implementing change in long-term care

a practical guide to transformation

Prepared by:

Barbara Bowers, Ph.D., R.N., Kim Nolet, B.S., Tonya Roberts, B.S., R.N., Sarah Esmond, M.S.
University Wisconsin–Madison, School of Nursing

table of contents

I. Introduction

A. Purpose

We all want to provide the highest quality of care possible for residents. But despite our desires and efforts, serious quality issues continue to plague long-term care. When we look closely, most of us can find care quality problems in our own facilities that we would like to correct. This manual was designed to assist organizations, and the staff who work there, to implement changes that will improve care quality. Whether you are contemplating a comprehensive, organization-wide culture change, or implementing a best-practice protocol in a single clinical area, knowing something about how to implement and manage change will help you achieve your goal. You will find suggestions about preparing your organization for change, assisting your staff to gain a sense of ownership over the changes, and sustaining the changes over time. Not all sections of this manual will be useful to everyone. Look for what you think is the most useful, and start there.

You will notice that each section considers how to involve staff throughout your organization, suggesting a wider involvement than is often the case. We know that lasting change is much more likely when it is understood and supported across the organization. Focusing only on the staff that will be directly involved in carrying out the new practice is generally insufficient to achieve sustained change. You will find suggestions and exercises throughout the manual that are intended to engage staff from across your organization in the changes.

Each section begins with a brief discussion of the topic, followed by practical suggestions and exercises. It is important for you and your organization to decide how to use the information in the manual to best align with your needs and goals. The topics may be covered out of order to suit a particular focus. For example, if you have already decided on a model of culture change, you may want to go directly to the section on developing teams. Additionally, the exercises and tools should be adapted to fit the needs of your organization. Encourage staff to read the relevant sections and discuss how examples in the manual can be adjusted to reflect your organization. Think of the manual as a guide, and modify portions appropriately.

The manual is based largely on feedback from staff in many organizations that have implemented significant practice and/or organizational changes. Their experience, insights, and wisdom guided the development of the manual and provide the examples of real change experiences.

B. Key Assumptions

Three key assumptions are reflected throughout the manual. They are that:

- Most nursing home staff are committed, intelligent, and hardworking. They are supportive of efforts that improve care quality, quality of life for residents, and quality of the work environment.

- Educational programs for nursing home workers will only be effective when they are guided by principles of adult education and supported by the environment.

- Achieving and sustaining clinical practice changes require changes in the knowledge and skill of individual care providers as well as organizational processes that support them. Successful change is more likely to occur, and be sustained, when organizational structures and processes are aligned to support the change.

C. Key Recommendations

Key recommendations for implementing and sustaining practice and organizational changes are summarized below. Details will be found in the various sections throughout the manual:

- Include middle- and upper-level managers directly in the organizational and practice change initiatives.

- Create strategies to introduce changes that engage staff at all levels, across departments and shifts, reaching most staff in the facility.

- Design changes with active, ongoing input from staff who will be involved in work process changes.

- Ensure active engagement of unit nurses and department heads in planning and supporting educational programs and practice changes involving frontline staff.

- Explore and address the organizational influences on planned practice changes.

- Acknowledge and address organizational, as well as clinical, barriers to clinical practice change.

- Support the development of problem-solving skills among staff involved in practice or organizational changes.

- Create accountability systems that will provide timely and effective feedback about the changes.

- Be sure roles of participating staff are clear and consistent with the goals of implementation.

D. Use of the Manual

This manual is not a recipe for change. Any significant change must reflect the particular mission, goals, culture, and internal relationships of individual organizations. Acknowledging that each organization has its own personality, history, commitments, and challenges, the manual is intended to guide you as you consider the changes you wish to implement by introducing you to what is known about change in general and about change in long-term care. It offers suggestions and includes exercises intended to bring

this knowledge to your particular change process, maintaining what is precious and unique about your organization while considering changes that will improve some aspect of the care or work environment. You are encouraged to consider what it is you value in your organization and to consider how to maintain those things while engaging in change. Mostly, the manual is intended to stimulate discussions and engage a wide range of staff within your organization as you plan, implement, and embrace important new initiatives.

E. Topics

Person-Centered Care and Culture-Change Models

Choosing a model of care can be a pivotal step in initiating change efforts. The principles, implementation, and outcomes of well-established models are described to facilitate decisions of a care model that will best suit the values of your facility. Even if you have chosen a model of culture change to pursue, this section will assist you in avoiding common pitfalls when deciding on a model and illustrates practical examples of how change has been accomplished.

Leadership

Strong leadership is an important ingredient to any successful practice or organizational change. The more extensive the change, the more important leadership becomes. Taking on the role of change champion, leaders often make the difference between success and failure. This section addresses the qualities and actions of strong and effective leaders.

Developing Teams

Many practice and organizational changes use teams of staff to plan, implement, and oversee the changes. Strong, inclusive teams are commonly seen as a vital element in successful change. This section will guide you in developing and using effective teams.

Developing Staff

Most significant changes require some skill development among staff. Many practice and organizational changes require staff to think in new ways, to engage in new behaviors, and to form new relationships within the organization. This often means significant staff development effort will be needed. This section suggests ways you can assist and support staff to develop the skills, approaches, and relationships that will lead to successful and sustained change.

Preparation Activities and Conducting Organizational Assessments

The previous sections are primarily intended to give you information that can be used to prime the climate in which changes will occur and be sustained. This section takes you to the next step, preparing you to critically look at your organization and where it stands now, while forming a picture of where you want to be. By doing several assessments in the assessment section, you will identify your strengths, weaknesses, and other needs as an organization.

Sustaining Change and Developing Accountability Systems

This section is intended to reinforce the idea of developing systems around the changes you are implementing and provide ideas for how to sustain changes.

Attachments

Clinical Care Training Materials

After you complete several preparation activities and form your teams, you may begin to identify clinical areas you'd like to improve upon. In Attachment 1 we have provided case studies and readings that may assist you in developing staff to meet your needs.

Organizational Assessment Worksheets

These worksheets accompany the material in section VIII and will be useful as you conduct your review of the organization.

Appendix

Several tools related to the above topics are included to assist in planning and conducting changes.

II. Background

For quite some time now, it has been generally recognized that there are problems in the nursing home industry with both the quality of care and the quality of work life. Efforts to improve the situation have included initiatives originating from outside the industry, as well as initiating from within the industry. State and federal legislation has been targeted at improving the quality of care. Some examples include: 1) the creation of public accountability systems for individual nursing homes; 2) linking reimbursement to nursing home performance (specifically the achievement of selected resident-outcome criteria); and 3) mandating training hours and content for certified nursing assistants (CNAs).

