Relationship Based Care is Here!

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INTRODUCTION

Relationship Based Care (RBC) is a model of delivering healthcare that has transformed the practice of nursing by returning us to our basic purpose: caring for and connecting with other human beings. Developed by a cadre of seasoned nurse leaders that have brought together all their years of providing, observing, coordinating, leading, educating, and writing about the care of patients, RBC has transformed the relationship between patients and their care givers.

The framework for the RBC model is a caring and healing environment that supports the other fundamental dimensions of leadership, teamwork, professional nursing practice, care delivery, resources and outcomes. Mary Koloroutis, one of the founders of RBC, states "the relationship between the patient and the nurse is the foundation of nursing practice and care. It is anchored in the simple truth that care happens between people. It is in these relationships that patients and families receive support and guidance necessary for them to recover and heal."[1]

RBC is unique in that it incorporates three crucial relationships of which the one between care provider and patient is at the core. The other relationships are the care provider's relationship with self and the care provider's relationship with others. It is well documented that providers who are content and at peace with themselves and with their colleagues can deliver the compassionate, quality care that led them into nursing in the first place.

Creative Healthcare Management 2004

BACKGROUND

In 2006, when the Magnet surveyors came to re-accredit Lancaster General as a Magnet organization, it became clear to nursing leaders that our staff could not adequately describe the care delivery model that they used to provide care to our patients. That realization began our journey to identify a model that aligned itself with the vision, mission and core values of Lancaster General Health (LGH) and with the Department of Nursing.

Through literature searches, list serves, and networking with other nationally renowned organizations, on May 18, 2007 the Nurse Executive Council (NEC) chose Relationship Based Care to be our model of care. The NEC is the overarching nursing body that oversees the practice of nursing and is comprised of 50% staff and 50% management. The Council felt that the RBC model aligned with where we are in our nursing practices, and would help us reach where we wanted to be. Nursing, along with other health care professions, has changed dramatically over the last twenty years. Gone are the days when patients were in the hospital for long periods of time. Coupled with that change have been advances in technology and the continuous introduction of regulatory and legislative mandates that have pushed nurses away from the bedside and into a world of computers, data, and equipment. We wanted a model that would enable nurses to return to forming relationships with the patients and their families. The NEC felt strongly that RBC would be a catalyst for that change.

OUR JOURNEY

We had no idea at that time what it would mean to adopt this model, because RBC was not just about changing a care delivery system but about a deeper transforma-

tional change to our entire current existence. It meant incorporating the principles of RBC not only into our practice but into our recruitment and hiring processes, performance reviews, safety and quality programs, and standards of conduct. The LGH Department of Nursing developed principles that are unique to our organization based on six components: Caring and Healing Practice Environments, Responsibility for Relationship and Decision-Making, Work Allocation and Patient Assignments, Communication with the Health Care Team, Leadership/Management, and Process Improvements.

Who developed these principles and who is leading this change? With many initiatives in organizations, change usually comes from the top and filters down. Instead, this change is coming from the bottom up, which means that our clinical hands-on staffs are leading this change with the support of nursing leadership.

It starts at the unit level with attendance of select staff at a three day seminar where they obtain a sense that their work is meaningful, purposeful, and life altering. From that base, they create visions for their areas that reflect the *extraordinary experience* that patients will have when they come to their individual units. Unit governing councils are created that are comprised of members of the unit and members of other departments that provide services to that unit. The governing councils begin the work of creating the behaviors, processes and outcomes that will reflect these visions in action on their units. Critical components of this process are the communication networks that each unit creates to ensure that all staff and physicians connected with the unit are engaged in the process. After 4 months, the Unit-based governing councils present their action plans to a Steering Council where they receive affirmation to begin their journey.

