Improving Professional Practice, Patient & Physician Satisfaction, Through the Relationship & Results Oriented Healthcare™ Certification Program

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"*Where the spirit does not work with the hand there is no art.* " Leonardo DaVinci

Current Status: Disengaged Healthcare Workers and Leaders

Humans who feel called to be healers are often disappointed when they enter today's healthcare workforce. The potential joy of serving as a soothing presence with a suffering patient, of making a difference, can be diminished because of healthcare systems that unwittingly do the wrong things for the right reasons. Ineffective communications create barriers to people helping people. Initiatives pile upon platitudes and pleas of "Can't we all just get along?" band-aid broken organizational supports. Those who entered helping professions to make a difference eventually lose hope that they can function on a winning team. Frustrated leaders work faster for longer hours in an attempt to make things work better under enormous odds and complexity, rarely certain that they are doing the right tasks to create a better future, wondering how work became so hard and unrewarding. Blame is often placed at the feet of the government, regulations, reimbursements, management or labor. Spirits are crushed and healers lose their capacity to heal.

Yet in some bright organizations, there is a sense of hope, of a growing capability to provide solace to the suffering, while celebrating and generating health for their communities. Departments collaborate in cross-disciplinary projects; respect for each other's roles offers individuals the freedom to be authentic and relate to patients and each other as people. A sense of abundance creates the ability to welcome new ideas & additional services. Care systems support all roles as care is delivered with team synergy. There is a waiting list for new hires in the personnel office.

Most healthcare organizations exist between these two polar opposites. Where is your organization on the continuum from offering your communities assistance toward vibrant health or barely mitigating disease? Which direction are you traveling? What makes the difference?

After pondering the key elements of success a hundred times while working with 160 hospitals over 19 years of consulting and extensive work with nursing care delivery systems, some answers have become clear. Distilling our concentration on nursing and what actually happens at the bedside with patients and families and the care delivery team, it became apparent that many leaders and nursing staff seem to have little knowledge of whether or not basic practice essentials are routinely occurring (Hansten, 2005). Nursing scientists have correlated insufficient professional nursing practice skills and resulting sentinel events, errors, and rapid turnover of personnel, but at the operational level, few are certain how to proceed to mend the gaps.

Many dream about reenergizing staff toward recognizing their own personal purposes and celebrating the effect of their efforts on the lives of those they serve, but have not been successful in their previous attempts at change. Educators and managers are often too busy with overwhelming, never-ending, fire-stomping tasks to take stock of the building blocks of practice that support and prepare patients and their families to safely navigate the healthcare system.

Closing the Gap through Applied Education

The Relationship & Results Oriented Healthcare™ program is a unifying philosophy and a bundle of best practices at the bedside that allows an organization to grow to be "brilliant at the basics" thereby able to become world class (Dow & Cook, 1996). Key missing professional practice skills are learned and applied and gaps are closed so that the foundations of nursing practice become routine. Where these practices are not a part of the daily work life, the quality results that we desire as healthcare professionals, and our patients and families expect and deserve, are difficult to maintain.

In the RROHC™ Certification Program expert practice has been analyzed, detailed, and made clear and concise, so that novices can learn and the jaded can be invigorated. Through research, experience, and trial and error, a three-level certification program in professional practice has been designed and tested. The RROHC program combines the principles of critical thinking, emotional intelligence, delegation and supervision, innovative learning strategies, coaching practice, and the science of teamwork. Application of this bundle of 10 best practices has resulted in improved patient and staff and physician satisfaction, improved recruitment and retention, and better clinical outcomes in the areas of falls, errors, and restraint use.

Marion General Hospital, Marion Ohio, grew their patient/family satisfaction from 18% to the top in the nation from 2001 to 2006, and improved the "excellent" nursing care rating by physicians from 12% to 82% (See Fig. 1 and 2).