The nursing home industry has also been searching for ways to enhance the quality of care and the quality of nursing home work. As a result, several initiatives have been implemented by individual nursing homes and by networks of homes working collaboratively. Some of these initiatives have focused on the physical environment of long-term care settings, some on improved worker training, some on developing new and more positive workplace climates, and some on creating more resident-responsive communities. Some of these initiatives are targeted at specific activities, such as dining, while others are much more sweeping and comprehensive. In many instances, it has been difficult to sustain the changes over time.

A. What Does the Research in Long-Term Care Tell Us?

To build a better long-term care industry, it is important to be clear about what we have learned from what others have done. Some of the things we have learned are:

- Care quality problems usually continue unless there is a systematic, organizational-level commitment to change practice. Focusing only on the direct care delivery makes practice change difficult to achieve and difficult to sustain.

- When problems with care quality are not addressed, they often become less visible because residents, families, and staff alike become accustomed. This means we often miss serious quality problems that are right in front of us.

- Residents and families often have a much less positive view than staff, administrators, and managers about the level of care quality in a facility. This is partly because families and residents generally have a broader view of quality than staff have.

A Practical Guide to Transformation

- Workers, especially frontline workers, frequently have a more negative view of their work environment than administrators have. Repeatedly, administrators and managers overestimate the level of staff satisfaction and the quality of the work environment. This is one of the areas that we know the most about. For over 30 years, researchers have been documenting the relationship between management practices and quality of work life for frontline staff. Research has repeatedly revealed that frontline workers do not feel respected by their direct supervisors. In addition, the observations and insights of frontline staff about the residents they care for are not routinely reflected in the residents' care plans. There seems to be a range of barriers preventing frontline staff from participating actively in planning the resident care they will be delivering. These workers often feel unacknowledged for their skills and commitment, and staff turnover has been consistently related to these factors rather than to the difficulty of the work or the characteristics of the workers.

- Many facilities that proudly point to good annual survey results, few formal complaints, and acceptable resident outcome scores are unable to see beyond these parameters to the residents' experiences. These positive objective outcomes can, unfortunately, coexist quite easily with a poor quality of life for residents and a poor quality of work life for staff.

- Many nursing home staff have reported difficulty in making effective use of the data generated by the Minimum Data Set (MDS). As a result, care problems reflected by an organization's MDS/QI scores are often not adequately addressed, even after they have been acknowledged.

- While available resources are undoubtedly important to care quality, research has confirmed that similar levels of resources across facilities (such as staffing) are associated with widely varying levels of care quality and staff turnover. While important, this suggests that increasing resources is not the solution to the problem of care quality or work life quality.

- Research has documented that frontline staff perception of work life quality is highly related to the degree of collaboration between frontline workers and their direct supervisors (the unit nurses). We also know that frontline workers routinely feel left out of decision-making and do not feel as if they are listened to or that their observations about residents are taken seriously by the unit nurses. Frontline workers want to be part of the team that makes decisions about resident care. They want their knowledge, skills, observations, and insights to be considered. In situations where frontline workers feel as if they are true collaborators, they find much more enjoyment and satisfaction in their work. It is vital that unit nurses and managers in long-term care understand that in almost every setting where these perceptions have been investigated, frontline staff and managers (including unit nurses) have very discrepant views on how much collaboration is occurring. Managers and unit nurses consistently claim a much higher level of collaboration with frontline workers than is validated by the perceptions of frontline workers in the same settings. There is no indication that this is a deliberate deception. Instead, there appears to be a real and significant difference in how frontline workers and managers interpret the significance of particular activities, what it means to be included in decision-making, and what activities constitute real participation. Administrators and unit nurses are likely continue to do what they believe is collaborative work, while frontline workers continue to feel disenfranchised from collaborative decision-making.

B. Nursing Home Culture Change: Industry Initiatives to Address Care and Work Life Quality

You likely know about at least some of the industry-initiated efforts to address the quality problems described above. Collectively referred to as nursing home culture change, the Eden Alternative, the Pioneer Movement, and the Wellspring Model are some of the better-known examples of systematic attempts within the industry to improve quality. Although there are important differences among these initiatives, they have much in common. First, each of these initiatives has recognized the necessity for improvement in both care quality and work life quality in long-term care, and each explicitly recognizes the important link between these. Second, each of these initiatives acknowledges the vital role of frontline workers in providing high-quality care, and the importance of "empowering" these staff to improve the quality of their work experience, including the effectiveness of their work. Finally, each of these initiatives explicitly identifies organizational culture as a significant part of the current quality problem and, as such, a necessary focus of change. This explicit recognition that staff training and education are not adequate for improving practice and/or work life quality sets culture-change initiatives apart from many other practice and quality improvement efforts in the industry.

C. Replicating Practice and Organizational Change Initiatives

While many of the organizations engaged in culture change have flourished, transferring culture change from successful programs to new settings has been much more difficult than anticipated. Many organizations involved in culture-change initiatives (even homes with the best intentions and considerable resources) have failed to achieve and/or sustain significant improvement in either care quality or quality of work life. There are many reasons for this. First, replication efforts may be difficult because organizations that have successfully transformed their cultures are often unable to tell others exactly what they did and how they achieved the transformation. In addition, individuals engaged in these initiatives are often so busy attending to the daily demands of keeping the organization going, while also transforming the way things are done, that they often don't have time to track and document either what they are doing or how they are doing it. Consequently, there is very little useful documentation available about how culture-change initiatives have actually been implemented and achieved. Vague suggestions about "empowering your staff," "supporting critical thinking," "promoting innovation," and "increasing collaboration" are not useful to organizations wanting to replicate the changes.

What does one actually do to empower staff? How does one support critical thinking or cross-departmental collaboration? What specifically is a strategy to achieve this? To compound the difficulty, each organization is unique. So now there is the added problem of trying to figure out what strategies are likely to work across organizations, and where these strategies need to be tailored for a particular organization or organizational type.

To further the challenge of successful replication, when trying to reconstruct what happened and account for successful transformation of an organization, individuals are most often able to describe only those events that were closest to their own daily activities. Each person who explains the change and how it was achieved can only describe the corner of the world that is visible from his or her vantage point. As a consequence, important players, processes, and systems are missed in any such account. When these

A Practical Guide to Transformation

important factors do not become part of the story and are therefore not incorporated into subsequent efforts to replicate the organizational change, this minimizes chances for successful replication. This may also lead to a perception that culture change is mostly about having a charismatic leader at any level of an organization and not about the hard (often tedious) work of constructing new systems or improving existing systems. Charismatic leaders do not always appreciate the importance of creating systems to support organizational changes. This will leave the organization totally dependent on the continuing presence and effectiveness of a single person to encourage (and thus sustain) a new practice or new model of care. When the leader moves on or, for some reason, does not continue to command the same level of commitment from staff, implementation will often falter and fail.

