

Introduction

Mary Koloroutis

We are creatures of community. Those individuals, societies, and cultures who learned to take care of each other, to love each other, and to nurture relationships with each other during the past several hundred thousand years were more likely to survive than those who did not.

—Dean Ornish, MD

An organization is commonly defined as “an administrative and functional structure—as in a business.” One is immediately struck by the huge disconnect between this rather technical and understated definition and what we know from experience to be true about organizations. We know that within organizations there is a complicated interplay between the needs and expectations of individuals and the needs and expectations of the organization as a whole. We know that organizations have unique cultures and pressures based on the contexts and demands of their particular environments.

We also know that *health care* organizations have a specialized and extraordinary purpose and function. Within health care organizations, profound human experiences happen every single day. Health care professionals come to work because they choose to care for people who are experiencing great vulnerability. The patients and families they come into contact with are under-

Overview

Organizations are dynamic and complex systems comprised of a diverse collection of human beings with different backgrounds and life stories.

going surgical interventions, facing serious or life-threatening illnesses, and/or experiencing the immense personal change associated with the joys and excitement of childbirth or the devastation of loss, grief, and death.

Just as there is a disconnect between the purely technical definition of *organization* and our knowledge and understanding of the human aspects of organizations, there is frequently the same sort of disconnect between *what drives* an organization and *what matters most* in an organization. In the past decade, health care organizations have been driven by complicated economic, political, and market forces. These forces create a chaotic environment that runs counter to much of what we value about health and healing. Health care leaders and staff often feel demoralized when they find themselves in the middle of a health care delivery system that seems to have lost touch with the very reasons they've chosen health care as their profession. Far too many report feeling like their core mission has been lost and that an unacceptable amount of their energy is spent on trying to survive the chaos.

Norman Cousins wrote *Anatomy of an Illness* about his own experience of being hospitalized for progressive paralysis, (ankylosing spondylitis) a degeneration of the connective tissue in the spine. He describes an experience of the gradual loss of control over his life and destiny in the partial list below (Cousins, 1979, p 153-154). This list, generated over 25 years ago, captures the complexity of the human response to illness and the daunting responsibility healers and health care organizations have to be conscious of the humanity of each person they serve. It magnifies the power and ethical imperative of connecting human-to-human.

There was first of all the feeling of helplessness—a serious disease in itself.



There was the subconscious fear of never being able to function normally again.

There was the reluctance to be thought a complainer.

There was the desire not to add to the already great burden of apprehension felt by one's family; this added to the isolation.

There was the conflict between the terror of loneliness and the desire to be left alone.

There was the lack of self-esteem, the subconscious feeling perhaps that our illness was a manifestation of our inadequacy.

There was the fear that decisions were being made behind our backs, that not everything was made known that we wanted to know. . . yet dreaded knowing.

There was the morbid fear of intrusive technology, fear of being metabolized by a database, never to regain our faces again.

There was resentment of strangers who came at us with needles and vials—some of which put supposedly magic substances in our veins, and others which took more of our blood than we thought we could afford to lose.

There was the distress of being wheeled through white corridors to laboratories for all sorts of strange encounters with compact machines and blinking lights and whirling discs.

And there was the utter void created by the longing—ineradicable, unremitting, pervasive—for warmth of human contact. A warm smile and an outstretched hand were valued even above the offerings of modern science, but the latter were far more accessible than the former.