Figure 1. Marion General: Physician Satisfaction

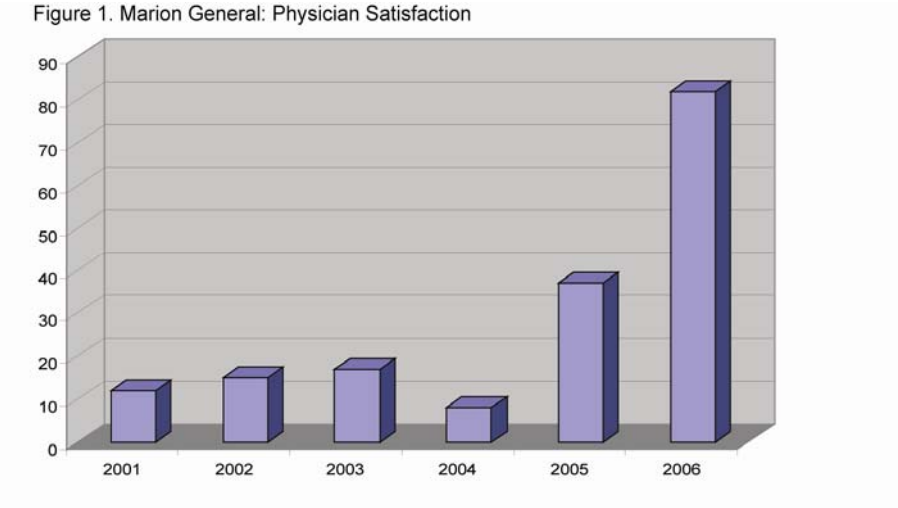
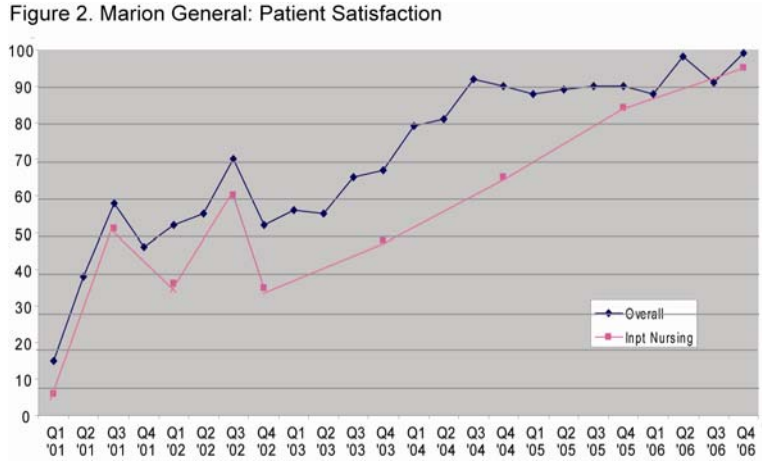


Figure 2. Marion General: Patient Satisfaction

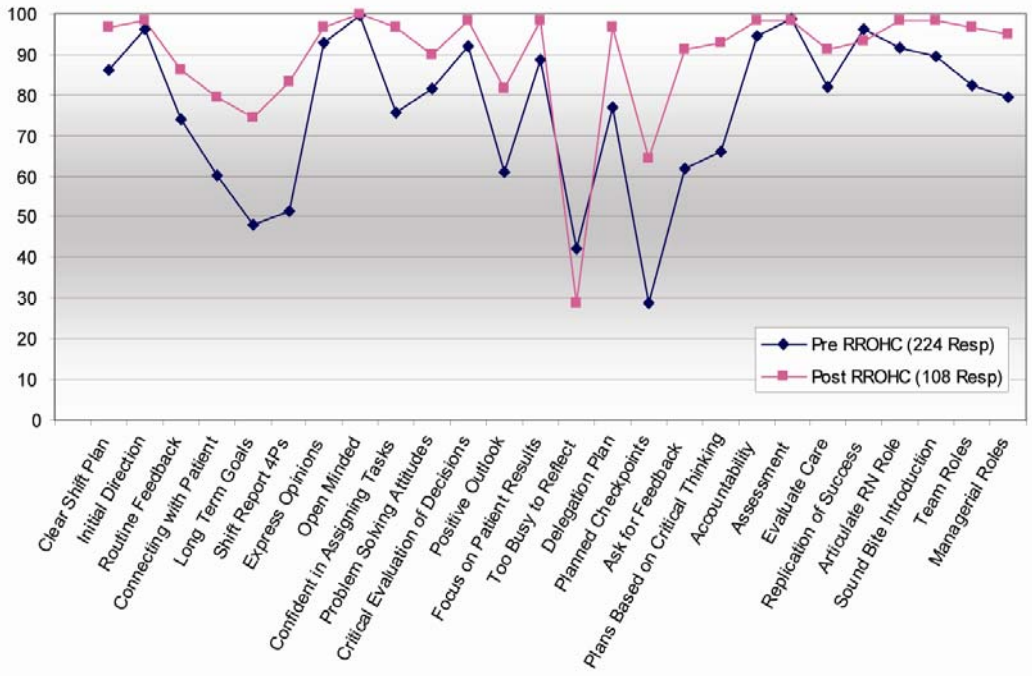


Harrison Medical Center, with two sites in Bremerton and Silverdale, Washington, in the summer of 2006 after a year of RROHC implementation, was considered by Gallup to be a "best practice mission driven organization" and have exceeded their goals for engagement levels of employees. This Gallup improvement parallels their improvements in Press Ganey patient satisfaction results as they have implemented the certification program.

Another Pacific Northwest medical center, with several hospitals and multiple sites in the southern Puget Sound area of Washington improved their RN retention approximately 52% in 2002, and saved at least $360,000 in recruiting costs of clinical leaders through the coaching program (McNally & Lukens, 2006).