Finally, an important challenge to replicating culture-change initiatives is that people leave. Organizational history is easily lost in an industry with turnover rates like those found in the nursing home industry. People with important information may be gone when efforts are made to reconstruct or evaluate the paths taken toward change.

Important questions for you to explore in an effort to consider some of the above challenges include:

- What is it about our systems that allow (or encourage) these problems to continue?

- Can we create systems to support the new initiatives that do not rely on individuals to remember and that integrate the changes into work routines at all levels?

- Can we create a system where ongoing learning is built into the daily routine, and good practice is automatically reinforced, rather than relying solely on sending workers to training programs and hoping they will learn, absorb, remember, and follow through?

Effectively addressing the above questions requires internal systems that can provide: 1) ongoing monitoring of residents and staff; 2) timely retrieval of data; 3) accurate interpretations of data; and 4) ongoing, timely, and appropriate feedback telling us whether our efforts are successful. In most nursing homes, these things are simply not done.

Working with many facilities that have implemented simple, or more comprehensive changes in their organizations, we have learned how important it is for all to understand and feel some commitment to the desired outcomes and to clearly understand the role they will play in achieving the outcome. This is actually much more difficult than it sounds. Staff come and go. Staff work different shifts and are too busy to attend informational programs on something they may not see as relevant to their own situation. Even administrators in some homes stumbled when trying to explain 1) the nature of the new initiative; 2) the organizational changes needed to implement the initiative; and 3) how they themselves would participate in the program.

III. Person-Centered Care

Is your facility providing person-centered care? Are you unsure if you are really providing it? What does person-centered care actually mean?

Person-centered care is a term that many people are familiar with, and many people say they already practice it in their facilities. However, when people are asked what it is or how they do it, they often have trouble putting it into words. The definitions and examples they give may be very different from one person to the next. One person may see it as meeting a resident's request, another may see it as adapting a standard treatment or care plan to individual needs, and others may believe it requires letting a resident decide how they receive their care. Some of the things nursing homes might do to implement person-centered care include:

- Neighborhood designs that make spaces feel more like "home" for residents;

- Choices in mealtimes;

- Expanding activity choices;

- Choices in bathing preferences;

- Letting residents take more risks by occasionally refusing medications or avoiding dietary restrictions;

- Encouraging families to bring in familiar items from home to decorate; and

- Inviting residents and families to participate in care planning meetings.

Each of these has an element of "person centeredness." As you can see, however, there are varying degrees to which a facility and/or staff members can embrace the person-centered concept. In a facility where they have fully integrated person-centered care, no decision is made without asking: "Has the resident (or residents) participated in this decision?" In most instances, for a fully person-centered care environment, the answer should be "YES!" or "No? Well, we'd better go talk with them!" Notice the important language of talking "with" them … not "at" them. Showing residents a presentation of how things will change is quite different than engaging them in the process of change and decision-making.

This section of the guide will help you focus your thinking about being a person-centered facility and broadening your applications. You will want to consider how to infuse your standards of person centeredness throughout the organization, providing staff with practical examples and clear expectations.

A. What Is Person-Centered Care, and How Is It Different from Traditional Care?

In traditional nursing home care:

- Decision control over daily practices is held tightly by management staff;

- Residents and direct-care workers are largely excluded from decision-making about care and daily routines; and

- Care is organized around a medical model in which care practices are driven by diagnoses, organized by tasks, and carried out by specifically trained personnel, rather than by resident preferences.

As an example, imagine a resident requests a bowl of soup in between meals because he was not hungry at his scheduled 6:55 a.m. breakfast. Knowing the resident has diabetes, the CNA seeks out a nurse to ensure the unscheduled snack is not contraindicated. The nurse says the resident's blood sugars have been fluctuating widely and delegates checking it to the certified medical assistant (CMA). The CMA reports back that the result was within normal limits, and the nurse approves the snack. While the CNA is assisting the resident with the soup, the soup spills. The CNA is about to go to the kitchen for more when the resident says, "Don't bother. It's lunchtime now anyway." The CNA then takes the dirty shirt to the laundry department and contacts housekeeping to clean up the spill. In this example, the soup request engaged an assembly line of tasks that would be completed by several staff members. Fulfilling the request became a medical task related to the resident's diagnosis of diabetes, and the resident was not engaged about the request or even asked what soup he preferred. Little needed to be known about this resident, except his diagnosis, to meet his request. The sequence of events is very unlike what would naturally occur in someone's own home.

In a facility that has incorporated principles of person-centered care, the resident would have a different experience. The resident would get up and eat breakfast whenever he wanted. A more universal worker role would eliminate the assembly line approach, allowing the CNA to prepare and clean up the soup. The medical diagnosis would inform, not dictate, the resident's request. The CNA would have the authority to support the resident's choice, avoiding the extensive and off-putting series of events required to produce the soup. Finally, fulfilling the request for soup would be an opportunity for CNA-resident interaction rather than a major frustration for both worker and resident

Person-centered nursing home care:

- Seeks to eliminate the assembly line approach to care and embraces a philosophy of residents as individuals;

- Seeks to improve quality of care and quality of life for residents and leads to a more satisfied life;

- Means residents are given choices and are able to make decisions;

- Requires staff to alter work routines to accommodate resident preferences; and

- Requires staff to have relevant knowledge and decision-making authority.

B. Approaches to Person-Centered Care: "Culture-Change" Models

Some of the most widely recognized clinical and household approaches to change are described in Appendix A. The table lists when each model was developed, their guiding principles, how each one is implemented, and significant outcomes expected for each. The table gives a means of quick comparison across approaches of major differences. It is by no means exhaustive and comprehensive but serves as an introduction. Choosing a model should not be based on the information in the table alone.

Choosing a Model

With the range of options for person-centered care, how is one chosen or created? Assessing your organization using the tools in the manual to understand the current state of the work and care environment is a good place to start. Honest and open discussions with staff, families, and residents about the nursing home environment—how it is now and how people would like it to be—will help you clarify your values and lead you to the option that is right for you. Once the facility's communal values have been made explicit, a model can be chosen that most closely aligns with those values.

If your intent is to closely imitate the original model (Eden, Wellspring) it will be very helpful to speak with staff from facilities that have implemented that model, to consult with organizations that are at different phases of implementation, and to use the tools that were designed for that particular model. By choosing an established model, there is benefit of assistance from experienced participants, the opportunity to learn from real-life examples, and the evidence that real sustained change can occur.

C. Practical Examples

Below are examples of person-centered care initiatives.

