CO-CREATING CARING RELATIONSHIPS: REACHING OUT TO IMPACT READMISSIONS AND SATISFACTION

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Introduction: Transitions taking place in health care are demanding more from providers than medical treatment, qualifiers like effectiveness and efficiency are also being evaluated. The stakes are higher than ever for providers to make a “connection” with their patients. Being successful will essentially mean being the best by standards of care and connection with greater emphasis than ever on the roles that providers and patients play in achieving optimal health. As the most active care provider at the bedside, nurses hold a pivotal role in this process.

Significance: From our beginning a root established by Nightingale, caring has been a fundamental aspect of nursing. Over time, much debate has arisen as to the actual definition of caring. Is caring more akin to Watson’s expressed or demonstrated embodiment of feeling and perception as related through the theory of human caring or is it more like Peplau’s nurse-patient relationship theory developed through the act of providing hands-on care (Duke, 2009)? The case can be made that the essence of caring comes from the connected satisfaction of the giver and the receiver of care within the moment. Thus, true caring comes in the form of the action and the feeling. More importantly, the essence of true caring comes as result of a co-created relationship between the nurse, the patient, and the family.

Transitioning from caring theory to the changes taking place in the American health care system, the two concepts appear to be totally incongruent. Among several issues, the focus on the Affordable Care Act of 2010 is the financial penalty health care institutions will begin feeling in relation their readmission rates (Cloonan, Wood, & Riley, 2013). At the same time, there is a greater competitiveness among medical centers to be the best by way of efficiency and effectiveness as evidenced by patient satisfaction and Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS) scores, which are being linked to readmission rates (Study links HCAHPS, readmission rates, 2013).

While caring theory and day-to-day health care reality appear to conflict with one another, coming together is the solution. Applying foundational caring to current issues of addressing readmission and satisfaction rates of patients, family, and staff, there is evidence of room to grow. Nursing has an opportunity to be leaders in making a difference. Readmissions can be signs of improving care quality, having better discharge plans, or missing follow-up opportunities (Eichler, 2013). By getting back to our roots of caring, engaging patient and family, and building relationships focused on healthy, quality-filled lives, nurses can influence a reduction is readmissions.

The largest consumer of hospital services are the elderly. Additionally, they are 20% of readmissions costing hospital systems $25 billion per year (Fields & Wilding, 2013). Acute Care for the Elderly (ACE) Units are prime areas to implement a nurse-patient-family relationship building to reduce the nearly 75% of readmissions that could be avoided (Fields & Wilding, 2013). Studies show that patients know when they are receiving care through the interactions and behaviors of the nursing staff (Finch, 2008). Being present from the point of admission and continuing beyond discharge home via follow-up telephone calls cements these relationships.

Purpose: The purpose of this project is to measure the benefits of co-creating caring relationships through the development of a nursing initiative to engage nurses with their patients and their families.
Setting and Participants: This project was conducted on the Acute Care for the Elderly (ACE) Unit at Wake Forest Baptist Medical Center in Winston-Salem, NC. ACE patients are over age 65. The target participants for this project are those patients who have been discharged home as they represent the most vulnerable for readmission.

Project Description/Process: Beginning January 1, 2014, discharge follow-up calls are being conducted with ACE patients discharged home or their designated family representative. Calls are being conducted approximately one week after discharge to assess patient perception of health since discharge, adherence to medication regimen, nutrition, mobility, and review of scheduled follow-up appointments.

Project Outcome(s)/Projected Outcomes: As this project is ongoing, the results are continuing to evolve. There is indication that an impact is being made and could continue. Nine of the patients admitted in January were readmits to WFBMC; however, only three readmits occurred from January discharges. As data can only be tracked within the WFBMC system, there is no way to truly account for hospital encounters at other facilities. One major success was the identification of a patient experiencing a post-discharge decline. Activation of immediate support efforts prevented her having a 30-day readmission.

Project Evaluation or Partial/Projected Evaluation if not completed: At this point, only subjective evaluation has taken place among the ACE leadership team. Initial feedback is positive, but it is too soon to have appropriate data to support this assessment. The most significant feedback has come from those patients outwardly sharing the feeling care from receiving follow-up of personal interest into their well-being.

Future Directions: An element of this program that has already morphed is a weekly family support group session being held in conjunction with the ACE Unit Chaplain. We are calling these sessions “Journeying with our Elders: A Group Support to Life’s Transitions.” Going forward, it seems as though new avenues the project could take present themselves daily. A prime example would be consideration of the impact to staff satisfaction.

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References