Figure 3 and Table 1 (page 10) shows the improvements in RN professional skill self-assessment. "Being too busy doing tasks to reflect on the results or impact I make in my job" dropped 13.4% after implementation of the Level 1 RROHC specialist program, showing a sense of purpose probably related to the 19.6% improvement in connection and presence with the patients and families. The educational concepts and the 3-level program that assisted these organizations in creating these positive outcomes helped create these organizational transformations.

Figure 3. Post RROHC™ Program Implementation Results



The Patient's 4-Ps: A Unifying Language

A unifying educational thread throughout the 3-level certification program is a conceptual framework for reflection and analysis: the 4-Ps (purpose, picture, plan, and part). Knowledge about human thinking and decision-making and education processes from antiquity to the present, combining such disciplines as philosophy, education, psychology, and neurobiology support the use of this idea (Hansten, 2001, Dissertation).

The importance of being clear about a vision (picture) for your life, having a purpose, and making decisions based on an integrated approach that made sense in terms of a life plan, first emerged with the Greek philosophers. Modern psychologists, philosophers, and self-help books also reveal that in order to emerge triumphant from trials and changes in our lives, we must consider our own personal purpose, a vision or a picture of success, possess a plan, and understand the part that we play as well as the roles of others that play significant roles in our lives (Covey 1994, Bridges, 1991, Klein & Izzo, 1999).

Current psychological research about those who have been successful in adapting and resilient in the face of extraordinary circumstances revealed that commitment to that personal purpose, understanding the significance of their actions, a reframing of change from victimhood to victory, and connection with other individuals and resources, makes a difference in adaptation (Britt, Adler, Bartone 2001). The RROHC program builds personal reflection about the professionals' 4-Ps and thus engagement in their work.

The practical aspects of the 4-Ps – purpose, picture, plan, and part – are basic to the bundle of best practices for any hospital in any community. Ask a housekeeper about how her job fits in with the hospital's strategic plan. Does she know the mission of the hospital? Would she consider it to be part of her job to hold an elderly, confused patient's hand? Walk to general medical surgical units. Ask a staff member to describe the purpose of this particular unit. Does he answer, "This unit is where they place patients when they can't figure out what to do with them. This is the dump unit. And that's what we get, garbage to work with." Or, does another staff member state "I am so proud to work on this unit! We are the most versatile of any of the healthcare professionals in the hospital. No matter what kind of patients and their diagnoses, we welcome them and their families to join us in a journey of healing. We are so proud of our teamwork, and all of the results that we achieve!" These conversations reveal whether or not the workers believe they are engaged in a significant use of their life force, and have a clear purpose, picture of success, a plan for each day and for the future, and understand the part that each person plays.

The idea of the 4-Ps is most helpful to organizing work in the patient situation. Let's consider a difficult, noncompliant patient: my father, who had a double total knee replacement. After surgery, he

was angry, confused, and became combative with the staff. While some of the discomfort was due to anesthesia and his age, much of the problem was the difference in the patient's 4-Ps and the staff's 4-Ps. The staff had a clear purpose in mind, with a critical pathway for total knees, and their picture of success was to get him ready to go home in 3.5 days of care. They did not expect him to remain at a zero pain level or to resist physical therapy. As is true of most individuals, unless healthcare providers discuss the plan openly, my father's "secret" 4-Ps and expectations were not met. He wanted to get rid of the pain in his knees (purpose) but his long-term picture of success was to be out golfing in Fargo within a month to six weeks. (It's a short golfing season in Fargo.) For the short-term, he thought he would have zero pain, and the plan he envisioned was one of himself in the hospital bed, unmoving, letting my mother care for him. Mismatched 4-Ps equaled an unhappy patient and frustrated staff.

Using another patient scenario with the 4-Ps as our guiding concept, consider the use of the 4-Ps as a shift report template. Mr. Jones' diagnosis is exacerbation of COPD and pneumonia. If we were to consider what the staff's 4-Ps may be:

"Purpose: Clear up the pneumonia for Mr. Jones and help him maintain his COPD at home.

Picture: In 2.5 days, place him in an appropriate care center or back at home.

Plan: Obtain culture and sensitivity for his sputum, deliver appropriate antibiotics and other medications, such as steroids, assess learning needs for discharge, and monitor his respiratory status.

Part: The admission nurse will obtain the culture and sensitivity, the nursing assistant will report oximetry results and vital signs every two hours on admission, the RN will do a full respiratory assessment and observe for changes in respiratory status."

If we ask Mr. Jones, "What results or goals do you have right now for the next shift and for this hospitalization?" at a bedside shift hand-off, in order to partner with him, we might hear the following:

"Purpose: I would like to be able to breathe better so that I can walk to the corner bingo parlor and make sure that I stay out of the nursing home. My priority right now is to be able to talk and to sleep. It's also really heavily on my mind that my cat needs to be fed in the morning.

Picture: I expect to be breathing really well, discharged by the end of the week, and to be able to get to bingo by Saturday. I have a big date."