Resident-directed routines

Resident-directed routines allow residents to continue patterns of daily life they had outside the facility. This is often interpreted as allowing residents to decide when they will get up and when they will go to bed at night. These are important elements of resident-directed routines, but certainly not sufficient. Flexibility in dining, bathing, activities, care workers, tablemates for meals, new treatments, and whether or when to take medications are all places for residents to have some say-so. A more homelike environment exists when residents are able to follow long-established routines and choice is fostered by increased options and attention to preferences. Allowing residents to choose what, when, and with whom they will eat is not a simple matter. It requires considerable change in the organization of work routines for kitchen staff, volunteers, CNAs, nurses, activities staff, and others. Successfully implementing this demands careful attention to all the systems involved in the change. A mistake that is often made is to simply tell the staff to give residents more choices while forgetting to change all the systems that will be working against them if they attempt the change. These changes often do not occur simultaneously in facilities, but rather in phases allowing time for each one to be accepted and revised as needed to function well.

Dining

Traditionally, nursing home meals are served at scheduled times on hospital trays. Staff is expected to bring residents to the dining room in a timely fashion. Food is distributed by table and within a short time

to prevent temperature loss. Often, few options outside of the planned menu are available. Residents are rarely asked who they wish to sit with. Instead, residents are clustered with staff efficiency in mind. Dining has changed significantly in nursing homes across the United States. Some examples are described below:

Buffet and family-style dining

- Residents can arrive when they want to find hot food and open seating available.

- Food may be placed in warmers allowing longer distribution times, such as two-hour windows. Several types of foods are offered, and staff assist residents with selecting food. Special diets may be emulated with example plates.

Snacks

- Snacks are made available upon request rather than at predetermined intervals.

- Residents may have access to the kitchen.

- Snacks are purchased and stocked according to what residents like and prefer.

Central kitchens

- Continental breakfast can be prepared directly in central kitchens by staff or residents whenever residents arrive for breakfast.

- Lunch and dinner may be prepped by dietary service and sent to households or units to be finished and served to residents. Or dietary staff may place food in steam tables to be plated for residents in a manner similar to buffet dining.

- Residents and CNAs are able to directly plan and prepare meals together in a central kitchen.

Bathing

Bathing schedules in traditional facilities are organized to enhance the efficiency of the work and to ensure that residents are bathed on a schedule. Some facilities have tub rooms that double as storage facilities, not the most relaxing environment. In many facilities, residents are transported through the halls to the showers, naked, covered by a blanket. Bathing should be an enjoyable and relaxing time, not something to fear or endure. Many nursing homes have targeted bathing for improvement. Some of the common changes that have been made are:

Spas

- Residents are asked to choose when, how often, and in what manner they bathe. For more information, please refer to www.bathingwithoutabattle.unc.edu/

- Spa rooms are created that are warm and aesthetically pleasing, sometimes with music the resident selects, and have candles, soft fluffy towels, and soft lighting.

- Rooms are redecorated to resemble spas. They are large enough—or are remodeled to be large enough—for a shower, tub, toilet, and dressing area to enhance privacy.

- An aide is assigned to do only baths, avoiding the rush that results when there are other residents waiting for assistance.

Private baths
- Some facilities, such as Green House, have provided private baths for each resident as part of the physical design of the facility.

Bedtime schedules
Commonly, resident bedtimes are determined by the work schedule. Residents are assisted to bed when workers have time, often starting directly after the last meal and lasting until nearly shift change. Similarly, residents are awakened in the morning in a manner that assures the most number of residents are up in time for breakfast in the dining room. These expectations and systems will interfere with the provision of person-centered care, seriously limiting residents' ability to make choices. Person-centered systems are different in that they support the following:

- Residents go to bed and get up according to what they prefer or did at home. Snacks are available for residents who may prefer to go to bed or wake up at a time such that 14 hours are exceeded between meals.

- Residents may have more time to do for themselves what they can, rather than resign themselves to fast-moving staff.

- Shift schedules for frontline staff can be rearranged to accommodate resident schedules.

Activities
In many nursing homes, activities are regimented. There is a predetermined schedule of activities and events. The only choice residents have is whether they wish to attend. The activity starts and stops as planned. Interaction and participation are considered therapy. For example, a resident who listens to music tapes in his or her room is having music therapy, and pets brought into the facility are a way of offering pet therapy. Turning usual, daily activities into "therapy" makes resident choice seem less important. Activities become treatments, not desired activities. Seeing this as a quality-of-life issue, rather than treatment, is a good starting point. Culture-change facilities seek to embrace spontaneity and variety with activities in addition to scheduled events. An attempt is made to make the facility feel more homelike as well.

Pets and children
- Pets and children become a part of the facility.

- Their care becomes the shared responsibility of the residents.

Groups and community
- Groups, such as community learning circles, meet to discuss daily life in the past, present, and future. Ideas are heard during these circles, and an opportunity presents to gain insight into the lives of the residents.

- Decisions for activities may occur at a household level and may include bake sales, fundraisers, or other group projects.

- Death is no longer silently addressed, but is embraced. In some facilities, a bell is rung when someone dies, and anyone who would like may come to that resident's room to say good-byes and reminisce about the person's life. Both staff and residents are included.

- Neighborhoods can be created in traditional double-loaded corridor nursing homes for sense of community. Small numbers of residents are grouped into a single community, based on room proximity. This group is staffed with permanently assigned workers and shares communal activities.

- Households can be developed in renovated or newly built nursing homes by physically designing them to only house a small number of residents. Some households or rooms are designed to resemble actual homes with front porches and doorbells, reflecting a more homelike environment. These small settings allow residents the opportunity to really get to know one another and develop a sense of family or community with others. These models often have a town square at the center of the households in which a general store, movie theater, or chapel may exist for additional opportunities for activities.

Spontaneous resident-directed activities

Resident preferences for entertainment, outings, and activities are considered seriously and effort is made to make it happen. These activities, for example, may be an unplanned fishing trip in the middle of the day, a trip to the county fair, or a random decision to bake pie.

Relationships

In a traditional nursing home, staff are often expected to keep relationships with residents at a distance, being warned not to "get too attached." Time is spent on task completion, and engaging socially with residents is often perceived as idle time. Opportunities to get to know residents personally are sporadic, rotating assignments are common, and acknowledging residents by room number or diagnosis can become a widespread practice. Culture change values and nurtures the relationships that can naturally occur between residents and their closest direct-care workers.

Staff-resident relationships

- Frontline staff are supported in discovering the likes and dislikes of residents and have the authority to do something about the residents' preferences.

- It is acceptable for frontline staff to share aspects of their own life with the residents, as well forming reciprocal, meaningful relationships.

- Staff members are given permanent assignments to ensure development of long-standing, close relationships with the residents.

- Staff members are allowed time to sit with residents and partake in meaningful conversation and activity, such as sharing a lunch with them or joining them in an activity.

