Objectives:

1. Outline 3 initiatives to implement and sustain RBC as a professional practice model using leaders from middle management as facilitators and change agents

2. Identify 2 outcome measures that impacted patients, nursing staff or physicians

Summary:

In the summer of 2007, a task force was formed to select a nursing professional practice model for our hospital as we were on the Magnet journey. We had a graduate student (MSN) who wanted to work on selecting a “model” as her project. In May 2008, 3 models were presented as possibilities to the CNO, Patient Care Services leadership team and the Nursing Practice Council (housewide shared governance committee). All 3 chose RBC as the model. Our hospital had many different initiatives that were being undertaken at this time – Service Excellence, Studer Group strategies (hourly rounding, leader rounding). The RBC model could be incorporated into the organization in sync with these other strategies. During the past 5 years, Creative Health Care Management (CHCM) has assisted us in implementing RBC among Patient Care Services departments in 3 waves. RBC was implemented with senior leadership’s approval, but the driving force leading this effort was a Manager and a Director.

VISION:

Our vision was to enculturate the question, “What is best for the patient and family?” into the organization. By focusing on what is best for the patient and family and including our relationships with them, our colleagues and self, we could improve the patient’s experience as evidenced by an increase in patient satisfaction scores. This initiative would also have a positive impact on the physician, nursing and employee satisfaction results, specifically relationships with one another. This would be accomplished over a 4 year period by engaging staff in the implementation process utilized by CHCM.

INSPIRATION:

Over a period of 6 months, we had several educational sessions on what a professional practice model entails and then gave a brief overview of the RBC model. The real inspiration came when we had an evening dinner event offsite for the first wave units and a couple units from the second wave. After a presentation of the model, the attendees were divided into 8 groups. Utilizing appreciative inquiry
questions, each group was assigned a dimension of RBC or “Caring for your co-worker.” Each group wrote on a flip chart, strategies/activities the unit or organization had already embraced that demonstrated the dimensions of RBC. As the nurses wrote their ideas down and then each group presented, you could see their enthusiasm increase. Doing this activity helped them understand the model in practice and set the stage for developing more strategies to improve the patient and family experience and help their colleagues as the groups went through a formal implementation of RBC on their unit(s).

INFRASTRUCTURE:

In 2008, after the RBC model was chosen, the 2 leaders (Manager and Director) attended the RBC Leader Practicum offered through CHCM. The 2 leaders attended the program with the idea that they would come back and implement RBC. It was evident during this practicum that we needed to engage Human Resources to assist us in this initiative. There were 2 leaders from HR that had experience in leading initiatives and leading change. Both willingly agreed and in the Spring of 2009, 12 more staff, including the leaders from HR, leaders from Wave I units and 2 staff nurses attended the Leader Practicum. Initially, we felt that there were leaders and educators at our hospital that could facilitate the Waves and started down the pathway of engaging several as facilitators. After 2 Waves, we felt that we could not be as effective in facilitating as the CHCM consultant was – she truly helped all the departments get on track. As each unit began the implementation process, those of us that had been engaged to assist in facilitating became a “coach” throughout their process.

Besides the education at the department level, we tried to incorporate RBC into many other activities. Our Clinical Ladder program was revised to model RBC, the relationships and dimensions. When staff apply, they answer questions or give examples based on all of the dimensions. We have a quarterly Nursing Newsletter and an annual report. RBC is the basis for this – for example, we may showcase “Outcomes, Leadership, Teamwork, Professional Practice,” etc. We have a shared governance council entitled “Nursing Assembly” which is composed of the chairs of each housewide council (3), leaders and at-large staff nurses. We start each of these meetings asking for examples of what staff have seen recently that exemplifies RBC. One of the other shared governance councils (Advanced Practice Nurses) follows the RBC dimensions and relationships as the agenda for their meetings. Human Resources briefly talks about RBC when orienting all employees to the hospital.

EDUCATION/TIMELINE:

1. Between the summer of 2007 and 2008 – offered multiple educational programs to staff on “What is a nursing professional practice mode?” At that time, a simple overview of RBC was given.
2. September 2008 – article in “Medical Staff Rounds” discussing RBC and the impact on patients and physicians
3. October 2008 - RBC leader practicum for 2 leaders
4. Spring 2009 – 12 more staff (including 2 staff nurses) attend the RBC Leader Practicum
5. May 2009 – Lynda Olender-Russo from CHCM spoke during Nurses Week
6. September 2009 – RBC presentation to the Patient Satisfaction leaders – to engage their commitment as part of improving the patient experience
7. November 2009 – RBC presentation at Leadership Forum; this initiative also pulled together the other initiatives in the organization including First Impressions/Lasting Impressions, Great Explanations, One Team Seamless Service and ICARE values. This also tied the pillars of our organization of Strategy, Quality, Satisfaction, Strategic Initiatives and Financial Stability and Growth together with RBC. Leaders discussed RBC at their department meetings in November and December 2009.
8. December 2009 – CHCM led forums with departments to identify strengths and examples of RBC already in place and articulate new or additional opportunities for transforming practices and processes.

9. February 2010 – High Awareness Days with CHCM (Jayne Felgen) for the entire organization

10. March – May 2010 – bus clings, employee garage posters, physician plasma screen, staff elevator slide – encouraged development of “elevator” speech for what RBC is

11. 12/09/09 – 6/24/10 – WAVE I units implement RBC with CHCM as consultant (4 units) – Units involved physicians

12. 6/24/10- 1/14/11 WAVE II units implement RBC (5 units)

13. During Nurses Week, posters were displayed from the units who had formally implemented RBC showcasing their initiatives and outcomes

14. 6/15/12 – 12/6/12 – WAVE III units implement RBC (8 units)

15. May 30, 2013 – there will be an RBC Post Implementation Check-in for all departments to showcase their strategies and outcomes related to RBC

**EVIDENCE:**

1. Patients: Patient satisfaction survey (PRC) – Patients’ Perception of “Overall Quality of Care” - Nursing Inpatient Percentile Ranking increased from 82.7%ile in 2009 to 96.5%ile in 2013

2. Physicians: Physician satisfaction scores – “Overall Quality of Nursing Care” Percentile Ranking increased from the 91.2 %ile in 2008 to the 98.6 %ile in 2012

3. Nurses – NDNQI survey – Job Enjoyment scale (T score) increased from 61.59 in 2009 to 65.46 in 2012 (60=high satisfaction)