When staff share **the plan** they have in mind, it will become clear from Mr. Jones' avoidance that his plan was to avoid the respiratory rehabilitation process that the staff has been forcing on him for the last two admissions, and **the part** he wants to play includes doing everything in his power to avoid being put into a nursing home. This discussion opens the opportunity for engaging the patient in that rehabilitation process so that he can achieve that compelling goal.

The patient's/family's 4-Ps is an organizing principle and concept for discussing care that allows the interdisciplinary team to focus on the patient and family's short-term and long-term outcomes and partner with him, using simplified, easily understood language. The 4-Ps can be used as a template for shift report, time-outs, team meetings, and other handoff information sharing (Hansten, 2003) and is synergistic with SBAR (Situation, Background, Appraisal, Recommend-ation) templates.

The Steps of the RROHC Process

A bundle of best practices, or the Relationship & Results Oriented Healthcare™ steps, are listed below.

The three elements of RROHC (pronounced "rock") principles include:

- the fundamental relationship of healthcare providers and the patient, partnering with the patient and family, so that their outcomes are known and shared;
- using critical thinking and problem solving to help patients/families achieve their preferred results, including a six step problem solving method (Hansten & Jackson, 2004);
- and, collaborating with the interdisciplinary team (including the nursing assistant, and physician, as well as other health care providers) so that the usual barriers dissolve and the team becomes trans-disciplinary.

An example of trans-disciplinary teamwork is when the nutritionist is sanctioned to comment on the patient's bowel status because the nurses are not the only ones who "own" the patient's bowels. These building blocks are the foundation of excellence in clinical results and patient safety.

In the education and certification program, each of the concepts and practices are taught in detail and applied with tools in order to coach, and evaluate the skill. The steps are aligned with 2008 National Patient Safety Goals, scientific evidence that support these practice, and provides a clear plan (JCAHO, 2006). A nurse would be able to visualize a day in the life of an expert RN, one who leads the bedside team effectively, coordinating care with other disciplines, and provides feedback to assistive personnel while using critical thinking to plan for the next shift. Although these steps seem simplistic, the foundation must be present for more complex processes to take place. These practices are easily applied to any department, including home health and outpatient clinics, and specific RROHC™ tools for various clinical areas have been developed to ease adaptation.

The Ten Steps

1) Make assignments for care providers based on the patient's 4-Ps and using critical thinking skills. This first step sets as a given that the right patients are being assigned to the most competent staff, based on actual knowledge of the patients' priorities and intended outcomes, and that assistive personnel are assigned with an RN rather than as independent practitioners.

2) Shift reports and handoffs have an outcomes focus. Short-term (shift) goals or outcomes and patient priorities and long-term plans (discharge or transfer), or the patient's 4Ps are identified through critical thinking and discussed in shift reports and hand-offs between departments (Hansten, 2003).

3) Think critically to make a plan for the day/shift/case and offer initial direction to team members. Use logical, creative, intuitive, and analytical mental processes in taking time to plan and offer initial direction as well as a plan for the day. Apply the critical thinking problem solving model to make a plan and in resolving patient care and team problems (Hansten, 2001, Dissertation).

4) Introductory rounds are essential for those in patient care. Introductions including name and role are vital for each person who interacts with the patient or family, to engender a sense of safety, control, and laying the groundwork for a healing connection and environment. Only 28% of patients were certain of the title of their care givers in a study of 100 patients (Lange & Polifroni, 2000).

5) Plan in partnership with the patient. RNs spend 3-5 minutes at the bedside early in the shift sitting down at eye level with each patient to discuss proposed shift outcomes and plan goals with the patient as a partnership. Each therapist or team member involved with patient uses therapeutic eye contact, body language, focused listening, to connect with the patient and/or family. This step is the most important for creating better patient and staff satisfaction and a cogent plan of care (Hansten & Washburn, 1999, 2001, Hansten, 2001 (Press Ganey).

6) Communicate the plan. Planned patient and/or family outcomes and any changes from the previous shift report are shared with the members of the healthcare team (allied health care professionals, members of the patient care team, physicians and other colleagues) so that all team members are following the same map. Short-term (shift) goals or outcomes and patient priorities and long-term plans (discharge or transfer) are identified through critical thinking and discussed in shift reports, "second report" to assistive personnel, interdisciplinary team planning rounds, in connecting procedures, tests, and therapies with the patient's purpose, and in conversations with the patient. The RN is the essential coordinator and communicator of this information and must set up checkpoints with assistive personnel early in the shift.

7) Use interdisciplinary rounds to evaluate progress. Each patient care team meets throughout the shift or patient "case" at specific agreed-upon times (i.e. interdisciplinary rounds) to evaluate outcomes and the progress of the plan, revising as necessary. An updated review of the 4-Ps: picture, purpose, part and plan for each patient occurs. This process can be adapted in each department to include measuring success for each patient. Many RROHC hospitals hold daily trans-disciplinary team rounds.

