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Relationship-Based Nursing Practice

Transitioning to a New Care Delivery Model in Maternity Units

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ABSTRACT

In a fast-paced, high-volume maternity unit, the goal for nursing care delivery is to provide care that is perceived by patients as personal and caring, is rewarding to nurses, and is in an environment of maximum patient safety. A care delivery model is the organizing structure that can facilitate this goal. Relationship-Based Nursing Practice is a care delivery model designed to transition nursing care from task-focused to relationship-based. A shared vision of the registered nurse as a professional member of the healthcare team, working in an optimally safe and family-centered care environment, inspired the model design. Three relationships—the nurse with the patient, the nurse with colleagues, and the nurse with self—provided the foundation for the creation of guiding principles. Guiding principles were operationalized to support 1 or more of the 3 relationships, contribute to improved patient safety, and actualize the role of the professional registered nurse, in daily patient care. Outcomes include improvement in patient safety, increased patient satisfaction, and perception of improved teamwork among nurses. The process for sustainability and ongoing evaluation of the model is discussed.

Key Words: briefing-debriefing, care delivery model, handoff communication, nurse handoff, nurse-patient relations, relationship-based, team attitude

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Since the release of the Institute of Medicine's (IOM's) report, *To Err Is Human*,[1] agencies and organizations such as the Agency for Healthcare Research and Quality, the IOM, the National Quality Forum, and The Joint Commission have made recommendations and put requirements in place to address patient safety. In addition, the Lucian Leape Institute, established by the National Patient Safety Foundation, states that patient safety depends on a significant transformation to achieve a culture of trust, reporting, transparency, and discipline.[2] This vision for healthcare includes doctors, nurses, and all healthcare workers who treat each other with respect, patients' interests are foremost, and patients and families are fully involved in their care. One key attribute of such a culture is transparency, so that everyone is encouraged and given the opportunity to talk openly about errors and mistakes. A second attribute is joy and meaning in work; to meet the challenge of making healthcare safe and caregivers feel valued.[2] At the core of such a cultural transition for nurses are 3 types of relationships. These relationships comprise nurse and patients; nurse and coworkers, management, and other members of the healthcare team; and nurse and self, in self-advocacy, autonomy, and responsibility for the safe and effective care of patients and families. The purpose of this article is to describe the design, the implementation process, and preliminary outcomes of a relationship-based nursing care delivery model with specific examples in maternity units.

CURRENT STATE OF NURSING CARE DELIVERY

In a tertiary care, university-affiliated children's hospital with full obstetric services and approximately 5000 deliveries annually, a significant transition in nursing care delivery was undertaken to realign priorities of care with the vision and goals of the organization. Before implementation, patient care was largely task driven

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with an emphasis on moving patients through their hospital stay as quickly as possible. In this functional model, care was provided primarily by registered nurses (RNs). However, the professional RN's role was poorly understood by nurses and other members of the healthcare team alike. Because of 12-hour shifts, rapid turnover of patients, and frequent adjustments to staffing patterns, continuity of care was a daunting challenge in the fast-paced, often-chaotic work environment. Critical thinking and clinical judgment were difficult to incorporate into nursing assessments. Nurses were hindered in their ability to develop therapeutic relationships with patients and families, to participate in team rounds, and to proactively plan the patient's care. Handoffs were memory based and variable in quality and did not enable safe transfer or continuity of information needed for coordination and care planning. Teamwork was hit or miss. The patient experienced fragmented care from shift to shift, which was often perceived as impersonal and lacking coordination. The hospital needed to transition nursing practice to a new, transformative culture.

This transition began with a vision put forth by the chief nursing officer. The 3 goals for achieving the cultural change were to focus nursing practice on caring where the top priority is building and maintaining a therapeutic relationship with the patient and family; establish a clear, tangible RN presence within the healthcare team; and clearly define and operationalize the role of the RN as a coordinator of the patient's plan of care. A nursing care delivery model was needed to provide the infrastructure for cultural transformation. The purpose of a care model is to organize the work that nurses do. It provides common language, formal structure, and processes for delivering optimal patient care. A care model defines the decision-making authority and responsibilities of the nurse and others in the healthcare environment, as well as work distribution, communication, and management.[3] By focusing on a relationship-based approach, the model would help transition patient care and the unit environment to a more optimal patient experience. This model would need to include core principles to guide nursing practice, roles and responsibilities of the RN and leadership, processes and tools, and desired outcomes for success.