Resident-resident and resident-other relationships

- Intimate household and neighborhood or unit settings are conducive to developing bonds among residents, as well as gatherings in common areas that are homelike and warm. For example, in a setting that groups only perhaps eight residents together, as opposed to 30, there is better opportunity for each person to get to know others well. Open seating in dining rooms also gives opportunity for residents to get to know others. Beautiful hearth rooms draw residents out of their rooms together in one area.

- Residents continue other everyday relationships, such as with pets and children, as some places have live-in pets and on-site day-care centers. One of the most difficult experiences for residents is leaving cherished pets behind. Some nursing homes allow residents to bring pets with them from home.

Medication administration

Medications typically are administered at predetermined times and according to the medication nurse's routine. Medication carts assist nurses in delivering medications to different locations in the facility, depending on where residents may be during administration times. Some nursing homes have attempted to bring more flexibility to medication administration and to make it seem less institutional.

Administration times

- Changing administration times simply to a.m., p.m., or bedtime is one way in which facilities have restructured the medication pass to enhance flexibility in administration and accommodate residents who prefer to stay in bed longer in the morning or attend activities.

- When medication timing is more important (maintaining blood levels), nurses discuss flexibility with residents, ensuring that they understand the importance of timing while still allowing residents to choose. Conversations with the prescriber are also important so that all providers are working together to honor resident preferences.

Administration location

- Some facilities have eliminated medication carts and have medications placed in a locked cabinet in resident rooms. This is seen as less institutional and as increasing flexibility.

Universal Worker

Many nursing homes have developed a universal worker policy in their facility. This gives workers greater flexibility in how they can respond to residents. Adding dietary duties to the CNA's work adds flexibility by reducing the number of people who are involved in each task (for example, getting a bowl of soup). To ensure accountability for duties, each staff member is permanently assigned to a household or unit. The members of each household are responsible for completing all the work. Staff members often do not spend the entire day in one job. Some staff members will spend four hours as homemaker for a household and then finish the last four as a CNA. A coordinator in each household, typically a department manager, may spend two hours in the morning in the manager role, the next four in the household as coordinator, and the final two again as manager. Work hours are not increased for the facility, but are redistributed, and pay for staff is based on their primary department. The universal worker is accomplished in three ways.

1. **All staff become nursing assistant certified.**
   All department heads and other staff become certified nursing assistants, even maintenance staff. This may be something the facility requires of everyone all at once or slowly over time. This allows all staff to function in response to residents' direct-care needs. CNAs may continue to do the bulk of hands-on direct care, but all staff are able to assist when needed, and it is an expectation that everyone will carry out direct-care duties.

2. **All staff become cross trained.**
   Department heads and frontline workers become cross-trained in dietary, housekeeping, laundry, and activities. Staff are assigned a primary job function, such as dietary, in which role they spend the most time. All staff members are expected to complete the routine dietary, housekeeping, and laundry tasks for the households, as well as plan and carry out activities with the residents.

3. **Homemaker role integrated.**
   A general homemaker role for staff is the most integrated role. The homemaker is responsible for all homemaking duties, such as preparing meals, doing dishes, laundry, housekeeping, and activities. This position requires the heaviest use of cross-training skills.

Suggested Readings: Person-Centered Care

Boise, L., and White, D. (2004). The family's role in person-centered care: Practice considerations. *Journal of Psychosocial Nursing and Mental Health Services*, 42(5), 12-20.

Campbell, S. L. (2003). Empowering nursing staff and residents in long-term care. *Geriatric Nursing*, 24(3), 170-175.

Krasnausky, P. (2004). Being who we say we are: "culture change" helps two long-term care centers align practice with their sponsors' values. *Health Progress*, 85(3), 50-54.

Misiorski, S. (2003). Pioneering culture change. *Nursing Homes: Long Term Care Management*, 24-31.

Misiorski, S., and Kahn, K. (2005). Changing the culture of long-term care: moving beyond programmatic change. *Journal of Social Work in Long-Term Care*, 3(3/4), 137-146.

Robinson, S. B., and Rosher, R. B. (2006). Tangling with the barriers to culture change: creating a resident-centered nursing home environment. *Journal of Gerontological Nursing*, 32(10), 19.

Sampsell, B. G. (2003). The promise, practice, and problems of the Eden Alternative. *Nursing Homes: Long Term Care Management*, 52(12), 41-44.

Scalzi, C. C., Evans, L. K., Barstow, A., and Hostvedt, K. (2006). Barriers and enablers to changing organizational culture in nursing homes. *Nursing Administration Quarterly*, 30(4), 368-372.

Weiner, A. S., and Ronch, J. L. (Eds). (2003). Culture change in long-term care. New York: Haworth Social Work Practice Press.

Traditional Nursing Home Care versus Person-Centered Care

Traditional Care	Person-Centered Care
Decision control over daily practices is held tightly by management staff	An environment in which residents are given choices and are able to make decisions. Staff are encouraged to alter work routines to accommodate preferences of residents.
Direct-care workers are often excluded from decision-making about care practices and work environment.	Staff are empowered with relevant knowledge and decision-making authority, enabling them to change care practices.
Organized around a medical model in which care practices are driven by diagnoses, organized by tasks, and carried out by specifically trained personnel.	Seeks to eliminate the assembly line approach to care and embraces a philosophy of residents as individuals with their own preferences.

Examples: Resident-Directed Routines

Dining

Buffet and family-style dining
Snacks
Unit kitchens that give more flexibility

Bathing

Spas
Private baths

Bedtime Schedules
Waking
Bedtime
Snacks

Activities

Pets and children
Groups and community
Spontaneous

Relationships

Resident to staff
Resident to resident
Resident to pets
Resident to children
Resident to community
Resident to family

Medication Administration

Administration times
Medication location

IV. Leadership

While not the only important factor, a strong leader is essential for successful organizational change. Fortunately, quite a bit is known about good leadership and how to become an effective leader. While many people believe that you must be born with good leadership skills, we know that people in leadership positions can do many things to increase their effectiveness as leaders. The following section is designed to help you think about your own leadership skills and where you might want to develop or build on the skills you have.

A. Introduction: The Leadership Challenge

Over and over we heard the following statements from long-term care staff:

- "Management doesn't support us."

- "They never get rid of bad employees."

- "They make decisions without consulting us, and we deal with the fallout."

- "If I say something, nothing changes anyway, so why bother?"

This doesn't always mean the statements are true. Sure, sometimes they are, but often the case is that management isn't deliberate and transparent enough. When embarking on changes in an organization, it is more important than ever to be deliberate and transparent in your actions as a leader. By doing both, you can naturally increase inclusiveness and staff buy-in.