8) Establish updating and checkpoints for teamwork. Specific plans are made by the bedside care team, to meet briefly at checkpoints before and after breaks and meals to update the plan and for assistive personnel supervision (Hansten & Washburn, 1999, 2001, Hansten & Jackson, 2004 & Hansten, 2001).

9) Use the reciprocal feedback process for feedback to each individual member of the team and to celebrate patient results that the team contributed to helping achieve (Hansten & Jackson, 2004). The last checkpoint of the shift or case gives a moment for reflection and sharing "what could we do differently if we had the same assignment tomorrow? How can we work together more effectively?" The celebration of results allows staff to challenge thinking processes and make that vital linkage between outcomes and their efforts.

10) Use the critical thinking problem solving process to develop plans for next care episodes based on feedback and evaluation the 4-Ps for each patient. This thoughtful consideration will help prepare shift or transfer hand-offs for the next episode of care (Hansten & Jackson, 2004).

Best Practices

Many hospital unit and departments do not structure their work for success with assignments that reflect good delegation and supervision practices as recommended by the National Council of State Boards of Nursing (Hansten, 2008, ANA & NCSBN, 2006). If assistive

personnel are assigned to a group of patients, but not to an RN, then parallel, unsupervised practice is often a result.

Hospitals that use RROHC principles combine the first steps into care delivery models and save time and streamline their care. On a telemetry unit, Sue Schulz, one of the RROHC Facilitators and unit manager at Oakwood Health Services in Dearborn Michigan, states that each nurse has saved 15 minutes per shift report, or ½ hour back to the bedside per day per nurse, due to bedside reporting including the patient. After several months of implementation, nurses are able to harvest an additional 40 minutes per day because shift report now takes 10 minutes. Many units include the oncoming nursing assistant at the bedside while the two RNs discuss the past shift's events and the 4-Ps for the next shift, while the off-going nursing assistants answer lights and continue with vital signs and other tasks. The nursing assistant then understands the plan for each patient and has increased accountability as the patient/family understands what to expect, when. Patient engagement is realized as patients and families describe their outcomes, priorities, or needs for the day, encouraging those receiving the care to participate in their healing process. Many hospitals have designed dry erase boards for the patient's room, so that care giver's names can be transcribed and priorities are delineated.

Another Michigan hospital began implementing the interview at the bedside, caregiver rounds, and checkpoint discussions in late 2006 on some units and continued with more training in mid-2007. They tracked improvement in Press Ganey overall inpatient ratings at about 10 percentage points higher and reflect an increase in "likelihood to recommend" by 15 points within the first months of training. Mean scores gained to the mid-80s to 90% from lows in the mid 60%ile (Figure 4).

Overall ratings of inpatient care had been in the mid-40% range in early 2007, but have been maintaining at 80% or above subsequently (see Figure 4 below). "Staff addressing emotional needs," "attention to special/personal needs," "and "nurses keeping you informed" all gained significantly as 2007 progressed and would comprise the building blocks of improved patient satisfaction.

Three Skill Levels for Applied Practice

The three levels of certification begin with an interactive eight-hour Relationship & Results Oriented Healthcare™ Foundations workshop that has been granted 6.0 continuing education credits by the Washington State Nurses Association. The objectives of that workshop include the below concepts, including practice and exercises that introduce and apply the care delivery model.

- Discuss the three elements of RROHC™ philosophy.
- List the 4-Ps of RROHC practices.
- Discuss current research initiatives and field results that demonstrate the impact of RROHC philosophy and practices.
- Analyze current level of RROHC practice.
- Employ an individual development plan, using 4Ps framework.
- Describe the components of critical thinking.
- List the 5 rights of teamwork.
- Using a patient scenario, demonstrate the RROHC processes.
- Apply the critical thinking problem solving six-step method to an actual problem.

At the end of the workshop, participants in the Level 1 RROHC Specialist program are introduced to their portfolio and their textbooks, and are scheduled for conference calls. At the end of the 16-week program, the nurse executive is sent a document including the critical thinking problem solving projects that have been completed, as well as stories or exemplars of professional practice.

Figure 4. Michigan Hospital: Overall Rating of Care Given, Inpatient Percentile Ranking Trend