REVIEW OF THE LITERATURE

There are several reports in the literature of a relationship between better care environments and better patient outcomes.[4–6] Care delivery models based on caring theories and relationships have shown improvements in overall patient satisfaction,[7] specifically in concern for privacy, meeting emotional needs, attention to special/personal needs,[8] and pain control.[7,8] Caring-focused care delivery models have demonstrated a positive impact on nursing retention,[7,9] nursing satisfaction,[7] and specific improvements in nurse-to-nurse relationships including mutual respect, gossip avoidance, decreased complaining, and nurse-to-nurse conflict resolution.[10] Relationships between patients and nurses, and nurses and coworkers, are common threads found in caring-focused care delivery models.

The philosophy and vision of nursing, and the organization's mission and values, must be in alignment with the tenets of the care delivery model and provide the basic foundation.[11,12] Traditional care delivery models (total patient care, functional nursing, team nursing, and primary nursing) have advantages and disadvantages and were developed to address past socioeconomic and cultural values in healthcare.[13] These models focused on delegation of duties and work allocation. Looking beyond division of workload and considering the work environment, a caring-focused care delivery model was needed to best achieve the organization's vision of family-centered, relationship-based care that would optimize patient safety, cost, and quality.

The organization wanted to improve the care environment, specifically teamwork and relationships among nurses and other colleagues through the process of team briefing and debriefing. The aim of team briefing and debriefing was to promote a sense of teamwork and professionalism, provide a consistent forum to provide input about safety and operational issues, and foster the relationship of the nurse with coworkers and colleagues. The concepts of briefing and debriefing have been in use among commercial and fighter pilots and were formalized in Crew Resource Management training by the National Aeronautics and Space Administration in 1979.[14] Briefing and debriefing in the hospital setting have been studied primarily in the operating room setting[15–17] and have been shown to reinforce professionalism and improve communication.[17,18] Debriefing has allowed for the identification and analysis of recurring problems through real-time reporting.[17,19] Nurses, surgeons, and anesthesiologists report that patient safety in the operating room has improved with briefings and debriefings.[19] The Salas Theory of Teamwork supports fostering teamwork through team briefing, which provides the shared knowledge necessary for a functioning team. The group is made aware of itself as a team, communicates the possible need for backup (helping each other) and adaptability (adjusting to work environment changes), and establishes team leadership. Mutual trust can be fostered through mutual understanding of the work to be performed.[20]

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Communication across a shift or episode of care can be fragmented with 12-hour shifts, part-time workers, and variable lengths of stay. The organization aimed to improve continuity of clinical and psychosocial information by addressing the change of shift RN handoff. The IOM's report, *Crossing the Quality Chasm*,[21] urged that healthcare organizations standardize the handoff process, linking patient safety with ensuring that information is not lost or forgotten during transitions in care. In 2005, The Joint Commission[22] found that nearly 70% of sentinel events in hospitals were caused by communication issues, and the majority of these occurred during handoffs, which led to the creation of a National Patient Safety Goal requiring standardized handoffs. The World Health Organization[23] and others[24] urge the use of common language and a standard communication tool such as Situation, Background, Assessment, Recommendation (SBAR). Standardized handoff communication can decrease adverse events and increase patient safety. It has been shown to improve compliance with medication reconciliation upon admission, which can reduce medication errors.[25,26] In a pilot study, the use of standardized nurse handoff communication using an Electronic Medical Record (EMR)–supported SBAR tool was related to a reduction in adverse nurse-sensitive outcomes, which are monitored and reported to the National Database for Nursing Quality Indicators. These included a reduction in patient falls, use of restraints, and catheter-associated urinary tract infections.[27] The literature was clear that a standardized RN handoff had the potential to improve patient safety and continuity of information by improving the transfer of information between nurses at the change of shift.

The concept of focus time was identified to provide structure to daily nurse-patient engagement. A cornerstone of building and maintaining therapeutic relationships between patients and nurses involves spending dedicated time with patients to understand their needs and concerns. Upon implementing Relationship-Based Care (RBC), 1 hospital found that both verbal caring behaviors (eg, discussing a topic of patient concern other than current health needs) and nonverbal caring behaviors (eg, sitting at the bedside, sustaining eye contact, and entering a patient's room without having been summoned) increased among nurses.[9] One of the key elements of the Caring Theory[28] is that direct caregivers sit at the patient's bedside for at least 5 minutes each shift to review and discuss the plan of care and desired outcomes. Within the Quality-Caring Model,[7] purposeful interaction is described as a caring practice in which the nurse sits down at the patient's bedside, looks at the patient, and initiates a conversation starting with something meaningful to that patient. These behaviors have been related to improved patient satisfaction related to nurses anticipating needs, responding to requests,[7,28] explaining procedures, and calming fears.[28]

