care delivery model provides. The use of three different methods to confirm results of a performance improvement project is the process of triangulation and helps to provide supporting evidence of research findings.

Analysis of Self

As Scholar

As a result of this quality improvement project, the author has acquired an expertise for the processes involved with relationship-based care. Also an understanding of the importance of positive interactions with and inclusion in care for patients and their families resulted. This expertise has solidified the author's belief in the relationship-based

triad; patient and family, self, and colleagues as the key to the successful change in culture needed to reinvent healthcare delivery. As a DNP-prepared nurse and through the work on this project, the ability to assess and change entrenched healthcare beliefs and outdated practice has flourished.

The author has acquired many valuable skills through the dissemination of this project. The improved knowledge of the process for writing and submitting a manuscript for publication has been valuable. Composition and presentation of an executive summary for key stakeholders has also added to the author's knowledge. Knowledge of the protocol for scientific posters and poster presentations was increased by the corporate research and a future national conference poster presentation. Public speaking skills have improved with the presentations to leadership at the practicum site and nursing leadership at the corporate level. Overall the experience and knowledge the author has gained from this project has been very rewarding. Implementing evidence-based practice requires skills in assessing and analyzing research, as well as, transformational leadership skills such as collaboration, facilitation and strategic planning.

As Practitioner and Project Developer

The design and implementation of relationship-based care has provided many learning opportunities that have increased the author's effectiveness as a collaborative agent for change. The most rewarding skills gained from this project were mentorship, facilitation, collaboration, program development, and planning. Each phase of this project provided opportunities to add to the knowledge and skills as a practitioner and project developer. From the initial idea for the project to the development of goals and objectives

at the start of the program through the evaluation of the outcomes many critical skills have emerged. Throughout the DNP curriculum each class was used to build the foundation that culminated in a successful quality improvement project. The need for this project to be collaborative required the author to strengthen the ability to facilitate meetings and to provide mentorship needed to overcome the resistance to change. Throughout the project assistance was provided to the team to evaluate the existing care delivery model and to develop the new care delivery model from the evidence. Through the use of mentorship and collaboration, the team members have developed a new understanding and appreciation for evidence-based care. This understanding and the desire to put the patient at the center were the elements that provided for a successful model of care.

Program development afforded the author the opportunity to engage in strategic planning and to function as a collaborative change agent. It is difficult to maintain the balance between personal desire and what is best for the group and the project. Throughout this project the need to change strategy to overcome resistance was present. The nursing staff believed some of the required elements of the care model added time to an already busy day. This required the use of education and persuasion to convince the staff that a relationship with the patient decreased the back and forth time because of the focus on the patients' needs.

Future Professional Development

Recognizing that there is a gap between research findings and their application in practice has helped to inform the author's future professional development. As a DNP

prepared nurse it is a responsibility to assist in closing the research-practice gap, through the application of current knowledge and the generation of new knowledge in the clinical setting. The author will serve as a content expert for closing the gap between research and practice, and advocate for evidence-based practice at the bedside and also in quality improvement projects. There has been concern since the introduction of the doctor of nursing practice degree that it would dilute nursing research and science. However, it is the author's belief that the DNP prepared nurse will work side by side with the research nurse to generate practice based knowledge and develop new clinical applications for the evidence.

Translational science is a new field that defines the processes by which new knowledge, methods and techniques are translated into new clinical approaches to improve the care provided to the population (Vincent, Johnson, Velasquez & Rigney, 2010). The phases of translation research are basic research, efficacy studies, effectiveness studies and implementation/dissemination studies (Vincent, Johnson, Velasquez & Rigney, 2010). With the amount of nursing knowledge growing rapidly each year the author's future professional development will be grounded in the translation of that knowledge into practice. This DNP project and the DNP curriculum have provided a solid foundation for lifelong pursuit of evidence-based practice and research translation.

Summary and Conclusions

Relationship-base care is a model of care that places personal relationships between caregivers, patients and their loved ones at the center of care delivery. This model provides tools for organizing care, effecting change, and transforming the culture

of a health care institution from a depersonalized, schedule driven system into patient-centered source of individualized care imparted within a caring healing environment (Koloroutis, 2004). This quality improvement project was based on an overarching concept that focused attention on relationships with patients and their loved ones, colleagues and self.

The model of care provided a way of being present in the moment with patients and colleagues. The infrastructure of this project provided the practices, systems and processes for the achievement of the goal of patient-centered care on a pilot medical-surgical unit. The use of evidence-based practice methodology impacted the individuals and collective change that drove day-to- day practice. The success of this project was due to the commitment and excitement generated from the executive suite to the bedside provider. The staff was inspired to deliver professional and compassionate care and that inspiration was awarded and recognized by leadership and patients alike. The members of the design team came to appreciate that relationship-based care was the best means for achieving both patient and employee satisfaction. The power of this model was the ability to change outcomes at the point of care and the ability to maintain the hospital's financial strength through strong employee engagement and personalized safe care and service by everyone.

Section 5: Scholarly Product

Executive Summary

The Design and Implementation of a Relationship-Based Care Delivery Model on a Pilot Medical Surgical Unit

Paula Rodney MSN, MBA, RN

DNP Doctoral Project

Introduction

The design and implementation of a care delivery model was undertaken as a result of declining patient satisfaction scores and concern for clinical outcomes on a pilot unit at the practicum hospital. The aim of the project was to develop a care delivery model that would encourage continuity of care and engagement with the patient. The goal was to ensure a positive patient hospital experience through the development of a care delivery model that outlined the structure and process of care, facilitated the nurses' contribution to patient outcomes and enhanced patient satisfaction and improved clinical outcomes.

This non-experimental correlational design quality improvement project answered the questions (a) will the design and implementation of a relationship-based care delivery model improve patient satisfaction on a medical-surgical unit and (b) will the relationship with the patient resulting from the new model of care decrease falls, hospital-acquired pressure ulcers and catheter-associated urinary tract infections.

Purpose of the Project

The purpose of this project was to combine information from patients and nurses, on what they perceive as caring, Kristen Swanson's five caring principles, and the elements of relationship-based care, to design and implement a care delivery model. The mission of this project was to promote quality outcomes and patient satisfaction through caring relationships with patients, families, self, and colleagues. The five objectives of the project were; (a) perform a needs assessment, (b) design a relationship-based care delivery model, (c) educate the bedside care providers to the new care delivery model, (d) implement the model and (e) evaluate the effectiveness of the design and make modifications as necessary. These objectives were achieved through the collaborative effort of the design team consisting of a student facilitator, the unit manager, three unit nurses, one nursing technician, one unit clerk, and an educator. Membership on the design team was voluntary and compensated.

Project Outcomes

Although the literature suggests that patients' and nurses' perceptions of care are quite different (Jennings, Heiner, Loan, Hemman, & Swanson, 2005), this did not hold true with the focus groups for this project. Caring behaviors for both groups fell into four categories; attention, information, kindness/empathy and knowledge. These categories served as the underpinning for the care delivery model. Both the patients and the bedside caregivers that participated in the focus groups believed that they received and or provided the care that they wanted only 50% of the time. This data was essential to the

development of components for the model of care that increased the time patients and care providers spent together.