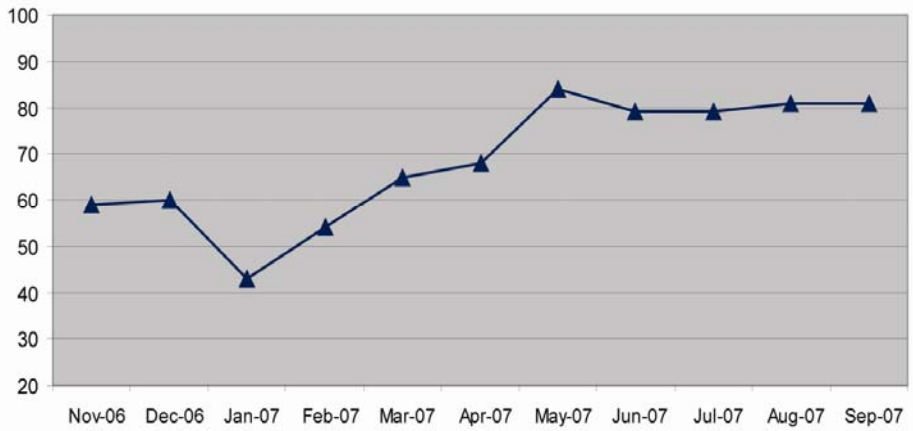


Table 2. Harrison Hospital: Press Ganey Results

Press Ganey Database	4/1-6/30/05	4/1-6/30/06	4/1-6/30/07	9/30/2007
Nurse	Rank	Rank	Rank	Rank
Friendliness/courtesy of the nurses	29	53	44	77
Nurses attitude toward requests	28	57	57	64
Nurses kept you informed	24	34	50	64
Tests/Treatments				
Explanations: happen during T & T	46	65	65	52
Personal				
Staff addressed emotional needs	29	59	45	55
Staff include decisions re: tmt.	46	58	55	45
Overall				
Staff worked together	52	64	78	75
Overall rating of care	48	74	62	74

This notebook is a compilation of practice development for Magnet Certification surveyors, Joint Commission or state reviewers, or for Nurses Week or other celebrations and can be transformed into marketing materials for the organization.

On the pediatric unit at Oakwood, Pat Sirwatis used her critical thinking project to solve the problem that the nursing assistants were not performing vital signs appropriately. She included the pediatrics nursing assistant in the solving this dilemma and she helped develop a pocket guide for float nursing assistants explaining the correct type and range of vital signs for each age group and how to measure them accurately. Not only did patient safety improve, but so did nursing assistant job satisfaction. Pat also has noted a marked increase in parent satisfaction since nurses began planning care at the bedside. Examples of other exciting professional practice projects at various organizations include development of a flow chart for shift report using the 4Ps, a specialty education process for new graduates, creative ideas for protecting patient privacy in double rooms, and clinical issues such as insulin administration and meal tray times.

The most rapid and effective results are achieved when the organization assigns a RROHC project coordinator. If a student lags behind or needs additional assistance, this individual can help facilitate the process. Faculty are available six days during a four-month period with a choice of four different times to join one-hour telephone coaching calls, in which the participants share their progress and answer questions. Specialist students also contact instructors by e-mail, and complete online surveys and tests as well as apply the principles on their specific units through a series of 25 worksheets.

Changes in professional practice skills related to the Level 1 specialist certification group are included in Table 1 (page 10) and in Figure 3 (page 3).

Table 3 shows on unit observation of select RROHC behaviors rather than self-assessment as shown in Figure 3, and corresponds with Harrison Medical Center's improvement in Press Ganey results (Table 2). As noted, overall care ratings have improved from 48% to 74%, and all other selected indicators have improved significantly except staff inclusion in decisions regarding treatment. Some of the variation has been correlated with managerial attention to measurement and coaching of RROHC behaviors as is discussed in Table 3. Departments in which leaders have educated staff thoroughly and expect RROHC skills to be the basic care delivery model have realized sustained positive results.

Table 3. Harrison Medical: RROHC Performance Indicators

RROHC	6-Jan	6-Apr	6-Dec
Staff introduce themselves at the begining of the day (shift), using their names and roles.	** 89% [9]	** 64% [6: 96%]	*** 93% [3]
RNs are supervising assistive personnel by giving initial direction, periodic follow-up and evaluation, and giving feedback regarding problems.	72.5% [9]	55% [6: 83%]	98% [3]
Team meetings and checkpoints are planned throughout the shift.	32.5% [9]	34% [6: 51.5%]	84% [3]
RNs sit at bedside of patients and partner with them to determine the projected goals or outcomes for the shift.	51% [9]	57.5% [6: 86%]	87% [3]
Staff are satisfied with the care they are giving this shift.	82% [9]	61% [6: 92%]	93% [3]

** # by adding % from each unit dividing by the # of units (9) = average of ALL nursing, but many of the units have a 0 or have not completed the indicators for that month.
[ ] = n, so with the 4/06 timeframe there were only 6 units of the 9 that responded in 1/06.
1SW and 2S, EDs, Optimum and Home Health are not included, either because I have never received any indicators from them or they did not exist or their questions are different and so collated separately.
*** n= 3, but notice that the % has risen in each of the 5 categories; when I review the entire Excel spreadsheet I see many 100%s.

During the Level 1 education process, poignant stories that reflect healing, professional growth, and improvement in delegation and supervisory

skills are shared along with problems that are solved using the critical thinking problem solving model. Based on participation in this program, at the specialist level, healthcare professionals will function as team leaders, charge nurses, unit practice council chairpersons, informal staff leaders, shift decision makers, and clinical educators.