DESIGN PROCESS AND DESCRIPTION

Relationship-Based Care[3] provided the inspiration for the care delivery model. The fundamental construct of RBC involves 3 relationships: the nurse and the patient, the nurse and colleagues, and the nurse and self. When optimized, this model can result in safe, patient-centered, well-communicated, and well-coordinated care. Clearly articulating the responsibilities, authority, and accountability of the professional nurse optimizes the role of the RN. Expectations of the role can be communicated to providers for better collaboration and coordination of care. These concepts resonated with the goals of creating an environment in which care is a priority and nurses are contributing members of the healthcare team. The focus on relationships with patients and families paralleled the hospital's core value of family-centered care.[29]

A project plan was developed that included initial input from nurses.[30] Successful implementation requires customization of the model for integration into the existing organizational system and infrastructure. This process acknowledges the strengths and best practices in patient care that currently exist and focuses on how to reach excellence.[31] The IOM's report, *The Future of Nursing*[32] recommends that healthcare organizations involve nurses in developing and adopting new patient-centered care models. The input from frontline nurses was essential in developing a model that would be realistic and achievable. The design team consisted of staff nurse representatives from councils within the nursing-shared governance structure, managers, and clinical nurse specialists. In a preparatory workshop, the team became grounded in the principles of RBC; the roles, responsibilities, and scope of practice of the RN; and the philosophy and vision for nursing at the organization. The 4 elements of a successful care delivery model, which are the nurse-patient relationship and decision making, work allocation and/or patient assignments, communication among members of the healthcare team, and the management and leadership of the unit or care area, provide additional direction.[33] The team developed 5 guiding principles related to the concepts learned in the workshop and 7 practices that operationalized the principles (see Figure 1).

Because the care delivery model was specific to the organization and its vision, it was named "Relationship-Based Nursing Practice" (RBNP). A shared governance leadership council comprised of RN unit council coordinators and nursing management gave feedback and

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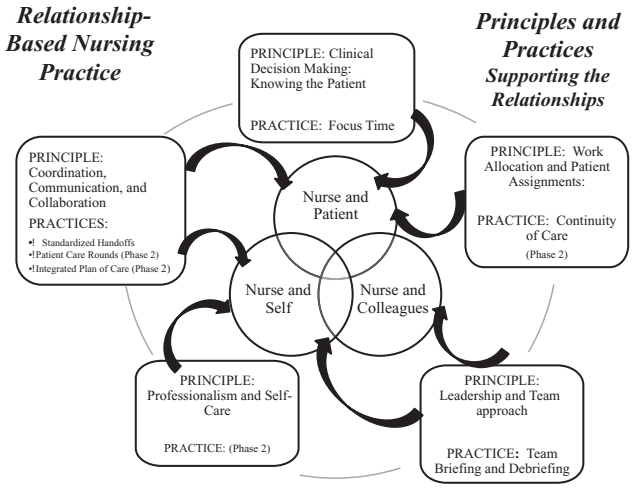

Figure 1. Relationship-based nursing practice: Principles and practices supporting the relationships. Used with permission from Lucile Packard Children's Hospital.

input to the creation of RBNP. The 7 practices that operationalize the guiding principles are described below.

Team briefing and debriefing

Principles taken from Crew Resource Management briefing and debriefing and adapted for the care delivery model include punctuality, which sets a tone of professionalism and respect, using a briefing checklist, introducing members of the team, and identifying potential patient care issues.[17] The team briefing begins immediately at the start of each shift with the off-going charge nurse *briefing* the oncoming unit staff about what to expect for the coming shift. A briefing checklist is used, and in the maternity units, this checklist includes such information as most critical or unstable patients, for example, those on magnesium infusions or on isolation, expected admissions and discharges, and which nurse may have the heaviest assignment (see Figure 2).

The charge nurse includes the shift staffing status, and whether additional staff will be coming in to assist with discharges or with patients in antepartum. When the off-going charge nurse describes what to expect, the oncoming nurses gain a shared mental model of the shift ahead. The oncoming nurses become aware of possible adjustments that may be needed, where strengths and challenges may lie among the team and patients, who may need help, and who is available to help.