Some of the important traits for leading an organization successfully through the change process include:

- Engaging in strategic planning and systems thinking;

- Constant assessment of the environment, both internal and external;

- Surrounding yourself with the right people for the job;

- Building trust among staff and management;

- Making communication a priority;

- Engaging staff, families, and residents in key decision–making;

- Empowering staff; and

- Providing tangible support to staff when needed.

These concepts are particularly important for leaders encountering a period of change in their organizations. Whether it be a culture-change initiative, new policies, or other major change, considering the above elements before you dive in can increase the likelihood that your initiative will succeed.

B. Qualities of Good Leaders

Definitions of what constitutes good leadership vary, but there are several core qualities that leaders should try to embrace during times of change. This Web site contains the following list, as well as a self-assessment around these qualities: *http://www.leadershipthatworks.com*

Leaders …

- **Provide Direction.**
  - Foster development of common vision.
  - Define priorities and plan strategically.
  - Clarify roles and responsibilities.

- **Lead Courageously.**
  - Take a stand for your values.
  - Confront issues and concerns promptly.
  - Challenge others to make tough choices.

- **Influence Others.**
  - Win support to broaden your impact.
  - Provide feedback that inspires action.
  - Negotiate and get others to act.

- **Foster Teamwork.**
  - Build team spirit and get results.
  - Encourage interaction among members.
  - Celebrate team accomplishments.

- **Champion Change.**
  - Assess readiness and resistance to change.
  - Involve others in the change process.
  - Motivate people to embrace change.

- **Coach and Develop Others.**
  - Identify and groom talent.
  - Offer developmental challenges.
  - Develop leaders at all levels.

- **Motivate and Inspire Others.**
  - Establish high performance standards.
  - Trust in people's competence.
  - Inspire people to excel.

- **Build Relationships.**
  - Leverage networks.
  - Embrace diversity.
  - Manage conflict.

C. What Can Leaders Do in Times of Change?

There are several important things you can do during times of change that may help facility leadership implement changes in a way that anticipates needs and shows concern for all employee positions.

1. **Be clear about why a change is being implemented.**
   For every action you consider, be sure you understand why that particular action is indicated, and clearly communicate these reasons to your staff. The reasons may seem obvious to you but may not be so obvious to others. Share your thinking with the people around you and the people affected by the change. You want to strike a balance between overwhelming people with information that might not pertain to them and making sure everything is communicated to the right people. This will take practice and feeling out your staff's reactions to communication. A safe rule of thumb is to target communication of new processes or information to the key players, but make sure the new information is available at some point to everyone. This can be done via a newsletter or regular policy and procedure updates that are clearly visible

2. **Understand what your staff are experiencing by actively participating in the change.**
   While having a good idea about what you are trying to achieve, leaders often don't understand what "implementing" is actually like for the staff in their organization. It is important that leaders understand what they have asked employees to do, and that employees see that the leader understands. A good way to do this is to participate actively, visibly, over time, and in different ways with different staff.

3. **What you do is more important than what you say.**
   Telling employees that you welcome suggestions from them is not sufficient. Showing employees that you are listening to and trying out   their suggestions is much more effective. Telling employees that it is safe to speak out will breed cynicism unless you take meaningful steps to ensure that the environment is safe. That means, for example, that leaders need to assess all the possible risks to speaking out and address them before telling people it is safe. A single experience to the contrary will generally be enough to convince people that the leader cannot be trusted.

4. **Anticipate and address staff responses.**
   New ways of doing things often make people anxious. Knowing this and addressing it up front, allowing people to express their concerns, and encouraging them to give it a try, help staff remain calm. It is also important, however, not to be dismissive of staff concerns. False assurance will likely make things more difficult and undermine efforts to change. It is important to understand that if the leaders are feeling anxious, the staff will feel anxious as well.

5. **Decide how you will determine whether you have been successful.**
   Every long-term care setting collects many forms of data. Look at what you already collect and decide whether these data will help you determine your success. Be careful to find measures that actually reflect the changes. For example, if your goal is to increase residents' feeling of a sense of community, the Minimum Data Set (MDS) and Quality Improvements (QIs) will not provide you with any useful outcome data. You may want to develop a new set of data to monitor how you are doing. If you predict that your practice or organizational change will result in a particular outcome, be sure to measure before and after the change. If you only measure after the change, you will have no basis for

comparison. For example, if you think staff will feel more in control of their work after a change in policy, measure this before and after the change so you can say whether there was any difference. You might consider contacting your quality improvement organization (QIO), local university, or other consultant to establish an appropriate measure to determine the success of your change. Measurement can be quite complicated. It is always a disappointment to discover, after the change, that there is no way to measure whether it has been successful.

6. **Look at whether your daily activities are consistent with the changes you are implementing.**
If you are trying to make staff more involved in problem solving, be sure that the mechanisms you use to solve problems are inclusive. You are the role model. Your staff will be watching your behavior. When you see staff in your organization engaging in behavior that is inconsistent with the direction of change, it is important to address that behavior. It is important for others to watch facility leadership in regards to this. For example, if the administrator continues to engage in very top-down decision-making, while the director of nursing is trying to encourage staff participation and shared decision-making, it's important to bring this to the administrator's attention.

7. **Respond to challenges that occur during change implementation by helping staff clarify the problem.**
People often jump to a solution without really understanding the problem. This undermines effective problem solving and often leads to a deadlock among staff with differing opinions. If the problem is initially identified as "not getting our work done" or "residents are waiting a long time for help," it would be easy to define the problem as "we need more staff." Asking questions about the nature of a problem and tracing the problem back to its source will lead to a comprehensive understanding of the problem. For example, in the following situation, the problem—"a resident fell"—can be traced back to a system-level issue. Trying to solve the problem without including the system level would likely result in continued falls and frustrated staff.

Focus on Problem Solving

The Five Whys is a common way to practice problem solving. By asking yourself "Why?" at least five times, you are more likely to get to the root of the problem.

Example:

1. "He was looking for a gait belt to transfer a resident. **Why?**"

2. "He knew it was important to use a gait belt and couldn't find one. **Why?**"

3. "There are only a few gait belts on the floor. **Why?**"

4. "They keep disappearing. **Why?**"

5. "We don't have a clear system in place for where gait belts should be located."

At this point, solving the problem involves considering several possibilities that might lead to a satisfactory resolution. For example:

- There needs to be a larger supply of gait belts in the facility.

- There aren't central places on each unit for storage.

- Frontline staff aren't aware of where to put gait belts after using them.

One common mistake that leaders make is to either solve the problem by themselves or determine a solution with input from a limited range of people and without making their deliberations visible to the staff who will be affected. Identifying the key players and including them in the discussions about both the nature of the problem and the possible solutions will increase the commitment of staff to implementing the change identified. Some important questions to ask are:

- Who needs to be involved in determining the problem?