The care delivery model included the following components (a) staff scheduling and assignments to enhance continuity of care, (b) seated bedside shift report, (c) use of whiteboards in the patient rooms for communication, (d) 5 focused minutes a shift with each patient for the development of a therapeutic relationship with the patient, (e) hourly rounding by the nurse and nursing technician, and (f) the development of the nurse advocate role.

Three months post implementation patient satisfaction score have demonstrated a steady improvement and clinical outcomes have improved. The overall rating for care provided on the unit increased by 14.5%, communication with nurses 13.2% and responsiveness 12.5%. The incidence of patient falls with injury, hospital acquired pressure ulcers and catheter-related urinary tract infections have all decreased.

Literature Review

Literature suggests that nursing shortages and economic challenges have resulted in a restructuring of the nursing workforce which has impacted the effectiveness of care provision (Fernandez, Johnson, Tran, & Miranda, 2012). Three articles on relationship-based care (Allen & Vitale-Nolan, 2005; Gerrie & Nebel, 2010; Winsett & Hauck, 2011) demonstrated increased patient satisfaction with care, increased verbal and nonverbal caring behaviors, improved quality of care and outcomes, improved nursing satisfaction and feelings of autonomy and a reduction in task oriented care with a move toward relationship-based care.

The models of care that result in greater nurse and patient satisfaction, as well as, improved outcomes are those which are patient-centered and promote engagement with the patient and family and provide continuous well-coordinated care. Allen and Vitale-Nolen (2005), found that the theory and process used to design the patient-centered process contributed more to nurse and patient satisfaction than the chosen model of care. The combination of the proper facilitator and the knowledge, wisdom and practice skills of the bedside provider determined the success of the design and implementation of a model of care for this project. This model's successful design required activities and educational approaches that fostered collaboration, empowerment and included consideration of personal and professional values (Allen & Vitale-Nolen, 2005).

Finally, in a randomized controlled study, Wolf, Lehman, Quinlan, Zullo, and Hoffman (2008), determined that relationship-based care positively impacted the patients perception of level of satisfaction and quality of care received. Patient experience and level of satisfaction influence the decision to return to a hospital and the model of care can impact those decisions. The relationship-based model empowers nurses to take the time to know their patients, seek out their input and priorities for care and involve them in all aspects of their care resulting in increased satisfaction and outcomes for both the patient and the nurse. It is apparent that nursing leadership must work collaboratively with nurses to improve processes in nursing practice that could enhance nurses' job satisfaction and improve patient care delivery (Wells, Manuel, & Cunnings, 2011).

Theoretical Framework

The theoretical framework for this project was Kristen Swanson's theory of caring (1991) in conjunction with the principles of relationship-based care created by Mary Koloroutis (2004). Swanson (1991) defined the structure of caring as five interrelated processes; (a) maintaining belief, (b) knowing, (c) being with, (d) doing for and (e) enabling. Relationship-based care is based on three caring processes: the relationship with the patient and family, the relationship with self and the relationship with colleagues. Swanson's theory provided a clear explanation of the links between caring process and patient well-being. The five caring processes provide a foundation for actions by the nurse that will establish a relationship that puts the patient at the center and improves patient satisfaction, clinical/quality outcomes and nursing satisfaction. The principles of relationship-based care provided guiding principles to transform care on this medical surgical unit from task-oriented to relationship-based. The primary vision was to provide care that was personal and caring for patients, rewarding for nurses and provided in an environment that was safe and nurturing.

Implications for Practice

The creation of a therapeutic relationship with the patient assists the patient and family to participate in their care, as well as, increases nurse engagement and teamwork. Increasing patient satisfaction and nurse engagement will improve the reputation of the hospital. It is logical that both public reporting and word of mouth will serve to attract more patients to choose the facility for their healthcare needs. In this volatile healthcare

climate full of uncertainty in regard to reimbursement; quality and reputation will help the hospital differentiate itself to payers, patients and physicians.

Enhanced nurse engagement will contribute to retention, as well as, reduce the costs of recruiting and orienting new nursing staff. Although the facility is not Magnet certified, a reputation for nurse engagement will influence nurses to seek employment with the hospital. Competition for nurses in this hospital's service area is significant because there are five hospitals in a twenty mile radius so any advantage will be a benefit. Relationship-based care is an opportunity for this hospital to be a role model for others in the community and also within the health system.

Recommendations

The recommendation based on this quality improvement program to improve patient satisfaction and clinical outcomes are to continue to implement the relationship-based care delivery model throughout the hospital. The evaluation of the care delivery model on the pilot unit indicates an improvement in patient satisfaction and clinical outcomes. Other identified benefits are improved teamwork as identified by consistent use of mid-shift huddles for the purposes of reassessing patient acuity and assignment, as well as, assignment of meal breaks and coverage. Each nursing unit should implement the care delivery model with the assistance of a facilitator. After all nursing units have completed implementation then other departments such as physical therapy, respiratory therapy, and social work/case management should be educated about relationship-based care. Ultimately the recommendation is that all departments and caregivers including physicians will have a good understanding of and participate in the care delivery model.

Another recommendation is to assess current interviewing, hiring, orientation and performance evaluation processes for the need of revision based on a relationship-based focus. This process can be concurrent with the implementation process so that it is readily available when conversion to relationship-based care is complete. The assessment and revision of processes will place further emphasis on the organization's commitment to relationship-based care and the need to hardwire this cultural change.

Plans for Dissemination

The plan for dissemination of this project is an executive summary to be presented to the senior management team of the practicum facility and a podium presentation to hospital leadership and the bedside providers. There will also be a podium presentation to the health system nursing leadership, as well as, local, state and national nursing conferences. Journal articles with the focus on this project's definition of caring, the literature review for the care delivery model and the design and implementation of a care delivery model will be written and submitted to nursing journals. This plan for dissemination informs the stakeholders, as well as, contributes to overall nursing knowledge both inside the hospital and globally.

Summary

The change in healthcare over the last two decades has led to task-oriented depersonalized care focused more on checking boxes and performing interventions on time, than on having a relationship with the patient. The idea of the patient as an active participant in their care is no longer a notion but a requirement. The era of physician driven care without regard to patient preference is not only ineffective; it is unrealistic. A

relationship-based care delivery model furthers the tenet that no decisions should be made about a patient without the patient's involvement. The nurse in partnership with the patient can establish a plan of care with clear goals that is known to all caregivers. An environment that provides time, shared responsibility, collaboration and trust will enhance both patient and nurse empowerment.

The design, training to, implementation and evaluation of a relationship-based care delivery model are the first steps in making the patient a partner in care. This care delivery model is a starting point that provides guidelines for decision making, care provision, culture change, and eventually practice changes that can be implemented hospital and potentially corporate-wide. Patient satisfaction and high quality outcomes are expected to be the incentive for caregivers to make the change to relationship-based care and to abandon historical task-oriented care that does not meet the needs of the patient in today's healthcare environment.

References

Allen, D. E., & Vitale-Nolen, R. A. (2005). Patient care delivery model improves nurse job satisfaction. *Journal of Continuing Education in Nursing, 36*(6), 277-282.

Burns, N., & Grove, S. (2005). *The practice of nursing research: Conduct, critique, and utilization* (5th ed.). St. Louis, MO: Mosby.