Debriefing occurs within the final 2 hours of each shift. The aim is to give nurses the opportunity to be heard and supported about operational and interpersonal issues, thus enhancing the nurse relationship with

Maternity Units

Date:	
Unit:	

Start Time: / Stop Time:

TOPIC	NOTES AM	NOTES PM
Staffing *(Unit appropriately staffed? RNs, NAs, USAs?)*		
# of patients on the units? F1/F2		
# of expected discharges? F1/F2		
# of possible discharges? F1/F2		
Sickest patients on the unit? (*e.g., high acuity, MgSO4, 1:2 ratio, isolation)*		
Fetal Demise /Condition of baby		
Any procedures expected? (*e.g., CT, MRI, US, PICC, Tubal, Circ, L&D events)*		
Any patients with confidentiality status? (*e.g., Visitor / phonecall restrictions / social issues?*		
Which RN has heaviest load?		
Stork Award recipient / Orientees / New Grads / Nursing students working this shift?		
New Protocols / Updates / Policies *(if applicable, refer colleague to policy or e-mail)*		
Systems upgrade/downtime, Meetings / Celebrations		
Briefing given by:		

Figure 2. Team briefing checklist. Used with permission from F1/F2 units, Lucile Packard Children's Hospital.

colleagues, as well as enabling near real-time reporting of patient-safety issues. Either in a group or individually, the charge nurse, assistant nurse manager, or manager elicits input from each nurse. In maternity units, the debriefing can include issues related to management of critical incidences, such as postpartum hemorrhage, difficulties with other departments, or other problems within the unit. The issues are logged on a debriefing checklist and addressed by the management team (see Figure 3).

Management then communicates the issues, actions taken, and follow-up status back to staff either in staff meetings or by posting the issues and follow-up. Debriefing promotes a more transparent culture of error reporting, as nurses are encouraged and supported to share their experiences and to provide input during debriefing sessions on every shift.

Standardized RN handoff

There were several compelling reasons to include a standardized RN handoff process in this care delivery model implementation. Nurse-to-nurse, change-of-shift reporting was based on a written report worksheet;

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Maternity Units
Debriefing Checklist
(Occurs 16:30 and 04:30 daily)

Start Time:_____/ Stop Time:_____/Date:_____

Lead By:

What worked well during the shift?
Who would you like to appreciate?
What needs changing for next time?
Patient Safety Concerns?
How did (pick one process from list) it go today?
Team briefing, Assignments, RN handoff, 5-min focus, Rounding, Team debriefing,

Figure 3. Maternity units debriefing checklist. Used with permission from F1/F2 units, Lucile Packard Children's Hospital.

however, the EMR was the source of truth for real-time, accurate information and was not being reviewed. With no visualization of patients at change of shift, there were sometimes discrepancies between the information given in reports and actual patient conditions. Critical information was left to hand-written notes or memory.

The design team wanted the RN handoff to support relationship-based nursing by enabling nurses to hand off not only patient information but the relationship as well. On the basis of the literature review, the new standardized RN handoff process included SBAR format. The team developed an electronic documentation form designed to capture the details unique to each patient. These details included an assessment summary statement; ongoing medical, psychosocial, and cultural concerns; recommendations such as patient/family preferences and interdisciplinary recommendations; priorities for the next shift and day; and goals for discharge. This information then flowed to a new RN handoff tab in the EMR, customized for the unique clinical information needs of each unit or region. For example, in the mother's EMR, current weight, gravidity/parity, reason for cesarean delivery, resulted laboratory values, attending physician and contact numbers, anticipated discharge date, and last charted values for fundal height, fundal tone, position, lochia color and amount, and estimated blood loss were pulled from other documentation to the RN handoff tab. The infant's RN handoff tab included Apgar scores, current weight, birth weight, lactation consult status, last stool and void, and last feeding. A standardized process for reviewing the EMR in SBAR format was designed to reduce memory-based handoff communication. The situation and background are reviewed from the patient summary tab, which includes presenting diagnosis, history of present illness, significant hospital events, and physiologic data in summary format. Additional background and current situation information along with assessment and recommendations are discussed using the RN handoff tab. Review of current orders, the medication administration tab, and the care plan ensured that all current relevant information was reviewed and validated. The face-to-face process provides the opportunity to ask and respond to questions. The nurses completed a joint visualization at the bedside, a timely assessment during shift change,[34] which includes review of therapies, infusions, catheters, tubes, drains, and any pertinent assessments, such as wounds and other relevant physical characteristics of the patient. To inform the patient and family of the change of care provider, the off-going nurse introduces the oncoming nurse,[35] explains what will happen over the subsequent few hours, and instructs to ask whether the patient has any concerns.[34] With couplet care, an abbreviated handoff process and checklist are used for handing off relevant information about the infant, for example, pertinent laboratory test results and breastfeeding status. Both mother and infant are included in the bedside joint visualization.