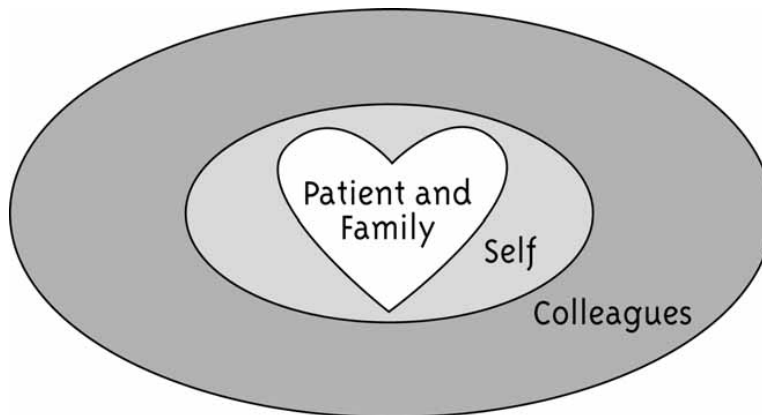


Relationship-Based Care

Finally, in this decade, health care organizations are discovering that determining what matters most to patients, families, and staff is the most logical starting point for creating a successful organization. And not surprisingly, focusing on the value of relationships has once again come to the fore. Health care organizations exist to provide compassionate care and service to people in times of illness and suffering. This is the core of the business—the purpose of the organization and *what matters first, last, and most* in health care. Marie Manthey, CHCM's founder, goes right to the heart of the matter when she says, *"I am convinced that the chaos we are experiencing in health care will settle down when we truly focus on the patient."*

Relationship-Based Care (RBC) is comprised of three crucial relationships: care provider's relationship with patients and families, care provider's relationship with self, and care provider's relationship with colleagues.

We experience the essence of care in the moment when one human being connects to another. When compassion and care are conveyed through touch, a kind act, through competent clinical interventions, or through listening and





seeking to understand the other's experience, a healing relationship is created. This is the heart of Relationship-Based Care.

In RBC, the care provider-patient relationship is one in which the care provider consistently maintains the patient and family as his or her central focus. The care provider knows that each person's unique life story determines how he or she will experience an illness. The care provider conveys an unwavering respect and personal concern for the patient, strives to understand what is most important to this particular patient and family, safeguards their dignity and well-being, and actively engages them in all aspects of the patient's care.

The second crucial relationship is the care provider's relationship with *self*. This relationship is nurtured by self-knowing and self-care. Self-knowing is a prerequisite for emotional maturity, healthy interpersonal relationships, and the capacity for empathy (Goleman, 1997). Without a clear understanding of one's self, a person's emotional reactions may adversely affect their capacity for caregiving and teamwork. Effective self-care means that individuals possess the skills and knowledge to manage their own stress, articulate personal needs and values, and balance the demands of the job with their physical and emotional health and well-being. The relationship with self is fundamental to maintaining each individual's optimum health, for having empathy for the experience of others, and for being a productive member of the organization.

The third relationship is among members of the health care team. The delivery of compassionate quality care requires a commitment by all members of the organization within all clinical disciplines to accept responsibility for establishing and main-

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taining healthy interpersonal relationships. Quality care occurs in environments where the standard among members of the health care team is to respect and affirm each other's unique scope of practice and contribution, to work interdependently to achieve a common purpose, and to accept responsibility for creating a culture of learning, mutual support, and creative problem-solving.

We believe that the Relationship-Based Care model promotes organizational health resulting in positive outcomes in all the critical arenas that measure success: clinical safety and quality, patient and family satisfaction, physician and staff satisfaction, effective recruitment and retention of staff, and a healthy financial bottom line. This book will introduce the reader to the components of Relationship-Based Care in order to provide readers with a practical framework to create the next generation of excellent care in their organization.

The Relationship-Based Care model is designed to assist leaders within organizations to strengthen or transform these three critical relationships to achieve the quality, financial, and organizational outcomes they desire. Remember, when we speak of "transforming" we are speaking of changing the condition of what currently exists.

I_2E_2 : A Formula for Leading change

Jayne Felgen developed a practical formula for change which defines four equal elements for transforming an environment of care. This formula simplifies the process of engaging individuals and groups in appreciating current successes while aspiring to a deeper integration of change within the culture of the organization. This formula for change is I_2E_2 ; Inspiration, Infrastructure, Education, and Evidence.