Campbell, M. P. (2004). Relationship based care is here! *Journal of Lancaster General Hospital, 4*(3), 1-3.

Centers for Medicare and Medicaid. (2011). Hospital value-based purchasing program. Retrieved from http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network

Cropley, S. (2012). The relationship-based care model: Evaluation of the impact on patient satisfaction, length of stay and readmission rates. *Journal of Nursing Administration, 42*(6), 333-339. doi: 10.1097/NNA.0b013e31825738ed

Dewar, B., & Nolan, M. (2013). Caring about caring: Developing a model to implement compassionate relationship centered care in an older people care setting. *International Journal of Nursing Studies, 50,* 1247-1258. doi: 10.1016/j.ijnurstu.2013.01.008

Dingman, S., Williams, M., Fosbinder, D., & Warnick, M. (1999). Implementing a caring model to improve patient satisfaction. *Journal of Nursing Administration, 29*(12), 30-37.

Ferguson, F. M., Ward, H., Card, S., Sheppard, S., & McMurtry, J. (2013). Putting the patient back into patient-centered care: An education perspective. *Nursing Education in Practice, 13*, 283-287. doi: 10.1016/j.nepr.2013.03.016

Fernandez, R., Tran, D. T., Johnson, M., & Jones, S. (2010). Interdisciplinary communication in general medical and surgical wards using two different models of nursing care delivery. *Journal of Nursing Management, 18*, 265-274. doi: 10.111/j.1365-2834.2010.01058.x

Fosbinder, D. (1994). Patient perceptions of nursing care: An emerging theory of interpersonal competence. *Journal of Advanced Nursing, 20*, 1085-1093.

Gerrie, J., & Nebel, A. (2010). Improving patient outcomes with relationship-based care. *Nurse Leader.* Retrieved from http//:www.nurseleader.com

Hedges, C. C., Nichols, A., & Filoteo, L. (2012). Relationship-based nursing practice: Transitioning to a new care delivery model in maternity units. *Journal of Perinatal & Neonatal Nursing, 26*(1), 27-36. doi: 10.1097/JPN.0b013e3182310284

Henderson, A., Van Eps, M. A., Pearson, K., James, C., Henderson, P., & Osborne, Y. (2007). 'Caring for' behaviors that indicate to patients that nurses 'care about' them. *Journal of Advanced Nursing, 60*(2), 146-153. doi: 10.1111/j.1365-2648.2007.04382.x

Hodges, B. C., & Videto, D. M. (2011). *Assessment and planning in health programs* (2nd ed.). Sudbury, MA: Jones & Bartlett Learning.

Institute for Patient and Family Centered Care. (n.d.) Advancing the practice of patient and family centered care in hospitals: How to get started. Retrieved from http//:www.ipfcc.org

Issel, L., & Kahn, D. (1998). The economic value of caring. *Health Care Management Review, 23*(4), 43-53.

Jean Watson: Nursing theorist. (2013). Retrieved from http://www.nursing-theory.org/nursing-theorists/Jean-Watson.php

Jennings, B. M. , Heiner, S. L., Loan, L. A., Hemman, E. A., & Swanson, K. M. (2005). What really matters to healthcare consumers? *Journal of Nursing Administration, 35*(4), 173-180.

Jesse, D. E. (2010). Watson's philosophy in nursing practice. In M. R. Alligood & A. M. Tomey (Eds.), *Nursing theorists and their works* (pp. 91-105). Maryland Heights, MO: Mosby Elsevier.

Kettner, P. M., Moroney, R. M., & Martin, L. L. (2013). *Designing and managing programs: An effectiveness-based approach* (4th ed.). Thousand Oaks, CA: Sage.

Koloroutis, M. (2004). *Relationship based care: A model for transforming practice.* Minneapolis MN: Creative Health Care Management, Inc.

LoBiondo-Wood, G., & Haber, J. (2010). *Nursing research: Methods and critical appraisal for evidence-based practice.* St. Louis MO: Mosby Elsevier.

McCance, T., McCormack, B., & Dewing, J. (2011). An exploration of person-centered practice. *OJIN: The Online Journal of Issues in Nursing, 16*(2). doi: 10.3912/OIJN.Vol16No02Man01

McCormack, B., & McCance, T. V. (2006). The person centered nursing conceptual framework. *Journal of Clinical Nursing, 56*(5), 1-8.

McCormack, B., Dewing, J., & McCance. T. (2011). Developing person-centered care: Addressing contextual challenges through practice development. *OJIN: The Online Journal of Issues in Nursing, 16*(2). doi: 10.3912/OJIN.Vol16No2Man03

Mind Tools Ltd. (2011). Gantt charts: Planning and scheduling more complex projects. Retrieved from http://www.mindtools.com/pages/article/newPPM_03.htm

Nelson-Peterson, D. L., & Leppa, C. J. (2007). Creating an environment of caring using lean principles of the Virginia Mason production system. *Journal of Nursing Administration, 37*(6), 287-294.

Otani, K. (2010). How patient reactions to hospital care attributes affect the evaluation of overall quality of care, willingness to recommend, and willingness to return. *Journal of Healthcare Management/ American College of Healthcare Executives, 55*(1), 25-37.

Papastavrou, E., Efstathiou, & Charalambous, A. (2011). Nurses' and patients' perceptions of caring behaviors: Quantitative systematic review of comparative studies. *Journal of Advanced Nursing, 67*(6), 1191-1205. doi: 10.111/j.1365-2648.2010.05580.x

Poochikian-Sarkissian, S., Sidani, S., Ferguson-Pare, M., & Doran, D. (2010). Examining the relationship between patient-centered care and outcomes. *Canadian Journal of Neuroscience Nursing, 32(*4*),* 14-21.

Schneider, M. A., & Fake, P. (2010). Implementing a relationship-based care model on a large orthopedic/neurosurgical hospital unit. *Orthopedic Nursing, 29*(6), 374-378. doi: 10.1097/NOR.0b013e3181edd845

Small, D. C., & Small, R. M. (2011). Patients first! Engaging the hearts and minds of nurses with a patient centered practice model. *Online Journal of Issues in Nursing, 16*(2). doi: 10.3912/OJIN.Vol16No02Man02

Swanson, K.M. (1991). Empirical development of a middle range theory of caring. *Nursing Research, 40*(3), 161-166.

Swanson, K. M. (1993). Nursing as informed caring for the well-being of others. *IMAGE: Journal of Nursing Scholarship, 25*(4), 352-357.

Swanson, K. M. (1999). What is known about caring in nursing science: A literary meta-analysis. In A. S. Hinshaw, S.L. Feetham & J. L. F. Shaver (Eds.), *Handbook of clinical nursing research* (pp. 31-60). Thousand Oaks, CA: SAGE Publications.

Tonges, M., & Ray, J. (2011). Translating caring theory into practice: The Carolina care model. *Journal of Nursing Administration, 41*(9), 374-381.

Watson, J. (1981). Nursing's scientific quest. *Nursing Outlook, 29,* 413-416.

Watson, J. (2008). *Nursing: The philosophy and science of caring.* Boulder, CO: University Press of Colorado.