Focus time

Focus time is the intentional, uninterrupted communication intervention between the nurse and the patient or family on each shift. The aim of focus time is to assist the patient and nurse in establishing and maintaining a therapeutic relationship. It enables the nurse to learn what the patient or family is most concerned about and to identify support needs, which can facilitate patient participation in care planning. When nurses are being educated about focus time, a common sentiment is that nurses already do this task, so there is no need to relearn it. Although nurses do spend time talking with patients and families, it is often done while they are multitasking, with the nurse standing and looking down at the patient. The nurse is often interrupted or may focus discussions on what is most important for the nurse to accomplish. The practice of focus time is intended to convey that nothing else matters at that time but the patient.

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Continuity of care

Continuity of care can contribute to the enhancement of clinical outcomes through a better understanding of the clinical response over time and can lead to more effective clinical decision making.[36] In designing this practice, the team emphasized the prioritization of assignment making in which continuity of assignments was the first priority when acuity and skill levels were not a consideration. In addition, the practice of continuity of care is translated into continuity of information, so any nurse can become familiar with the patient's clinical and psychosocial picture. From shift to shift, during break coverage and rapid changes in assignments, continuity of information is maintained on the RN handoff tab in the EMR. Further work in phase II of the project will address staffing and scheduling to promote continuity.

Role of the RN in rounds

Nurses must overcome many systemwide barriers to be able to consistently attend rounds. A multiple-patient assignment often means multiple sets of rounds. In the university-affiliated medical center, teaching rounds, subspecialty rounds, and interdisciplinary rounds, among others, each occurring at different times and/or overlapping, pose a major challenge to the bedside nurse. The initial goal in this care delivery model is for each nurse to attend rounds on a minimum of 1 patient of his or her assignment. The aim is for physicians and nurses to experience better communication and coordination of care, thus supporting the changes required to standardize rounds scheduling and roles. As a part of phase II of the project, the medical center is collaborating with its physician teams to schedule and structure rounds that will enable the active participation of the bedside nurse in shared decision making about the plan of care for the patient.

Coordination of the plan of care

To operationalize a truly interdisciplinary patient plan of care, where the goals for the patient from the medical team, ancillary services, and nursing are in 1 location, the team is redesigning the care planning functionality of its EMR, as a part of phase II. In the meantime, the care delivery model is the vehicle for defining the role and responsibilities of the RN as the coordinator of care. The nurse learns what is most important in the care of the patient from focus time and communicates that in a standardized handoff to other nurses. By participating in rounds, the nurse takes information to and from the healthcare team. Focus time, handoffs, and participating in rounds provide the nurse with necessary tools and information to manage the patient's plan of care.

Implementation

The care delivery model was implemented in 1 unit or care area at a time in a wave approach.[31] This method allowed each care area to further customize the practices to apply to the patient care context, while meeting the intent of the guiding principles. With each wave, the project team and nursing leadership learned to develop best practices that were shared with the next unit or care area. The implementation plan for the care delivery model was structured around the change management model of Inspiration and Infrastructure, Education, and Evidence.[37] Inspiration involves creating a shared vision of the future of nursing among stakeholders. Infrastructure means designing the processes, tools, roles, and responsibilities to support the change. Education is required to convey the rationale and specific details of new procedures, processes, roles, and responsibilities. Evidence is defining the metrics and targets to evaluate how the change is leading to the original vision. The Leadership Launch, a day-long work session, was designed to inspire the informal nurse leaders and management team to champion the change on the units. The leadership team included the shared governance unit council members, charge nurses, unit clinical nurse specialist, and managers. The team became immersed in the guiding principles and practices of RBNP. The infrastructure of the care delivery model was defined as the processes, roles and responsibilities, and tools needed to implement the practices, as well as a communication plan. The unit leadership team customized the practices to the unique complexities and patient-care context.