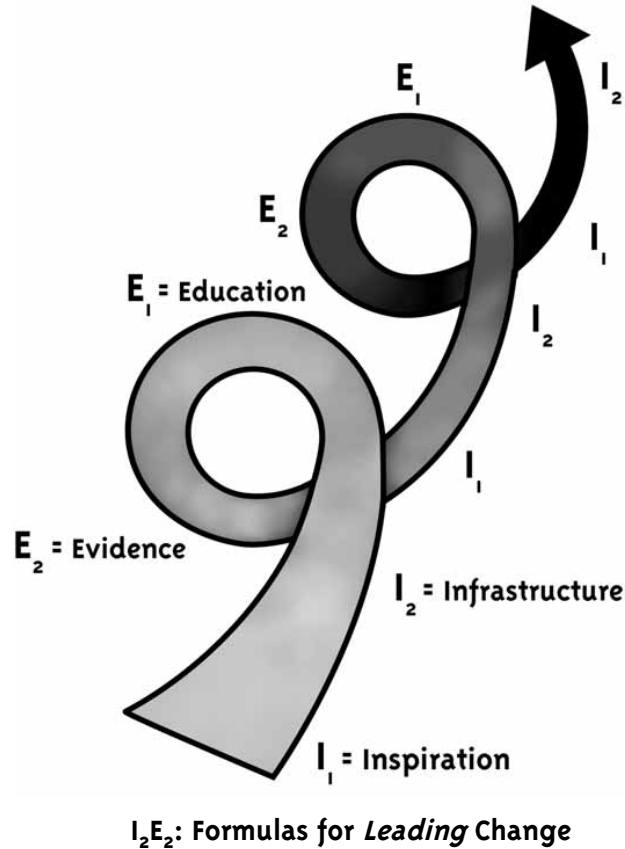
I₂ = Inspiration and Infrastructure

Inspiration promotes movement within an organization. To inspire means to “draw forth or bring out.” People participate fully when they believe that what they have to offer is valued and that they are contributing to a vision they find compelling, valuable, and life-affirming. Leaders implementing the RBC model inspire others through their clarity of vision and their ability to influence others to share that vision. Successful leaders in an RBC system will maintain an unwavering focus on what matters most: *caring and healing relationships at the point of care.*

All members of an organization become inspired by this patient-centered approach to fulfilling the purpose and mission of the organization as patient well-being is so often the basis for their own personal call to their profession. This inspired vision and purposefulness result in an organizational culture in which people are valued and respected as individuals, recruitment and retention are strong, and morale is high.

Infrastructure establishes the practices, systems, and processes through which the vision is achieved. It lays the underlying foundation that makes change possible. Infrastructure changes are necessary when we wish to implement any change in how we experience roles and relationships, operating principles and practices, communication processes, decision-making structures, and the existing tools and systems to support the work. The infrastructure must support the organization’s overall vision at strategic, operational, and tactical levels.

Leaders inspire others when they have clarity of vision and purpose, confidence and ability to influence others to share their vision, and a laser focus on what matters most: caring and healing relationships at the point of care.



E_2 = Education and Evidence

Education promotes competence, confidence, and personal commitment. Our commitment to education is born of the belief that people want to do a good job. Continuing education encourages and supports staff members to learn and develop to their greatest capacity, ultimately fostering in them the confidence to be more creative, productive, and satisfied with their work. Our highest priorities for educational development are in the areas of self-awareness, patient and family experience of care, developing and maintaining healthy relationships, proactive positive communication, creative thinking, critical thinking, and leadership.



In the RBC model, personal growth and professional development are viewed as an integrated whole. We believe people possess infinite potential. If the work culture is one which appreciates and promotes potential, the possibilities for growth are limitless.

Evidence demonstrates that something has indeed happened or changed. In addition, evidence demonstrates that the change *lives* within the infrastructure of the organization in its standards, position descriptions, performance evaluations, and most importantly in daily practice. Evidence of success lets people know that all their work is paying off and that progress is happening. Evidence links directly back to inspiration—as there is nothing more inspiring than seeing the fruits of our labor. In RBC, clearly defined measures based on the vision and goals of the desired change are articulated and evaluated to mark success.