As we went through this process, we often heard the concepts: Responsibility, Authority and Accountability (R+A+A). This means: a) there is a clear and specific allocation and acceptance of responsibilities; b) individuals have the authority to act in those areas where they have accepted responsibilities; and c) they review their judgments and decisions, demonstrating accountability for their own effectiveness.[2] R+A+A are embedded in all components of the RBC model: leadership, teamwork, resource driven practice, professional practice, and care delivery. It is critical to define the responsibility, authority, and accountability for roles, processes, and practices.

CURRENT STATUS

All change takes time to execute completely. Nine units have begun the implementation, with 24 more to follow. Our goal is to have all units live by August of 2010.

In developing their action plans, the staffs have been creative while also adhering to the fundamental principles. Some of the ideas that have been put into practice on the RBC units include:

- Completion of *Getting-to-Know-You* forms by patients so staff can interact with them on a personal level.
- Having the primary RN sit with the patient for five uninterrupted minutes every day to determine what the patient would like to accomplish that day.
- Institution of "Quiet Time" to allow patients to have down time in their potentially chaotic day.
- Development of "Commitment to Co-Worker" statements that are signed and posted on units to reflect the commitment to one another to work as a team.
- Carrying out shift-to-shift hand-offs at the bedside to include patients in the transition.
- Ensuring that staff is getting lunch/dinner breaks to allow them to have downtime.
- Instituting scheduling practices that allow continuity of care-giver assignments for the patients.
- Having nurses round with physicians to facilitate open communication about patient care.
- Placing communication white boards in patient rooms with pertinent information they need such as care providers, physician, and discharge dates, etc.
- Making hourly rounds on patients, with assessment of PEEP (Positioning, Elimination, Environment and Pain).
- Using the SBAR (Situation-Background-Assessment-Recommendation) communication tool for communication between nurses and physicians/LIP's (Licensed Independent Practitioners).

OUR FUTURE

We must always ask how we will measure the impact of these changes. The answer is: through our established systems of patient loyalty scores (Press Ganey), employee and physician satisfaction scores, and patient quality indicators. Below are five questions that will be sent to

employees of the RBC units each quarter, and will be documented on each unit's scorecard:

- I often leave work with a feeling of satisfaction about my job.
- I have enough opportunities to participate in departmental decisions affecting my job.
- The people I work with work well together.
- The physicians I work with treat me as an important member of the healthcare team.
- I feel there is a partnership between the physicians and the employees of the organization.

Nurse Managers will continue to make rounds on patients and seek input. In addition, some units are conducting 30 second surveys of patients and families in order to obtain up to date responses. From these results, appropriate adaptations to plans will be made. The LGH web site currently has a section for RBC that is located under the Nurses tab of the intranet, where anyone can follow our units through their journey.[3]

We strive for more comments such as these:

> "Thank you again for all you do every day for so many people. You have the opportunity to touch so many lives . . . Know that even on days when what you do may seem unappreciated, there are lives that you have saved and changed. Keep up the awesome work!"

> *"Words can't describe the enormous amount of gratitude that we have for the entire staff. All of you have been so helpful in making our seven week journey an easier one. Thank you for caring for our daughter and loving her when we weren't there. We will be forever grateful."*

> *"Relationships at work are inevitable. They're going to happen with patients and coworkers. Relationship-Based Care is a reminder that I am free to choose to make the most out of each encounter for all parties involved. It's not about me…but it starts with me."*

Our goal is to continually provide our patients and families an extraordinary experience every time through Relationship Based Care. Our ultimate goal is to spread RBC to our physicians and other departments so together we may all provide that extraordinary experience to all the communities we serve.

REFERENCES

1. Koloroutis, M. 2004. Relationship Based Care: A model for transforming practice. Creative Healthcare Management. Minneapolis, Minnesota.

2. Creative Healthcare Management. 2003. Leading an Empowered Organization: Participant Manual. Minneapolis, Minnesota.

3. http://intranet.lha.org/content/AssetMgmt/Nursing/RBC/Principles%20of%20RBC%2009_05_08.pdf.

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