Wells, J., Manuel, M. & Cunning, G. (2011). Changing the model of care delivery: Nurses' perceptions of job satisfaction and care effectiveness. *Journal of Nursing Management, 19,* 777-785. doi: 10.111/j.1365-2834.2011.01292.x

Wessel, S., & Person, C. (2004). Adapting relationship-based care principles to your organization. In M. Koloroutis, J. Felgren, C. Person, & S. Wessel (Eds.), *Relationship-based care: Visions, strategies, tools and exemplars for transforming practice* (pp.221-223). Minneapolis MN: Creative Health Care Management.

Winsett, R. P., & Hauck, S. (2011). Implementing relationship-based care. *Journal of Nursing Administration, 41*(6), 285-290. doi: 10.1097/NNA.0b013e31821c4787

Wolf, D. M., Lehman, L., Quinlin, R., Zullo, T., & Hoffman, L. (2008). Effect of patient-centered care on patient satisfaction and quality of care. *Journal of Nursing Care Quality,* 23(6), 316-321.

Woolley, J., Perkins, R., Laird, P., Palmer, J., Schitter, M. B., Tarter, K., . . . Woolsey, M. (2012). Relationship-based care: Implementing a caring, healing environment. *MEDSURG Nursing, 21*(3), 179-184.

Yeakel, S., Maljanian, R., Bohannon, R. W., & Coulombe, K. H. (2003). Nursing caring behaviors and patient satisfaction: Improvement after a multifaceted staff intervention. *The Journal of Nursing Administration, 33*(2), 434-436.

Appendix A: Mission, Goals, Objectives and Activities

Relationship-Based Care Delivery Model Project Design	
Mission	To promote quality patient outcomes and patient satisfaction through caring relationships with patients, families, self, colleagues.
Goal	Ensure a positive patient hospital experience through the development of a care delivery model that outlines the structure and process of care, facilitates the nurses' contribution to patient outcomes and the environment, enhances patient satisfaction and improves clinical outcomes.

Objectives	Activities
Assessment: By August 23, 2013, the student will perform a needs assessment for the project and present results to the hospital key stakeholders.	• The student will perform a literature review. • Nursing focus groups will be held and facilitated by Director of Organization development and Marketing to determine what nurses perceive as caring. • Patient focus groups will be held and facilitated by Director of Organizational Development and Marketing to determine what patients perceive as caring. • The student will organize and interpret data to determine caring behaviors. • The student will present assessment data to leadership, nursing staff and the Patient Family Advisory Council. • The student will confirm the accuracy of data interpretation through a presentation to stakeholders.
Design: By December 20, 2013 the student and the design team will design a relationship-based care delivery model for the pilot medical surgical unit.	• The student and unit manager will recruit design team members from the pilot unit. • The student and members of the team will begin weekly design meetings at agreed upon date, time and place. • The team will review current

	practice for behaviors to retain and those to be added. • Based on literature and the two models for the project, the team will create a care delivery model for the pilot unit based on trialed behaviors and observations. • The team with the assistance of the education department will develop education materials to be used to educate the staff on the pilot unit to the new model. • The team, key stakeholders and leadership will celebrate completion of design and accomplishments. • The student will present the final care delivery model design to key stakeholders and leadership for feedback and possible suggestions. • There will be an evaluation through the use of observation and role modeling the appropriateness of the behaviors in the model of care. • Evaluate the reading level and appropriateness of reading materials and the quality and accuracy of behaviors on the video tape.
Education: By July 12, 2014, the education department in conjunction with the design team will educate pilot unit staff about care delivery model in preparation for implementation.	• The team will assemble learning packets/video for distribution to the staff. • The team will distribute educational materials to the staff and provide timeframe for completion. • The staff will review education materials and provide return demonstrations of education as indicated. • The team will complete education and collect and compile documentation of education for presentation to the education department for inclusion in education files.

	• Evaluate quality, accuracy and effectiveness of educational materials Evaluate the educational materials for appropriate reading level and clarity, preview videos for accuracy.
Implementation: By September 1, 2014, the student and the design team will implement the model on the pilot unit through the use of mentoring and issue identification and resolution.	• The team will plan and execute a kick-off celebration for the care delivery model. • Design team members will schedule themselves on unit to serve as mentors for the new model. • The team will assess progress of implementation weekly. • The team will address care delivery issues and modify model as needed. • Evaluate if program was implemented as planned by observing and chart review. Determine if training was adequate to meet caregiver and patient needs
Evaluation: Beginning November 1, 2014 and every three months thereafter the care delivery model will be evaluated by the student and hospital quality improvement team for increase in patient satisfaction and improvement in clinical outcomes.	• During assessment gather baseline data from patient experience survey on the questions about responsiveness; answering call bell, help with going to the bathroom. • During assessment determine what the patient wants during hospital stay and what the nurse thinks the patient wants. • During assessment use nursing unit scorecard to determine areas of focus for care delivery model. • During design gather baseline data on hospital acquired pressure ulcers, catheter associated urinary tract infections and falls. • During design assess the frequency of hourly rounding, bedside handoff and multidisciplinary rounds. • During education determine if the educational materials are for appropriate reading level and

clarity.
- During education preview videos for accuracy and ease of understanding.
- During implementation use patient satisfaction, clinical outcome and nurse satisfaction data to determine if the project had intended impact.
- During implementation review budget, training and observe interaction between caregiver and patient to determine if the model is meeting the goals and objectives.

- After implementation determine if short term impact has been achieved through review of satisfaction and outcome data. Adjust the model if needed based on analysis of the data.
- After implementation evaluate the long term impact on policies and procedures as well as the impact on reimbursement and hospital reputation.
- Ongoing continue to monitor data and adjust the model as needed to meet the needs of the target population.

- The student and team will analyze the data to determine the impact of the care delivery model.
- The team will prepare to continue the implementation of the care delivery model by choosing the next unit to begin the process.

Dissemination:

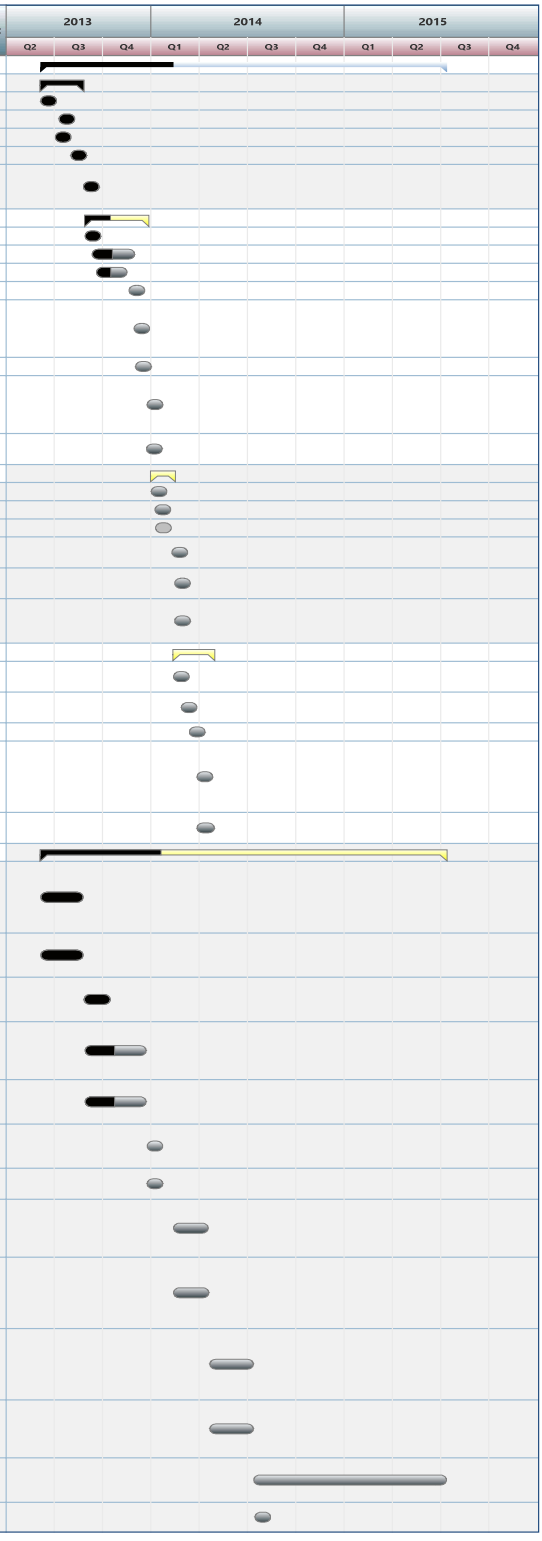
Beginning November 1, 2014 the team will present the findings and results of the performance improvement project to key stakeholders and nursing leadership both in