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I₂E₂ works when leaders at all levels of the organization are committed to transforming practice and understand five key conditions—the 5 Cs—that support people’s ability to engage in change:

1. *Clarity*—When people know why the change is happening, where they are going, what the benefits are in going there, how they will know when they have succeeded, and what part they have in making it successful, they support the change. A clear understanding of the scope of their own responsibility, authority, and accountability for the work involved frees them to take action.
2. *Competency*—When individuals know what is expected of them and feel skilled in taking action, they are more able to participate in the change process. Their

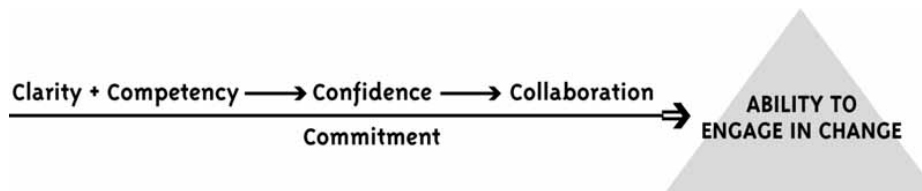


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competency is developed when they are provided the education to expand their knowledge and skills.

3. *Confidence*—When individuals know what they are expected to contribute, and when they have the knowledge and skills to make that contribution, they feel confident. Confidence provides the emotional foundation for exercising judgment and taking action. It enables individuals to contribute and actively collaborate with others.
4. *Collaboration*—Change requires people to work together to achieve a shared goal. When individuals understand the part they have to offer, feel competent and confident in their abilities to accomplish the work, and respect the contributions of others, collaboration and teamwork thrive.
5. *Commitment*—True commitment to accomplishing a shared goal comes from each individual's contribution, ownership for their part, and competence and confidence in accomplishing the work in collaboration with others. When these conditions are in place, progress is steady, problem-solving is creative and proactive, and desired results are achieved.

The figure below illustrates the way the 5 Cs support change. Commitment becomes the foundation upon which clarity, competency, confidence, and collaboration flourish.



The Relationship-Based Care model has evolved from CHCM's 25 years of experience in health care. Through our work in hospitals and health care settings across the United States and the United Kingdom, and through examination of evidence-based practice and research in the field, we have learned that:

The Relationship- Based Care Model

- Patients and families define “caring and healing environments” as those in which they are actively involved in their own care—where they feel as though they are seen as whole people (body, mind, and spirit), and where they have established an individualized relationship with physicians, nurses, and other care providers.
- The nurse-patient relationship is the foundation of excellent care delivery, and nurse accountability for a therapeutic relationship with a patient and the patient’s family is essential to achieving quality outcomes.
- Clinical proficiency based on a sound knowledge base and understanding of the theories and science of practice, forms the foundation for the delivery of compassionate, quality care.
- Interdisciplinary communication and teamwork are vital as they promote mutual respect and role clarity.
- Patient involvement and confidence in their care is increased by positive relationships with their care providers.
- Patient safety is most effectively safeguarded when an advocate in the health care system (most practically, a nurse)



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knows the patient, the patient's family, and what matters most to all of them.

- Continuity of nurse-patient/family relationships, as well as continuity of team relationships, can be achieved through carefully designed scheduling practices and patient assignment methods. Continuity of care reduces the likelihood of medical errors.
- How an organization's leaders regard the value of the nurse-patient/family relationship within the context of a collaborative team effort determines how work is structured and what is prioritized.
- Attitudes, expectations, and structure of work practices either enhance or detract from therapeutic and healing relationships.
- The culture of care is a reflection of the people who work in that health care environment.
- Organizations with caring and healing environments and a focus on relationships have higher patient, staff, and physician satisfaction and higher productivity.

These lessons are congruent with patient satisfaction findings in which patients report that what matters most to them are the interpersonal skills of the hospital staff. Attributes such as attitude, communication, and caring behaviors are most closely correlated with patients' overall satisfaction with care and whether they would recommend an organization to others (Press and Ganey, 1997). When asked what made a difference to them in their health care experience, patients consistently respond that what matters most is being "seen as a person— not a diagnosis."