Education about the change began with the leadership team's communication plan and formal training for each nurse prior to the start date. The 4-hour training session curriculum design included instructor-led content on the vision, guiding principles, and 7 practices; staff nurse videos to show suboptimal and optimal handoff and focus-time processes; hands-on computer training for the handoff; and focused discussion on likes, concerns, and possible issues and barriers to success. Summary evaluation of the training enabled improvements with each session. During the preparation preceding the start date, the unit leadership met to track communication and resolution of issues and barriers identified by the nurses during the training sessions. Modeling robust relationships with coworkers and colleagues by the leadership team began with the leadership launch and continued through the preparation, training, and implementation of RBNP. The evidence illustrating that the practices were leading to improvements in patient satisfaction, nursing satisfaction, and patient safety were defined as metrics and

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targets, which were built into the process for daily monitoring of the practices.

Implementation began in 2009, and by 2010, RBNP was successfully implemented in the pediatric medical/surgical units. In the fall of 2010, RBNP was implemented in the maternity unit.

RELATIONSHIP-BASED NURSING PRACTICE IN MATERNITY

The maternity unit is a 52-bed, combined postpartum and antepartum unit. There are 12 dedicated antepartum beds for high-risk patients with diagnoses ranging from diabetes, pregnancy-induced hypertension, premature labor, and various types of adherent placentas. In 2010, there were 4582 births, of which 16 were triplets and 226 were twins. The average cesarean delivery rate was 32% and the average length of stay was 3.2 days. In 2010, the ethnic makeup of the patient population was 41% Hispanic, 32.1% white, 21% Asian, 3% African American, and 2.9% Pacific Islander. It is not uncommon to see patients with comorbidities such as human immunodeficiency virus, various cancers, asthma, thrombophilia, and sickle cell disease. The maternity unit receives transports from other counties determined by neonatal or maternal morbidities. Couplet care is practiced at the bedside, with a nurse-to-patient ratio of 1:3 couplets for the first 4 hours of a 12-hour shift (days or nights). The smaller ratio allows for better discharge preparation and more time at the bedside at the beginning of each shift. The nurse-to-patient ratio is increased at 11 AM and 11 PM to 1:4 couplets. With higher-acuity patients, such as those recovering from postpartum hemorrhage, a 1:1 or 1:2 ratio is used. Clinical outcomes from the implementation of RBNP included those related to patient satisfaction, nursing perception, and patient safety.

OUTCOMES IN MATERNITY

After implementation of the model, performance outcomes were measured to monitor the level of compliance of nurses performing the practices. This step is critical in determining whether the changes to care delivery can produce improved patient care outcomes. The targets for team briefing were for it to occur on time, at every shift, for no more than 5 minutes and be attended by all oncoming staff. The team-briefing checklist included start/stop times and attendance tracking and was used to monitor the targets. The target for the RN handoff process was that all nurses would be able to demonstrate the process with a score of at least 90% of the steps, using a standardized audit tool. Registered nurse handoffs were observed and monitored by the nurse manager, assistant nurse managers, and the clinical nurse specialist. The target for focus time was that all patients would receive focus time at each shift. Focus time performance was tracked by the charge nurses and was based on self-report by the bedside nurses. The target for debriefing was also 2-fold: It should occur within the final 2 hours of every shift and include all nurses on shift. The person conducting the debriefing documented issues and compliments using the debriefing checklist. Compliance with the 4 practices met targets of 80% to 90% during the first 2 weeks. Daily monitoring was adjusted to 3 to 4 times per week on varying shifts. Any reduction in compliance targets resulted in a period of increased monitoring, one-on-one coaching, and reinforcement through email communications and staff meetings.

SATISFACTION AND PATIENT SAFETY OUTCOMES

The project team surmised that RBNP would improve patient satisfaction with nursing care through enhanced nurse-patient relationships. The organization mailed the Press Ganey Family Satisfaction Survey[38] to patients' homes 10 days after discharge to evaluate patient satisfaction. Survey results were used to evaluate the impact of RBNP on indicators related to nurse-patient relationships. The indicators selected were as follows: addressed emotional needs, kept the patient informed, and treated the patient with respect. At about 7 months postimplementation, the patient satisfaction scores of the 3 indicators during that time period (October 2010 to May 2011) were compared with scores from the same time period a year before (October 2009 to May 2010). The mean score is the average of all responses to a specific question based on a Likert scale, in which a score

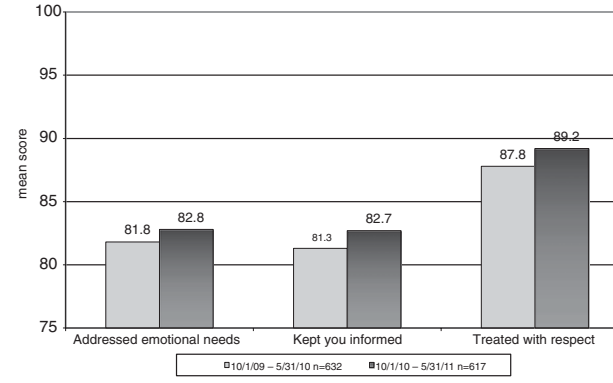

Figure 4. Obstetrics unit at Lucile Packard Children's Hospital at Stanford Inpatient Survey: Press Ganey Associates, Inc. Used with permission from Lucile Packard Children's Hospital.