- Who needs to be involved in determining the solution?

- How does the issue, or the proposed change, affect each department?

- Who can help?

- Who needs to know about the change?

One useful strategy might be to make a master list of each department and the workers in those departments (don't forget things like human resources and groundskeeping staff). Go through the list and think about how each would be affected by the proposed change. Be sure to include people from each of those areas as you consider the effects of change.

A Practical Guide to Transformation

D. Systems Thinking

All behavior in organizations is affected by the system in which the behavior occurs. For example, when the staff is trying to be more responsive to residents who are experiencing pain, there will be many "system" factors that influence success of that effort. The pharmacy system, the policies concerning medication passes, the mechanisms for contacting physicians, the general staff knowledge, and the systems of accountability for responding to residents are only a few of the systems issues that influence management of resident pain. Looking only at the responsiveness of a particular nurse or the ability of a particular CNA to identify resident pain will not go very far to address the problem. It might improve the situation for one resident, at one time, but is unlikely to have any impact beyond that. Implementing an accountability system for pain management will, on the other hand, affect many residents and influence all shifts and all levels of staff.

While it is ideal if all staff can learn to think about the system influences on how they provide care and how the work gets done, the leaders in the organization are the ones who need to take the lead. First, it is important that leaders respond (and are seen to respond) to problems by looking at system contributors as well as other more local factors.

- **A useful Web site: Innovation Associates Organizational Learning:**
  http://www.innovationassociatesol.com/index.htm The site lists several readings and courses on this and other useful topics.

E. Strategic Planning: The Proactive Leader's Tool

A surprising number of directors of nursing have told us that they are not involved in their organization's strategic planning. A surprising number have even indicated that they see strategic planning as a formal process, distant from and irrelevant to their work. This is an unfortunate situation. Strategic planning, first of all, has in important impact on how the overall system operates and what priorities drive decision-making and resource allocation, and are, therefore, relevant to the core work of the organization.

> "Strategic planning determines where an organization is going over the next year or more (Vision, Purpose), how it is going to get there (Direction), and how it'll know if it got there or not."
>
> —Carter McNamara, *Field Guide to Nonprofit Strategic Planning and Facilitation (2003)*

Strategic planning is proactive, long-range planning that addresses an issue that concerns the entire organization. Strategic planning can:

- Help address external and internal factors during times of change and turbulence;

- Help plan and use staff and other resources most effectively and efficiently;

- Help focus the organization's culture and its customer base; and

- Build consensus about where an organization is going.

Strategic planning is an opportunity to be a proactive leader. As a long-term care leader, you can look at what you want your organization's culture to be like and who you want your customers to be. By involving multiple levels of staff in the planning phase, you tend to maximize communication, buy-in, and dissemination of efforts across the organization.

Models of strategic planning

Generally, all models of strategic planning have the following steps:

- Assess the current state of the organization or unit;

- Develop a vision (purpose) of where to go;

- Determine the "gap" between current state and the vision;

- Set a direction, including baseline goals, to close the "gap";

- Implement the strategic plan; and

- Evaluate the strategic plan periodically.

The SWOT Analysis and Environmental Scan models are two tools that are useful to assess the current state of your organization. A sample of the SWOT model is included in Appendix D. It is important to engage in continuous assessment of the organization, not just once during strategic planning. Build those assessments into your work routine.

Measurement

A way of measuring the effectiveness of the strategic plan is needed and must be initiated at the time the strategic plan is implemented. Evaluation measures must be reviewed and adjusted each time the strategic plan is adjusted. Measures might include:

- Clinical indicators (Quality Improvements, Quality Measures, etc.);

- Risk management indicators (e.g., events reported, insurance claims, lawsuits);

- Customer satisfaction (e.g., customer satisfaction survey scores, hotline complaints);

- Human resource indicators (e.g., staff turnover and retention, staff complaints and grievances, staff satisfaction survey scores);

- Financial indicators (e.g., census, profit and loss data)

- Timing measures (e.g., are strategic plan goals being met according to plan?)

Can you think of others?

F. The Right People for the Right Job

Long-term care has a few unique challenges that can lead to poor hiring techniques. With nursing shortages, high rates of turnover, and tight budgets, hiring and retaining the best staff can be difficult. It is easy to become desperate and take all the "warm bodies" you can find, even if the employee is not the best match for the position. There is considerable research documenting the negative impact of hiring the wrong person, especially in long-term care.

While making changes in your organization, you'll want to ask yourself, "Are the right people employed in key positions?" For frontline workers, do they have the right skills and attitudes to move forward with the spirit your change requires? By asking these questions early in the change process, you can develop a plan to build your staff into an aligned, effective workforce. Enacting a thorough recruitment and interview plan can help guide future staff selection. According to *Right Person, Right Job: Guess or Know—The Breakthrough Technologies of Performance Information* (Russell, 2003), there are three "matches" that employers need to look for when screening applicants:

- **Skill match**

  - Education
  - Work history
  - Skills testing
  - Background check

- **Job match**

  - Demonstration of complex, critical-thinking skills
  - Interest of applicant
  - Personality
  - Comfort

- **Organization match**

  - Demonstration of matching values
  - Demonstration of integrity
  - Interviewer and interviewee comfort

You've probably focused on getting a warm body with the right skills in the past. Often, you will get lucky and get a good employee by looking for the right skill match and checking references. With a little more effort and consideration, you can minimize luck and take fate into your own hands.

Strategies to Hire the Right Employees

- **Plan**

  Don't wait until you are desperate for a body to start the hiring process. Encourage current employees to give ample notice. It can take many months to find the right applicant pool for the job, so any lead time you can get is desirable. If someone quits with little notice, it's important to remain calm and begin planning the search for the right person for the job.

- **Network**

  Sometimes traditional methods of advertising don't result in the best pool of applicants. As the employer, it's also important who you know. Talk to the people you do business with. Let them know you are searching. Let the staff know you are searching, and encourage them to get the word out. If you have a local college or university in your area, find faculty with whom you can form relationships. Sometimes they can recommend new graduates for positions.

- **Consider your needs**

  With all the changes you are planning in the organization, consider the skills required for the position beyond the usual duties. Are there personality traits you desire or functions you hope a new person can fill? Are you looking for someone that will help you lead the change?

- **Consider new ways of screening**

  There are several free tools on the Internet to help you screen applicants. Resources may help you develop better prescreening tools, interview questions, and assessment techniques (see link at the end of this section). There are also several professional services that, for a fee, will provide skill, personality, and other assessment tools and scoring. You may find this is a worthy investment if you've struggled with high employee turnover and other problems in the past.