In the seminar, *Reigniting the Spirit of Caring*, patients and families talk with health care participants about what constitutes caring behaviors. They consistently say they want to be listened to, treated with respect, and cared for gently. They want to know that the people caring for them talk to each other and coordinate their activities. They want honesty, timely information, and guidance so that they can make informed decisions.

Patient satisfaction research which measured the effect of an implementation of *The Caring Model*^{™*} (Dingman, et al, 1999) further validated that a care provider's response to requests and anticipation of needs are most significant to patients and their families, followed closely by their abilities to calm fears, communicate effectively, inform them about tests and procedures, and show concern.

The Fetzer Institute and the Pew Health Professions Commission Task Force identified the concept of relationship-centered care as key to the delivery of quality health care, recommending that *relationship* be brought back into health care (Tresolini, 1994). Their work is built on the long history of the nursing profession's emphasis on caring relationships from both practice and philosophical perspectives (Benner & Wrubel, 1989; Peplau, 1952). Despite this long history, caring relationships have not become a defining force in health care. The call of the Pew Health Professions Commission Task Force was to identify the practical infrastructure and educational support necessary to make relationship-centered care truly come alive in contemporary health care organizations.

The RBC model provides both the philosophical foundation and practical infrastructure to achieve organization-wide transformation in the

*The Caring Model[™] is a trademark and servicemark of Sharon K. Dingman.



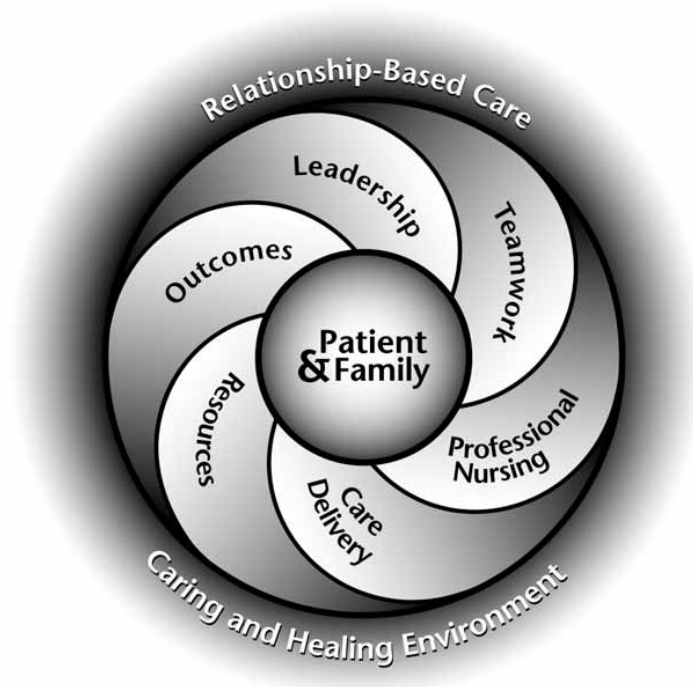
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way care and service are provided to patients and their families. In this model, relationships are the central focus and people from every level and area of the organization are invited to contribute to the organization's transformation. It is essential that the transformation of a health care organization be a team effort based on common vision, values, and anticipated outcomes. It truly "takes a village" to deliver world-class patient care. Everyone's work is valuable, regardless of his/her role or setting of care (Person & Marsh, 2002). Caring can occur in every relationship.

While holding in high regard the essential value of *every* individual's contribution to care, the Relationship-Based Care model also emphasizes the pivotal impact of Professional Nursing care on patient care and satisfaction. Research shows that patient reaction to and satisfaction with nursing care is the most important predictor of overall satisfaction with hospital care (Williams, 1993). Because nurses provide the greatest percentage of patient care within hospitals, a highly developed Professional Nursing Practice has the potential to distinguish one hospital from another.

The RBC model is illustrated on the following page. The six dimensions essential to the implementation of Relationship-Based Care are: leadership, teamwork, Professional Nursing Practice, patient care delivery, resource driven practice, and outcomes measurement.