Executives can expect the following skill growth:

- An understanding of the RROHC philosophy & practices for immediate application on the job
- Practical information on how to delegate, supervise & lead a clinical team
- Experience applying critical thinking & problem solving skills to clinical scenarios
- Methods to communicate effectively & resolve conflict
- Understanding about the coaching relationship.

At the specialist level, tools for measurement of RROHC behaviors in clinical areas such as home health, perioperative, emergency, and outpatient therapies have been developed to supplement the inpatient acute care grids.

Either concurrently or subsequent to Level 1 training, students exhibiting leadership in the organization may be chosen as a participant in the Level 2 RROHC Facilitator training. An intensive three-day session in a remote and beautiful location follows preparation by reading and online surveys and self-assessment. The retreat setting encourages team building within organizations and among professionals.

These facilitator candidates continue with monthly (or more frequent) conference calls, sharing their successes and failures with other leaders from across the country. Each facilitator must prepare an organizational case study, a book report, web log or blog entries at www.RROHC.com/blog, and participate in conference calls. The faculty offer organization-specific coaching, as well as individual or group coaching for all RROHC participants. Earning designation as an officially certified Relationship & Results Oriented Healthcare Facilitator requires a minimum of a year of participation. Senior facilitators often continue to attend conference calls and group coaching in order to share strategies from their own experience with others who are beginning the journey. The facilitator group often are educators in their own organizations, presenting workshops and on unit coaching. Additional tools for coaching, measurement, and development of a RROHC focused organization are offered in the Facilitator training.

In her own words, a facilitator made this blog entry after her first year as a facilitator:

"Well, almost a year later, (after having taught) many RROHC 8 hour classes under our belts, yearly educational days with the RROHC principles explained, meetings with the management that I never in a million years thought I would be doing…and my dinosaur tail (sense of confidence and competence) has definitely grown. Thank you! I look at my career and practice now, and I never imagined that I would be involved in what I am involved with now. I own my practice now! I am also very aware of helping others take ownership of their practice too. I am using RROHC principles in my practice without having to think twice about it…it has become part of my everyday routine, not something I have to work at doing. So once again, thank you for seeing the need to turn nursing back to the patients and giving us the tools to do so…. and a big thank you to my fellow facilitators all over the US."

Kim Ragsdale, RN, Harrison Medical Center

Facilitator skills and aptitudes acquired through program participation:

- Customize & conduct RROHC training using adult education principles
- Apply advanced content on interdisciplinary teamwork
- Increase emotional intelligence for self & others
- Anticipate obstacles & facilitate team members learning new behaviors
- Conduct basic coaching conversations with team members to accelerate learning RROHC
- Use tools for conducting department-based auditing & focused problem solving.

The Facilitator group's projects have included development of a new care delivery model for their organization, measurement of RROHC behaviors correlated with patient satisfaction, ROI (return on investment with dollars spent), and ER throughput. The William Beaumont Royal Oak Facilitator team has created cartoons for educating nurses in how to respond to patients or families in ICU settings or those who are not interested in discussing their own goals for care. Several projects have generated articles that have been accepted for publication. Professional development has been aided by use and adaptation of the RROHC Toolkit tools and sharing of information and ideas across organizations.

Those who achieve the Master Coach level are able to expertly lead and coach organizational change, students generally applying the RROHC principles over a two to three-year commitment from beginning the program. A 360 degree assessment is undertaken to prepare the coach candidate for new growth in emotional intelligence. In-depth training in coaching processes and application of Relationship & Results Oriented Healthcare principles occurs through a retreat and on going telephone coaching, and Master coaches continue to interact with the Level 1 and Level 2 participants to guide and mentor them.

Master Coach skills and aptitudes acquired through program participation:

- Diagnose organizational needs & orchestrate the change process to implement RROHC

- Coach in a variety of situations — for development & performance improvement
- Create a coaching culture
- Benchmark results & measure the rate of adoption
- Communicate progress to stakeholders.

RROHC Facilitator Intensive Retreat
7 Organizations Represented

Outcomes

As Whiteside noted in her work with the critical care unit, clinical judgment comes from first providing models, concepts, and ideas, followed by repeated experiential application in order to create the productive memory for critical thinking (Whiteside, 1997).

Experiential learning has shown us that it is impossible to expect nurses to practice at the highest level of professionalism without providing a method or model that makes sense and connects with their own personal purposes (Allen & Vitale, 2005).

Repeatedly, nurses have said to us "this RROHC program exemplifies why I became a nurse!" Others have stated that they now feel comfortable in organizing their newly efficient days according to patient and family priorities, rather than running from task to task, finishing the day with no sense of satisfaction. An eight hour class is insufficient to achieve optimal results, that of nurses re-organizing their practices and becoming more accountable and engaged workers. The Level 1 certification course work and portfolio preparation allows each nurse to grow professionally by applying sound clinical and leadership principles in depth. These "RROHC stars" become the unit or department experts and leaders in best patient care, and solve problems using a six step critical thinking problem solving model. Facilitators are often called on to act as magnet certification coordinators, quality improvement personnel, committee or practice council coordinators, and are developed as overall emerging leaders.