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of 0 indicates Very Poor and a score of 100 indicates Very Good (see Figure 4).

Although the improvements are small, a trend is in the positive direction. Patient satisfaction scores significantly improved among Spanish-speaking patients during a 3-month trial of dedicated interpreter support for focus time (see Figure 5).

The comments sections of the Press Ganey Surveys have indicated positive response to RBNP. For example, patients have mentioned the bedside handoff as one of the highlights of their maternity experience, contrary to nurses' belief that going into patient rooms during the early hours of the morning or late hours at night may interrupt patients' sleep.

To learn nurses' perspectives on how the practices influenced nursing care, the RBNP Nursing Impact Survey was developed and then administered 6 months after implementation with a 59% response rate. Approximately 73% of respondents replied that team briefings provided valuable information that helped nurses understand the unit and who they could assist. Teamwork improved because of team briefing according to 69% of the respondents.

The new handoff process was challenging for maternity nurses to adopt. The process required 3 "Plan, Do, Study, Act" cycles[39] to improve the flow of information from the EMR. The standardized handoff process was initially designed for use in pediatric acute care units. The process had to be customized and streamlined so that using it for an assignment of 4 mothers and 4 infants was achievable within the 25-minute change-of-shift timeframe. Prior to the start of RBNP in maternity, a baseline survey found that only 29% of nurses in maternity reviewed the EMR during the handoff. Through the RBNP Nursing Impact Survey, 96% of nurses responded that they used the standardized RN handoff process, including review of the EMR. Not only was there a new process to learn but many nurses also had to learn how to access information in the EMR in a concise and efficient manner. Because of the new RN handoff process, 79% of nurses reported feeling better prepared to assume responsibility for the patient's care. Although no preimplementation patient-safety data related to RN handoffs were available, perceived improvements in patient safety because of the handoff process were striking: 68% of nurses reported that omissions, errors, duplications, or near misses were identified during the handoff process. Nurses described 30 patient safety–related issues, nearly 50% of which were medication-related, including documentation errors and verification issues. Catching missed laboratory orders in the EMR resulted in early interventions and aborted care failures (see Figure 6).

Focus time seemed simple to nurses at the outset, but in practice proved to be challenging. Focus time challenges many nurses because it requires them to move away from their standard checklist and reflect on what the patient is saying and not saying. The use of Spanish interpreters enabled nurses and Spanish-speaking patients to talk about personal issues, uncovering a case of potential domestic abuse in 1 situation. According to the Nursing Impact Survey, 81% of nurses agreed that focus time helped them learn things to better address patient needs and influence care. Debriefing was most effective when nurses were asked for input individually by the charge nurses or management team within the final 2 hours of each shift. Approximately 72% of nurses reported that they gave important information about what gets in the way of patient care. Through the debriefing process, nonurgent issues were batched all at once during the shift. The management team experienced fewer interruptions and was able to address reported issues in a timelier manner.

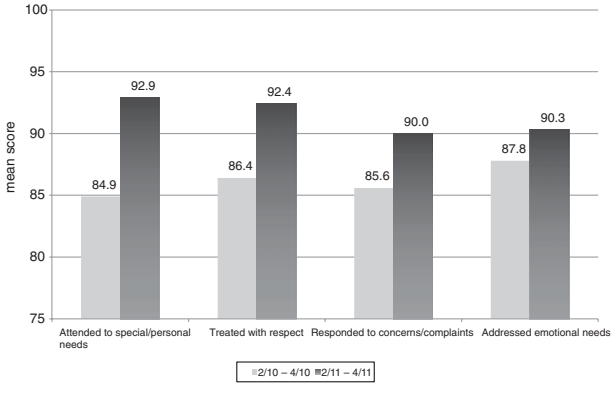

Figure 5. Obstetrics unit at Lucile Packard Children's Hospital at Stanford Monolingual Spanish-Speaking Patients Inpatient Survey: Press Ganey Associates, Inc. Used with permission from Lucile Packard Children's Hospital.