Relationship-Based Care: A Model for Transforming Practice is organized around the Relationship-Based Care model on the next page, with a chapter dedicated to each dimension identified within the model. Reflecting the integrated work of Creative Health Care Management over



the past twenty-five years, this book taps into the deep knowledge and experience of a team of individuals within the company working with health care organizations around the world. Each chapter has been authored by members of the CHCM team.

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The term *Relationship-Based Care* refers to both the philosophical foundation of the model and its operational framework. Health care is provided through relationships. The activities of care are organized around the needs and priorities of patients and their families. All care practices visibly demonstrate the mission and values of the organization, including those of clinicians and staff members from all disciplines, departments, and services.

Elements of the Model

Caring and Healing Environment

Jayne Felgen creates the context for Relationship-Based Care in Chapter One, by describing the essential components of a caring and healing environment. She explores caring theories and identifies ways to put those caring theories into practice. She helps care providers find ways to promote the healing power of relationships, to understand the patient's unique story, and to advocate for the active involvement of the patient and family in planning and managing patient care.

A caring and healing environment makes Relationship-Based Care possible. In a caring and healing environment, care providers respect the dignity of each patient and effectively utilize resources to accommodate the needs of the whole patient—mind, body and spirit.

Leadership

In Chapter Two, Mary Koloroutis discusses how to develop the leadership vital to creating and sustaining a *culture* that supports Relationship-Based Care. She discusses the nature and attributes of caring leaders, introduces a practical framework for leading change in daily practice, and explores the implications for roles and relationships of leaders and staff within organizations. In addition, she elucidates the concepts of *responsibility, authority, and accountability* within a decentralized decision-making structure.

Leaders create caring and healing cultures. In this book, the term *leaders* is used in its broadest sense. Here leaders are not defined by position, education, or licensure. Leaders exist at all levels in every organization. Leaders know the vision, act with purpose, remove barriers to quality care, and consistently make patients, families, and staff

their highest priority. Leaders solve problems creatively to get results, and they model and support the changes they desire.

Teamwork

In Chapter Three, Donna Wright describes healthy, interdependent teamwork as one of the most statistically significant predictors of quality care. She outlines the qualities of healthy team relationships, and pays special attention to the pivotal role the physician-nurse relationship plays in the delivery of safe, high quality patient care.

Healthy teams are essential to making RBC a reality. Teamwork requires a group of diverse members from all disciplines and departments to define and embrace a shared purpose and to work together to fulfill that purpose. In healthy productive teams, members contribute their unique knowledge and skills commensurate with their established level of responsibility, authority, and accountability. Unified, collaborative interdisciplinary teams learn together and create the energy and interdependence required for well-coordinated, high quality patient care delivery and outcomes.

Professional Nursing Practice

Professional Nursing Practice is described in Chapter Four. Mary Koloroutis presents a nurse's therapeutic relationship with the patient as a privileged, sacred trust—and the cornerstone of Professional Nursing Practice. This chapter explores nursing's social responsibility, scope of practice, six professional practice roles, delegation practices, competency, and *caring* as the essence of effective Professional Nursing Practice.



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Professional Nursing Practice exists to provide compassionate care to individuals and their loved ones, helping them heal, maintain health, cope during times of stress and suffering, and experience a dignified and peaceful death. Professional nurses achieve these aims through more than *clinical* knowledge and proficiency. Professional Nursing Practice requires knowledge and understanding of the human condition.

Patient Care Delivery

In Chapter Five, Colleen Person presents a patient care delivery system that has evolved from the complementary disciplines of Professional Nursing Practice and Primary Nursing. The system frames the way in which the activities of care are accomplished and is built upon the concepts, principles, and values of Professional Nursing Practice. In addition, Person outlines the four elements of care delivery and contrasts four common care delivery systems. She also discusses the ANCC's *Forces of Magnetism* as a guide for implementing this system of care delivery.

In Relationship-Based Care, the patient care delivery system provides the structure to support the professional role of the care provider, to promote collegial relationships among all members of the team, to organize work, and to effectively utilize resources. Its focus is to establish a therapeutic relationship between nurses and patients and families, create alliances between members of the health care team on behalf of patients and families, and to accomplish essential nursing interventions.