Leonardo DaVinci could have been speaking about nursing when he said that "Where the spirit does not work with the hand there is no art." The RROHC™ certification program provides fuel to the spirit by engaging nurses' personal purposes, and the canvas is provided by a template of 10 expert practice steps. The paints are applied by each practitioner in his own individual colors, but the art that we create together is the picture that the patient and family visualize. That's the art of nursing.

Acknowledgments

Dr. Hansten wishes to thank Kimberly McNally RN MN, McNally & Associates, for her participation in the ongoing development of the RROHC program as faculty and coach, and Marcie Thomas for her expertise in administering and supporting RROHC program growth. Ruth, Kimberly, and Marcie also wish to salute the efforts of all their partner organizations.

The results speak for themselves. Excellence in healthcare is possible. Granted it's hard work, but these kinds of results resound of vision, commitment, and persistence.

Table 1. Pre and post RROHC graph of behavior improvements

Information		Pre RROHC 224 Res	Post RROHC 108 Res	Change
Clear Shift Plan	At the beginning of the shift, I have a clear plan in mind for the shift in how I will work together with my coworkers.	86.20%	96.60%	10.40%
Initial Direction	I feel comfortable giving initial direction to team members.	96.30%	98.30%	2.00%
Routine Feedback	I routinely give feedback, both positive and negative, to those with whom I work.	73.90%	86.40%	12.50%
Connecting with Patient	Every shift, I find that I truly connect and am present with the patients that I care for. I feel that I "know" them and their most important priorities for that shift.	60.10%	79.70%	19.60%
Long-term Goals	I always know where my patient lived prior to admission and where we are planning to discharge after hospitalization.	48.20%	74.60%	26.40%
Shift Report 4Ps	My shift report includes the 4-Ps (purpose, picture, plan, and part) and clearly indicates why the patient is here, his priorities, and the plan for the next shift.	51.40%	83.10%	31.70%
Express Opinions	I stand up for my opinions or intuition.	92.70%	96.60%	3.90%
Open Minded	I try to be open-minded about new ideas and hear other's options.	99.50%	100.00%	0.50%
Confident in Assigning Tasks	I am very certain regarding how I should assign patients or tasks on my team based on results.	75.70%	96.60%	20.90%
Problem Solving Attitudes	I normally follow a problem solving process in which I take into consideration how my attitude, assumptions, and frame of reference may affect the way I approach the issue.	81.70%	89.80%	8.10%
Critical Evaluation of Decisions	I reflect on my decision-making and make changes in my work based on this critical evaluation of my work.	92.20%	98.30%	6.10%
Positive Outlook	I often ask, "What's good about this issue?" rather than focus on what's wrong.	61.00%	81.40%	20.40%
Focus on Patient Results	I focus on patient results, not just tasks.	88.50%	98.30%	9.80%
Too Busy to Reflect	I feel that I am so busy doing tasks that I rarely take time to reflect on the results or impact I make in my job.	42.20%	28.80%	-13.40%
Delegation Plan	After report, I feel comfortable meeting with my team to plan the shift.	77.10%	96.60%	19.50%
Planned Checkpoints	I plan specific times to meet with team members throughout the shift.	28.90%	64.40%	35.50%
Ask for Feedback	I ask for feedback from those I lead re: my leadership style and their assignments.	61.90%	91.20%	29.30%
Plans Based on Critical Thinking	I make plans based on that feedback to plan the next shift.	66.10%	92.90%	26.80%
Accountability	I am aware of my accountability for the total care of my assigned patients, even when they are given care by other providers (i.e. students, LPNs, NAs, etc.)	94.50%	98.30%	3.80%
Assessment	Assessment (as part of the nursing process) means looking at the big picture as well as the head to toe and vital sign data.	98.60%	98.30%	-0.30%
Evaluate Care	I routinely evaluate the care given by other care providers (when I act as leader) by observing, seeing the results, getting feedback from the patient or family.	82.10%	91.40%	9.30%
Replication of Success	I am aware of what satisfies me in my work and what comprises a "good" shift for me and try to duplicate those events or processes.	96.30%	93.20%	-3.10%
Articulate RN Role	I can clearly articulate my role as a professional nurse and describe what I do.	91.70%	98.30%	6.60%
Sound Bite Introduction	I use a specific "sound bite" or statement when I introduce myself to my patients, making sure they know who I am and how I will lead the care.	89.40%	98.30%	8.90%
Team Roles	I am clear about the roles of each member of my team and their expectations of me.	82.60%	96.60%	14.00%
Managerial Roles	I am clear about the roles of those in managerial, supervisor, or education roles that support my work.	79.40%	94.90%	15.50%

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