CHALLENGES AND FUTURE WORK

Changing long-held practices and behaviors in a healthcare environment can be daunting. The wave approach to implementation enabled improvements in the implementation process with each new unit. The initial scope of the project included all 7 practices. This proved to be too much to monitor and manage for both the nurses and the management teams. The implementation process was scaled down to include the first 4 practices instead of all 7. Metrics and targets were standardized for the project so that outcomes data could be compared across the organization. Some experienced nurses seemed to have greater difficulty embracing the standardized RN handoff and focus time. A common expression was, "We already do this!" Reinforcing the

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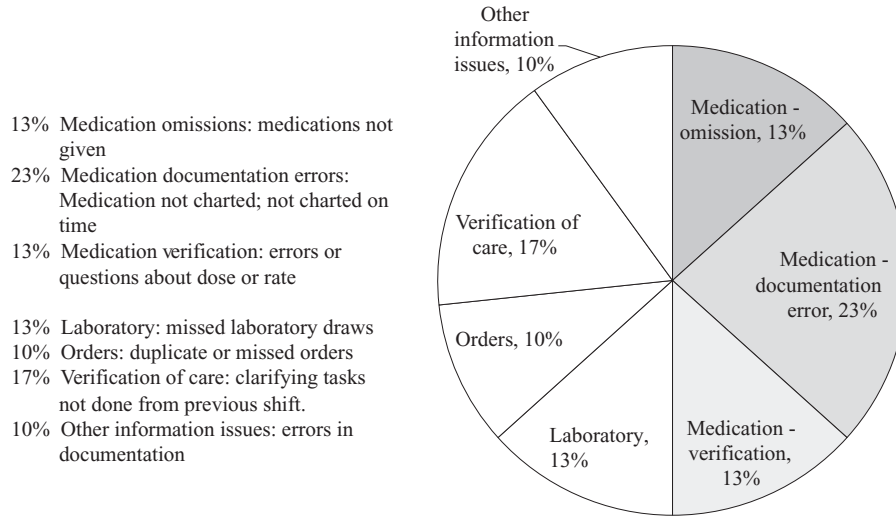

Figure 6. Patient-safety issues reported with RN handoff ($N = 30$). Used with permission from Lucile Packard Children's Hospital.

concept of standardization to improve patient safety and enhance nurse-patient relationships was key. Unit management encouraged nurses to give recommendations during debriefing. Relaying positive patient and family comments about focus time and introductions at handoffs was also effective in reinforcing the value of the changes.

A significant challenge of implementing RBNP in the maternity units was monitoring the performance metrics and meeting the target goals. Multiple competing priorities reduced capacity for monitoring, coaching, and performance counseling. A project steering committee was formed to provide oversight and governance at the executive level. The management team met periodically with the project steering committee to give a status report of the targets and discuss issues and barriers to successful sustainability. This process promoted accountability and provided executive-level support for the change process at the unit level. As of September 2011, the organization is transitioning to a model of continuous performance improvement.[40] By shifting the focus of RBNP from a project with a start and end date to being part of a daily management system, monitoring of nurse performance will be made a part of daily operations.

Nurses and nursing management continue the organization's transitioning work with evaluation of the care delivery model practices through Plan, Do, Study, Act cycles. Phase II implementation will include standardizing the RN role in rounds, building a technology-supported integrated plan of care to optimize care coordination functions, and improving the organization's capacity for continuity of care through optimizing scheduling models. Finally, the future work in phase II implementation will focus on relationship with self, addressing self-advocacy, personal/professional development, and a holistic approach to work-life balance.

SUMMARY

To successfully implement a transition from a culture of tasks, silos, and production pressures to a culture with the nurse-patient relationship as the cornerstone, nurses need leadership support and attention on an ongoing basis. The implementation of RBNP has driven a change in how nurses in the maternity unit work together, communicate with patients and families, and call out patient-safety concerns. These changes are the beginning of the vision for healthcare described by the Lucian Leape Institute.[2] Focusing on the relationship between the nurse and the patient places the patient's needs first. Building teamwork and improved communication between nurses and leadership is fostering transparency and respect. Joy and meaning in work come from being able to spend time listening and learning about what matters most to patients, and then being able to act on what is learned. While cultural transformation takes years, a care delivery model provides the common purpose, language, and infrastructure to drive the transition forward.

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