- The team will present the results of the evaluation to the bedside care providers, Patient and Family Advisory Council and key leadership within the hospital.
- The team will prepare poster

the hospital and on a local, state and national level.	presentations for hospital, state and national meetings. • The student will compose an executive summary for senior and corporate leadership. • Articles for publication will be written and summited to relevant journals and online sites. .

Appendix B: Gantt Chart

#	Task	Start	End	Dur	% Complete
	Relationship-Based Care Delivery Model	6/3/13	7/12/15	550	33
1	Needs Assessment	6/3/13	8/23/13	60	100
1.1	Literature Review	6/3/13	6/21/13	15	100
1.2	Nursing Focus Groups	7/9/13	8/6/13	21	100
1.3	Patient Focus Group	6/30/13	7/29/13	21	100
1.4	Organize and interpret data	7/31/13	8/19/13	14	100
1.5	Evaluate the accuracy of data interpretation through a presentation to stakeholders	8/23/13	8/23/13	1	100
2	Design	8/26/13	12/24/13	87	42
2.1	Recruit team member from pilot unit	8/26/13	8/30/13	5	100
2.2	Begin weekly meetings	9/8/13	11/29/13	60	50
2.3	Review of current practice	9/16/13	11/15/13	45	50
2.4	Develop and record final model of care	11/18/13	11/26/13	7	0
2.5	Evaluate through the use of observation and role modeling the appropriateness of the behaviors in the model of care	11/27/13	11/29/13	3	0
2.6	Develop educational materials	11/30/13	12/20/13	15	0
2.7	Evaluate the reading level and appropriateness of reading materials and the quality and accuracy of behaviors on the video tape.	12/21/13	12/24/13	2	0
2.8	Celebrate completion of design and accomplishments	12/20/13	12/20/13	1	0
3	Educate	1/1/14	2/14/14	33	
3.1	Assemble learning packets/video	1/1/14	1/7/14	5	0
3.2	Distribute educational materials	1/8/14	1/8/14	1	0
3.3	Staff to review educational materials	1/9/14	1/31/14	17	0
3.4	Finalize education, collect documentation	2/8/14	2/12/14	3	0
3.5	Evaluate quality, accuracy and effectiveness of educational materials	2/13/14	2/14/14	2	0
3.6	Evaluate the educational materials for appropriate reading level and clarity, preview videos for accuracy.	2/13/14	2/14/14	2	0
4	Implement	2/11/14	4/29/14	56	
4.1	Kick off celebration for the model of care	2/11/14	2/11/14	1	0
4.2	Design team to serve as mentors for the new model	2/25/14	3/10/14	10	0
4.3	Assess progress of implementation	3/12/14	3/25/14	10	0
4.4	Evaluate if program was implemented as planned by observing and chart review. Determine if training was adequate to meet caregiver and patient needs	3/26/14	4/14/14	14	0
4.5	Address care delivery issues and modify model as necessary	3/26/14	4/29/14	25	0
5	Evaluate	6/3/13	7/12/15	550	30
5.1	During assessment gather baseline data from patient experience survey on the questions about responsiveness; answering call bell, help with going to the bathroom	6/3/13	8/23/13	60	100
5.2	During assessment determine what the patient wants during hospital stay and what the nurse thinks the patient wants	6/3/13	8/23/13	60	100
5.3	During assessment use nursing unit scorecard to determine areas of focus for care delivery model.	8/24/13	10/15/13	37	100
5.4	During design gather baseline data on hospital acquired pressure ulcers, catheter associated urinary tract infections and falls.	8/26/13	12/20/13	85	50
5.5	During design assess the frequency of hourly rounding, bedside handoff and multidisciplinary rounds	8/26/13	12/20/13	85	50
5.6	During education determine if the educational materials are for appropriate reading level and clarity.	12/21/13	12/23/13	1	0
5.7	During education preview videos for accuracy and ease of understanding	12/21/13	12/23/13	1	0
5.8	During implementation use patient satisfaction, clinical outcome and nurse satisfaction data to determine if the project had intended impact.	2/11/14	4/18/14	49	0
5.9	During implementation review budget, training and observe interaction between caregiver and patient to determine if the model is meeting the goals and objectives.	2/11/14	4/19/14	49	0
5.10	After implementation determine if short term impact has been achieved through review of satisfaction and outcome data. Adjust the model if needed based on analysis of the data.	4/20/14	7/12/14	60	0
5.11	After implementation evaluate the long term impact on policies and procedures as well as the impact on reimbursement and hospital reputation.	4/20/14	7/12/14	60	0
5.12	Ongoing continue to monitor data and adjust the model as needed to meet the needs of the target population.	7/12/14	7/12/15	260	0
5.13	Determine the next unit to begin the design process	7/14/14	7/14/14	1	0



This Gantt chart is a visual representation of the project, objectives and activities, the projected timeframes and completion percentage of each. The use of a Gantt chart outlined all of the tasks involved in the project, their order, and showed them against a timescale (Mind Tool Ltd., 2011).

Appendix C: Team Charter and Ground Rules

RELATIONSHIP-BASED CARE TEAM CHARTER

Purpose:

The Relationship Based Care Team will design, educate, implement and evaluate the relationship-based care model on IMC. The team will generate enthusiasm so that others may embrace the idea.

Goals:

1. To improve patient experience.
2. To improve staff morale.
3. Put patient at the center of care.
4. Focus on the relationship with the patients and team members rather than tasks.
5. To go live with the model of care by January, 2015.

Membership:

The team will consist of representation of all areas of care on IMC. Each shift and each discipline will be represented. The team members will form a partnership to develop and implement relationship based care. Every member's opinion is of equal importance.

Communication:

1. There will be multiple ways of communicating the progress of this team. Huddles, emails in Outlook, post meeting minutes, standing item for staff meeting, divide staff among team members for purposes of education and information.
2. Include float staff and PRN staff in the care delivery model.