Resource Driven Practice

Resource driven practice is discussed in Chapter six by Marie Manthey and Mary Koloroutis. This

chapter explores ways that clinical staff and managers share responsibility for the resources required to provide care. Manthey and Koloroutis discuss changing the nursing mindset about staffing, roles, relationships, delegation, critical thinking, reflection, and common sense decision making.

Resource driven practice requires both critical and creative thinking and is vital to the success of RBC. A resource driven practice is one which maximizes all available resources—staff, time, equipment, systems, budget—in the interest of achieving desired outcomes and safeguarding patient care. Resource decisions include determining staffing levels, skill mix, staffing schedules, and patient assignments. In resource driven practice, the use of resources at the point of care delivery is managed judiciously and authoritatively by the managers and clinical staff responsible for that care, and is based on the therapeutic relationship with the patient and family.

Outcomes Measurement

In Chapter Seven, Leah Kinnaird and Sharon Dingman present a simple, practical process for measuring outcomes to elevate standards and enhance the value of Relationship-Based Care in your organization. They begin with the premise that the RBC model has a positive impact on outcomes; the subsequent challenge is to create a meaningful representation of these outcomes on paper. They propose that data need not only be meaningful, but also motivating in order for leaders and practitioners to change the way they work.

Readers will learn strategies for capturing, processing, analyzing, and reporting relevant data that are trusted throughout the entire organization and useful from the bedside to the boardroom.



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Their approach uses indicators recognized by the American Nurses Credentialing Center (ANCC), ANCC Magnet Recognition Program™, the National Center for Nursing Quality (NCNQ), Institute of Medicine (IOM), and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Achieving quality outcomes requires planning, precision and perseverance. Periodic, systematic outcome measurement assures that Relationship-Based Care stays current and relevant.

Using this Book

This book presents a fully developed model of Relationship-Based Care. Some of its readers will gain a deeper appreciation of familiar concepts, while others will encounter new concepts they may find difficult to integrate immediately. We ask this second group of readers to be patient and allow their understanding to build as concepts introduced in one chapter are elaborated upon in subsequent chapters.

Our intention with this book is to provide health care leaders *at all levels of the organization* with practical guidance in all of the key dimensions of designing and leading change in patient care delivery in their care organizations. Teamwork in interdisciplinary practice is essential. Nonetheless, readers may notice an emphasis on the role of the Professional Nurse. Within the context of interdisciplinary practice, one of our key intentions is to clarify the role of the Professional Nurse in RBC.

The nurse has a pivotal role at the point of care delivery. Subsequently, the relationship between the nurse and patient/family provides the foundation for the care experience. To be effective, this



relationship must be clear to the nurse, to the patient, to the family, and to the members of the health care team. Additionally, when all members of the interdisciplinary team understand the role of the Professional Nurse, and how that role impacts patient care, they are more able to collaborate and coordinate care on behalf of the patient and family.

Each chapter begins with an overview of the dimension. A discussion of the theory behind the dimension is followed by approaches for practical application. All chapters end with a summary of key concepts along with questions to help readers assess how this dimension is currently represented in their organization. The questions can be used for personal reflection or as discussion starters with colleagues and staff.

At the end of each chapter, exemplars are presented under the heading “A Moment of Excellence.” These exemplars are authored by health care leaders in the field and describe an application of the RBC dimension in real-life examples. They have been organized based on I₂E₂.

Inspiration (I₁): What inspired the change or strategy? What strategies were particularly effective in inspiring others toward a common vision?

Infrastructure (I₂): How does the infrastructure support the change at the strategic, operational, and tactical levels? What changes were made to assure the infrastructure supported the new vision?

Education (E₁): What initial education was provided to build skills and knowledge to enhance the

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changes? What education is being provided to promote and sustain the change?

Evidence (E₂): How was success defined, and which measures of evidence were helpful in tracking outcomes and leadership support?

These exemplars illustrate the theoretical aspects of the dimension as well as provide practical tips for bringing Relationship-Based Care to life.