Responsibilities: Team

1. Define and describe relationship-based care as it will look on the IMC unit.
2. Design the model of care, educate the unit, implement and evaluate.
3. Develop a timeline for the design, education, and implementation.
4. Evaluate progress of implementation and suggest changes and revisions as needed.

Responsibilities: Individual

1. All team members will attend all meetings unless prevented to do so by emergency or illness.
2. If unable to attend a meeting, team member will notify another team member.
3. Team members are responsible for checking Outlook email for appointments, minutes and updates.
4. Team members missing meetings are responsible for obtaining information that was missed at that meeting.

MEETINGS:

1. Meetings will start and end on time.

2. Meetings will be kept to one hour.
3. Minutes will be taken at all meetings and copies of same distributed to team members by the Wednesday following the meeting.
4. Agendas will be made available on Wednesday before the meeting.
5. All team members will complete assignments on time.

CONDUCT AT MEETINGS:

1. Each member will be respected regardless of opinion.
2. Open and honest communication will be expected.
3. Respect of each team member's contribution is expected.
4. Resolution of differences will be made determined by the majority.
5. Constructive feedback is important to goals and will be respected.

CONDUCT OUTSIDE OF MEETINGS:

1. It is important for the framework of the team that no negative or disrespectful comments are made outside of the meeting to non-team members.
2. Positive attitudes and uplifting comments about the team and its goals to outsiders is encouraged.

RELATIONSHIP-BASED CARE TEAM
GROUND RULES

ATTENDANCE:

5. All team members will attend all meetings unless prevented to do so by emergency or illness.
6. If unable to attend a meeting, team member will notify another team member.
7. Team members missing meetings are responsible for obtaining information that was missed at that meeting.

MEETINGS:

6. Meetings will start and end on time.
7. Additional meetings will be scheduled on an "as needed" basis.
8. Minutes will be taken at all meetings and copies of same distributed to team members within forty eight hours.
9. Agendas will be made available at the beginning of the meeting.
10. All team members will complete assignments on time.

CONDUCT AT MEETINGS:

6. Each member will be respected regardless of opinion.
7. Open and honest communication will be expected.
8. Respect of each team member's contribution is expected.
9. Resolution of differences will be made determined by the majority.
10. Negative attitudes/body language will not be allowed.
11. Constructive feedback is important to goals and will be respected.

CONDUCT OUTSIDE OF MEETINGS:

3. It is important for the framework of the team that no negative or disrespectful comments are made outside of the meeting to non-team members.
4. Positive attitudes and uplifting comments about the team and its goals to outsiders is encouraged.

Appendix D: Instructional Video Script

SHOT/IMAGE	SPEAKER	SCRIPT
HS Paula	Paula	*Hi, I'm Paula Rodney, student facilitator guiding the Relationship Based Care Process Improvement team. At MedStar Montgomery Medical Center, we want our patients to have the **best** experience and the **best** outcomes possible. To achieve this, we are implementing the concept of Relationship Based Nursing Care. This new model of care is simple and allows the nurse to optimize her relationship with the patient, her nursing team, and the interdisciplinary team by placing the patient and family at the **core** of the nurses' and the hospital's priorities.*
b-roll of 5W RNs smiling, interacting with pts, doing work TEXT OVER VIDEO: Relationships with - Patients, families - Colleagues - Self ---------- b-roll of white board, RNs interacting with patient TEXT OVER VIDEO: Relationship with Patient Communication - Rounding, white boards - Patient contribution to goals ---------- b-roll of RNs interacting, giving report, smiling, mentoring TEXT OVER VIDEO: Relationship with Colleagues Commitment - Clinical knowledge, mentoring - Safe hand-off of information - Rest periods - Continuity of care	Paula	*Relationship based care is a nursing care delivery model that emphasizes the **intentional, personal** relationship between the nurse and the patient, the nurse and her colleagues, and the nurse and herself.* *The first relationship is with the patient. The **cornerstone** of our connection and relationship to our patients is communication. This includes addressing patients by their preferred names, hourly rounding, and using white boards, but more significantly, it means we are **deliberately** seeking the patient's participation in the plan of care and allowing **the patient's** priorities to guide the goals of care.* *The second relationship is with our colleagues. Nurses connect with other nurses and team members in the form of **commitments**. Everyone on the team, advocate and associate nurses, techs, clerks, and leadership must be committed to the elements of relationship based care. Commitments include the responsibility of developing clinical knowledge and understanding. This includes a*

---------- b-roll of _____ vs. HS of Paula TEXT OVER VIDEO: Relationship with self		*nurse's work to deepen her own clinical knowledge. It can also be a mentoring relationship between a more experienced nurse and a novice nurse. The team must also commit to giving effective and efficient hand off; to supporting team members for breaks, and to implementing scheduling practices that allow for continuity of care.* *The relationship is that between the nurse and herself, or "self-care."* WHAT DOES/SHOULD THIS LOOK LIKE AT MMMC?
HS Paula vs. shots of general nursing care on 5W	Paula	*The intentional relationships we cultivate with our patients, our colleagues, and ourselves result in improved patient satisfaction, improved clinical outcomes, a more supportive team, and decreased work intensity, as work is better distributed and the team is supported.*
HS Paula	Paula	*To give you a perspective on why we need to make a change, let's look at how we are doing now.*
Wide shot of room, pt. in bed, room is cluttered	Kaitlyn and Enma	KB: Hey EA: Hey, ugh, today has been so rough. We were short; one of the techs went home sick after lunch. I'm so ready to go. Let's do this. KB: k. EA: This is Mrs. Smith, she came in this morning after a fall where she fractured her hip. She also is dehydrated and had a fever from UTI. Cultures were sent, and we gave her fluids and Tylenol, She's got normal saline running at 50 an hour, her next dose of Cipro is at 6. She hasn't needed any more Tylenol, and her temp is fine now. KB: When was her last bowel movement? EA: Nothing for me KB: Is she in pain? EA: Zero out of 10 all shift KB: Am I supposed to get her out of bed? EA: "Um...I don't know if she got into the chair at lunch, _____, the tech, helped her eat. I'm not sure if the doc wrote anything specific about activity". KB: So what's the plan for Mrs. Smith? EA: "I guess just check her blood pressure, antibiotics...you know. I think the doc said he'd come in

		tomorrow to check her out. OK, well that's my last patient so I'm out of here". RN 1 in room putting commode away, organizing supplies on side of bed near camera RN2 enters, stands on other side of the bed Pt looks back and forth to RNs as they speak RN1 leaves the room RN2 stands, quietly, writing some notes
Close up of IV pump		IV pump starts beeping – IVF is done
Med shot of RN, patient	Enma	Scoffs, leaves room Patient has questioning look on face, watches RN2 leave
HS Paula	Paula	*In this example, the patient was nowhere near the center of care for these nurses. We have to do better for our patients. They deserve it and you deserve to have the tools you need to provide the best care possible. Let's look more closely at some of the elements of relationship based care.*
TEXT ON SCREEN: Meaningful Bedside Report - Establishes relationship with pt. - Includes patient in goal setting - Safe hand-off of information	Karen	*Meaningful bedside report is the first opportunity to establish an intentional and therapeutic relationship with your patient. It provides space for communication with the patient, it allows for nurses to include the patient in the plan of care and review of goals, and it is key to safe, effective handoff between nurses.*
Wide shot of the room	Kaitlyn	Room is neat, IV pole/pump behind patient Nurses enter room with chairs and sit next to pt. *Enma, this is Mrs. Smith--she prefers to be called Judy--we've had a great night, now let's talk about the next 12 hours .*
	Enma	RN2 shakes hands with Judy, makes eye contact, smiles *So nice to meet you, Judy.*
	Kaitlyn	Speaking to RN2, pt. *Ok, so Judy was admitted around 3am and came to us after a fall with a hip fracture. She was dehydrated and also had a temp of 101 when she got here, and is positive for a UTI. Is that correct, Judy?*
HS of patient	Patient	Speaking to RN1, RN2 *Yes, I felt very weak when I was trying to get out of my chair and I fell.*

Wide shot of room HS as appropriate	Kaitlyn	Looking naturally between Judy and RN2 *Yes, Judy had a fracture but isn't a candidate for Surgery. Judy I am going to tell Enma some details of your care so far. She's received 2 liters normal saline since she arrived, her blood pressure improved from 82/49 to 102/65* Facing Judy *Judy, what's your normal blood pressure?*
	Patient	*About 100, 105.*
	Kaitlyn	*Blood and urine cultures have been sent, and she's had her first dose of Cipro at 6am; she also got Tylenol for that fever – just one dose around 5am, and her repeat temp was 98, so she hasn't required another dose.* *She has arthritis, but no other history, but she did tell me that she hasn't been as active recently.*
	Enma	*Sounds like we need a PT consult. I can follow up with Dr. Green.* *Judy, we'll talk about the importance of staying mobile and active. A physical therapy consult will help us evaluate your strength and will make some recommendations for maintaining your strength once you're back home. While you're here, though, we're going to get you out of bed, and walk you around our beautiful unit. You're also going to sit in a chair so you're lungs stay healthy and open and so you're using your muscles.*
Shot of white board, RN2 writing		*Let's go over the plan for the next shift, Judy. You know my name. Your tech's name is Ebony. She'll be in a few minutes to take your blood pressure and see if you need anything. We've drawn one cardiac enzyme lab and there are two more to go. We're going to continue to check your blood pressure to see if you need more IV fluids. We're going to check your temperature to see if your fever has returned.* *We talked about ambulating around the unit and sitting in a chair when you're not sleeping; and we're going to get a physical therapy consult.* Writes "ambulate, OOB to chair" Writes "PT consults"

		Did I miss anything? Judy, is there anything you want to add?
HS Patient	Patient	*Nope, I think that covers it.*
Shot of RN2 at white board	Enma	*Ok, now Kaitlyn and I are going to look at your IV and your room.*
Wide shot, new angle to capture pt., IV pole, head of bed	Kaitlyn	*I just hung this bag of normal saline, and you can see the tubing is dated for today. Her IV site was flushed and is patent.* *Judy, have you had any pain with that IV in your hand?*
	Patient	*No, it's fine.*
	Enma	Sits again to have eye contact with Judy, RN1 remains standing at IV pole *Alright Judy, I'm going to get report on my next patient, but I'll be back to round on you and to get you into a chair. If you need anything before I get back, this is your call bell. If you push it, a signal goes immediately to me (?), and I'll be able to answer you from wherever I am in the unit. Before I go, do you need anything? Water? To go to the bathroom?*
	Patient	*Thank you. I don't need anything right now.*
	Enma	*Judy, your comfort is a top priority for me. Since you have a hip fracture and the physical therapist is going to start working with you, I want to be sure that you understand how we manage pain in the hospital. I would like you to watch an educational video on pain management, and also one about how your pain medications work. Do you want to start watching the videos now or later?*
	Patient	*I would like to start watching now, please.*
	Enma	*OK, I'll turn it on for you. When I come back around, I'd like to hear your thought on the videos and what questions you have.*
	Kaitlyn	RN1 moves to exit the room, but makes last eye connect, touch with patient *I hope you have a great day. I'll be back tonight.*

	Patient	*Turns to watch video as RNs leave*
HS KAREN	Karen	*Clearly this interaction was safer, more robust, and had the patient at the very center of care. Meaningful bedside rounds is a **thoughtful exchange of information** with the result being a well-informed and supported nursing team, and a patient whose needs are met and whose trust in the care team is solidified because of the transparent and inclusive conversation about her health and plan of care.*
b-roll of 5W nurses, previous hand-off video, etc. TEXT OVER VIDEO: Advocate Nurse & Associate Nurse - Establishes POC based on pt.'s personal goals - Forms partnership with pt. & family - Revises plan and goals	Paula	*The next concept of relationship based care is the role of the Advocate Nurse and Associate Nurse. These two providers, along with a patient care tech, form the care team for a set of patients. The Advocate Nurse **leads** the team and has **responsibility** for establishing the plan of care, which is based on the patient's needs and personal goals. These are discovered by forming a **partnership** with the patient and family.* *The Advocate nurse coordinates the plan of care from admission through discharge and works with the patient and family to evaluate goals and timelines and revise if necessary.*
Med shot over patient's shoulder, RN2 enters room	Enma	RN2 knocks, enters the room, draws chair next to bed and sits *Hi Judy, it's Enma. How are you?*
HS PATIENT	Patient	Looks up from reading *Hi, I'm doing pretty well. I'm so glad that I am not going to have to have surgery.*
Med shot, new angle, with pt. and RN2 sitting	Enma	*Me too. I want to take a few minutes to ask you some questions and to make sure you understand everything we're doing for you.* *You mentioned you haven't been very active, and I'm wondering if your arthritis is preventing you from getting around your house to cook meals for yourself.*
	Patient	*Well, I live with my son, so he usually prepares dinner, but with my arthritis, I do have a hard time making lunch. I'll have a cup of coffee in the morning, but I guess I don't eat much else during the day.*
	Enma	*Oh, you live with your son, that's wonderful. I'm sure it's nice having family so close. Do you think he's going to come in and visit today?*
	Patient	*Yes, I know he is.*
	Enma	*Would you like for him to be part of the conversation when Dr. Kokatokis rounds? We're going to talk about questions you might have for the doctor, but I wonder if your son might have some questions, too.*
	Patient	*Yes, I'd like that*
	Enma	*Great. Judy, I'll ask Dr. Kokatokis for an occupational therapy consultation and maybe a nutrition consult, as well, since you may not be getting enough nutrition because your arthritis is so limiting. What questions you have for Dr. Kokatokis?*

	Patient	*Well, I've been thinking about that. I want to know how long I'll be on antibiotics. And I want to know what I should do for my arthritis.*
	Enma	*Sounds good. And what's the most important thing* ***I*** *can do for you this shift?* *Writing*
	Patient	*Well, seems like I need to be moving around and eating and drinking more, so I guess getting out of bed and getting lots to drink is important. But I'll tell you, I'm going to need to go to the bathroom if I drink a lot of water.*
	Enma	*No problem. I'll make your goals ambulating and drinking lots of water, and making sure your call bell is answered quickly when I'm not right here so you can get to the bathroom in time.*
	Patient	*And I want to be stronger…now and when I get home*.
	Enma	Great, Judy; you're really motivated to get better and stay healthy. That's wonderful.
Video of RN2 interacting with MDs, going to rounds, sitting with patient/family to share information, updating white board	Mahlet	The communication from the Advocate Nurse to the Associate Nurse and physicians is a crucial responsibility of this role. The Advocate must ensure all members of the care team are collaborating to meet the patient's needs and are keeping the patient at the center of care. The Advocate Nurse must also communicate information from the team back to the patient and family to maintain the therapeutic relationship and to keep the patient informed of her progress toward meeting her personal goals. The Advocate Nurse also has the responsibility of supporting a learning environment for the Associate Nurse. This includes effective communication of the plan of care during meaningful bedside rounds and connecting the physician's orders to the patient's plan and goals.
HS Melissa TEXT ON SCREEN: 5 Golden Minutes - Undivided attention - Personal connection - Discover patient's goals - Connect POC to pt.'s goals	Melissa	*The perfect time for the advocate nurse to establish a relationship with the patient is during the 5 Golden Minutes, which is also the last concept of Relationship Based Care.* *The 5 Golden Minutes is the opportunity for the nurse to give his/her undivided attention and to make a personal connection with the patient. It is the time to talk with the patient about her concerns and to demonstrate an interest in the patient as an individual*.
HS Melissa, other video	Melissa	The 5 Golden Minutes is an opportunity for the nurse to demonstrate compassion and to establish a healing bond with the patient that can result in the patient becoming more engaged in her own care. This time positions the nurse as the Advocate for the patient. It is now **this**

		nurse's responsibility to ensure the **patient's** goals are **communicated** to the team and are **incorporated** into the plan of care. Initially, the 5 Golden Minutes may seem like a lot of work and a lot of time out of the nurse's already busy day. But taking this time to find out what is important to the patient and the family at the beginning of the shift will actually **save** time. The patient's needs have been met and her trust in the care team is strong. Call bell use should decrease and the nurse has all the information needed to efficiently convey the patient's goals to the rest of the care team.
HS Paula	Paula	Introducing Relationship Based Care to MedStar Montgomery Medical Center is a reset for our culture and the way we interact with patients and colleagues. Keeping the patient at the center of care and building supportive relationships with families and colleagues around the patient will improve the quality of care we deliver and will lead to better outcomes and satisfaction for our patients.

Appendix E: Pre and Post Tests

Relationship Based Care Pre Test **NURSE**

As we continue our transition to implementation of Relationship Based Care (RBC), the RBC team has created an educational video that will be shared with all staff on 5W. Utilize information previously provided during in services, huddles, staff meetings and handouts to answer the following questions:

1. Identify the three intentional and personal relationships of the nurse/nurse tech.
   a)_____
   b)_____
   c)_____

2. List three duties of the RN Advocate nurse.
   a)_____
   b)_____
   c)_____

3. How will your role as the RN Advocate nurse differ from your current practice?
   _____
   _____
   _____
   _____
   _____
   _____

4. Describe the purpose of the "Golden Five" minutes._____ _____
   _____
   _____
   _____
   _____
   _____

5. Identify three important requirements of purposeful, bedside handoffs?_____
   a)_____
   b)_____
   c)_____

RETURN COMPLETED QUIZZES TO CTC OFFICE.

Relationship Based Care Post Test **NURSE**

Congratulations on the Go Live of Relationship Based Care!!
Utilize information provided in the Relationship-Based Care (RBC) video, huddles, in services, and staff meetings to answer the following questions (the RBC video is available for viewing on the MMMC intranet):

1. Identify the three intentional and personal relationships of the nurse/nurse tech.
   a)_____
   b)_____
   c)_____

2. List three duties of the RN Advocate nurse.
   a)_____
   b)_____
   c)_____

3. How does your role as the RN Advocate nurse differ from your previous practice?
   _____
   _____
   _____
   _____
   _____
   _____

4. Describe the purpose of the "Golden Five" minutes._____ _____
   _____
   _____
   _____
   _____
   _____

5. Identify three important requirements of purposeful, bedside handoffs?_____
   a)_____
   b)_____
   c)_____

RETURN COMPLETED QUIZZES TO CTC OFFICE

Appendix F: Nurse Advocate Role Education

The RN Care Advocate and team form a partnership with the patient/family in order to know the patient's needs and to incorporate this into the plan of care. This is accomplished through sitting at the bedside and asking the patient "What is the most important thing we can do for you this shift?" Progress toward meeting the patient's needs is evaluated with the patient during nurse and nursing tech hourly rounding. The team consists of the nurse and the nurse tech and the associate nurse for the oncoming shift. Patients and their families experience cooperation among all members of the health care team. The RN Care Advocate incorporates the five caring processes into the planning and caring for the patient.

- Knowing: Putting the patient in the center, engaging with the patient and family to better get to know the patient and their needs, understanding the patient's diagnosis and how the physician's orders (tests and medications) relate to that diagnosis. Being mindful of change in patient condition and how that could affect the plan of care. Patient assignments and staff scheduling provide for continuity of care.
- Being with: Taking five minutes each shift to talk with the patient to get to know them, understand their concerns and help them understand their condition and the steps they are comfortable with to resolve issues. Being present during interactions, focused on the patient and not workload or other things that need to be accomplished during the shift. Serving as the patient advocate during multidisciplinary rounds by knowing the patient and communicating the progress toward established goals.
- Doing for: Maintaining competence and using critical thinking skills to address the patient's condition and care needs. Providing comfort, protecting the patient's privacy, honoring the patient's wishes, speaking to the healthcare team on behalf of the patient and family. Ensuring patient safety through assessment and implementation of fall precautions, skin assessment and care, foley assessment and care and other assessments and interventions. Providing a focused and patient involved bedside shift hand off.
- Enabling: Keeping the patient informed of what is to come in terms of treatment. Discussing the alternatives, supporting and helping the patient and the care team understand what is needed. Making sure care is provided in a timely and patient focused manner.
- Maintain Belief: Helping the patient believe they will get better or if not helping the patient and family to accept and plan for the end of life. Being there for the patient and family during times of fear and sadness, providing them a realistic hope for the future.

Appendix G: Patient Care Communication Note Card

PATIENT CARE COMMUNICATION NOTE

****PLEASE CHECK EACH SHIFT AND UPDATE AS NEEDED**

- **DATE:**
- **NURSE ADVOCATE FOR SHIFT:**
- **WHAT PATIENT LIKES TO BE CALLED:**
- **WHAT IS MOST IMPORTANT TO THE PATIENT:**
- **PATIENT CONCERNS OR ISSUES:**

Appendix H: You Got Caught Form

RELATIONSHIP-BASED CARE
CARING MOMENTS (YOU GOT CAUGHT!!)

DATE: _____ STAFF NAME: _____

□ RN □ NURSE TECH

□ 5 GOLDEN MINUTES

□ GOAL ON WHITEBOARD

□ HOURLY ROUNDING

□ IDENTIFIES SELF AS NURSE ADVOCATE

□ MIDDAY HUDDLE

□ SEATED BEDSIDE REPORT

□ UTILIZES PATIENT CARE COMMUNICATION TO SHARE INFORMATION

COMMENTS:_____
_____
_____
_____