- **Rely on feedback from many**

  Have potential employees meet with a variety of staff in your organization. A panel of interviewers is one way to obtain multiple perspectives. An alternate method is to offer a second interview in the form of having the candidate meet one-on-one with key staff. Each person should plan casual conversations about the job and facility and convey their feedback to human resources.

- **Appraisal of applicants**

  Once you have several pieces of data to work with (interview notes, resume, feedback from others, references) you can complete a full appraisal. Consider the following areas when ranking applicants, deciding which are of most value to your organization:[1]

  - Skills and knowledge
  - Responsibility
  - Communication
  - Initiative
  - Commitment
  - Motivation
  - Flexibility
  - Creativity
  - Leadership potential

A good Web site, with several tools to help you reshape your employee selection procedures, is ***http:// hiring.inc.com/tools.html***.

---

[1] From ***www.employeradvisornetwork.com***

A Practical Guide to Transformation

Dealing with Problem Employees

So you've made some hiring mistakes in the past and are still sorting through the resulting problems. Now what? Hoping the problem will soon go away (the person quits, or everyone else finds a way to work around this person) won't get you very far. Sure, sometimes you get lucky and the person leaves, but the more likely result is that everyone tries to work around this person, creating more work and resulting in less communication and more confusion. The person can drain the morale and energy from even your best staff. The worst-case scenario, and often the most common, is that the good staff leave, and you are left with the problem. Nurse aides have identified this as one of the most demoralizing problems in their work setting, having to work with an aide who is not a good worker or not a good coworker. When a nurse aide sees an employee providing bad care to residents, they can become frustrated, angry, and disaffected. This leads to turnover.

Adding to the difficulty of dealing with problem employees, it is common for supervisors to overlook the importance of certain skills if an employee is skilled in another important area. For example, supervisory skills, as well as clinician skills, are vital for nurses who oversee nurse aides on their unit. Nurses often have no supervisory training and may be ineffective at this very important part of their work. It's never a good idea to accept low skill in an important area. Lack of attention to that area, especially supervision skills, can have a serious negative effect on other employees. Assess the skills needed and come up with a plan to raise the level of skill in one area, while acknowledging the existing skills in other areas.

Another very common problem in long-term care settings is for unit staff to "go around" the charge nurse, directly to the director of nursing or other manager to express concerns or suggest changes that need to be made. Working around the frontline supervisor can create serious, long-standing problems for everyone. First, it prevents the employees working together on a unit from learning to solve their problems together. Second, it prevents the charge nurse from knowing what is going on with the staff she is supervising and from seeing how the unit is operating. Finally, if you are trying to develop supervisory skills in your charge nurses, this will quickly send the message that you don't really think they can do it.

There are several resources to help you deal with problem employees or problems brought to you by employees. Nolo publishes several books on human resources that are reasonably priced and well-respected:

- Delpo, A., and Guerin, L. (2007). *Dealing with Problem Employees: A Legal Guide*. Berkeley, CA: Nolo.

- Mader-Clark, M., and Guerin, L. (2007). *The Progressive Discipline Handbook: Smart Strategies for Coaching Employees*. Berkeley, CA: Nolo.

G. Building Trust Between Management and Staff

During times of change, employee trust is an essential ingredient for retaining employees and engaging them as reciprocal partners in change efforts. In *Building Trust in the Workplace*, by Amy Lyman, the author shares the example of Continental Airlines:

> *"At Continental, employees in the baggage reclamation department were faced with the possibility of layoffs in 2003. When this news reached employees, they did an interesting thing. They met and came up with a plan for all full-timers to move to part-time status so that no one would need to be laid off. They took the proposal to managers and waited to see what would happen."*

What could some of the other outcomes have been? You can certainly guess: employee turnover, greater suspicion of management actions, fear, rebellion. Certainly, you'd prefer the proactive approach of Continental employees. How did management elicit that response? Trust makes a difference. Employees who perceive management as credible, fair, and respectful of employees will often spend more energy working with management in a positive manner. You may need to lay the groundwork of trust before employees will be willing partners in implementing change.

Credibility

Assuring management has credibility with staff can mean deliberate change in systems and leadership practices. Be *honest* and *open*. Leadership in the organization needs to make it excessively clear to all staff what will be openly and honestly communicated. Consider an "everything is everyone's business" approach. Of course, there are some things that need to be kept confidential, but be clear to employees in the beginning what you must keep confidential and why. Leadership should talk to supervisors about how to handle sensitive information in a way that can keep employees in the loop, yet not give any confidential details. If a crisis within the organization occurs, bringing employees into the communication loop early, even if it's to give minimal information, can build enormous amounts of trust. In *Building Trust in the Workplace*, Lyman shares the story of Griffin Hospital. Griffin was the site of an anthrax death after the 9/11 tragedy:

> *"Griffin president, Patrick Charmel, came under significant pressure from the FBI to withhold information from employees about the patient and her subsequent death. Yet, he decided to inform 200 day-shift employees about the case, recognizing that it would result in making the issue public…. 'My decision to tell employees was never in doubt … I could not violate or put in jeopardy the trust relationship Griffin and I have with our employees and the community.'"*

Of note, Griffin Hospital was number 21 on the 2007 Fortune Magazine "100 Best Companies to Work For" list and enjoys a consistently low turnover rate of less than 15 percent.

Showing respect

Engaging in collaborative activities with staff is an excellent way to show you respect their work and input. A time of significant change in the organization can provide many opportunities to collaborate with a variety of staff. This will allow staff to participate in identifying priority issues, developing solutions, and leading change. Leaders should be prepared to acknowledge employee participation in the process and give specific feedback on how the employees made a clear difference. A simple "thank you" is somewhat meaningful, but a specific thank you, made public, can have significantly larger impact.

Fairness

There is an inconsistency in how managers and employees can perceive fairness. A stringent policy that leaves little room for negotiation can be seen as fair by some, but often doesn't acknowledge there are different circumstances and degrees of action leading to discipline or even positive works. Thus, employees can feel unfairly punished or unequally rewarded. Enlisting employees' help in designing guidelines can be a useful way to increase fairness and show respect.

Communicating clear expectations to staff can also lead to perceived fairness. Examine the expectations you have for employees, and consider their fairness. Are you expecting more of some, and if so, are they being fairly compensated (financially or otherwise) for the extra responsibility? Are you unfairly holding a problem employee to a lower standard of expectations because you are frustrated and unsure how to handle it? All leaders within your facility need to examine their expectations. Additionally, encouraging employees to communicate their expectations of managers can be a very useful tool to guide changes in your facility.

H. Employee Empowerment

Employee empowerment can be a rather ambiguous term in long-term care. Many leaders are unsure what constitutes empowering their staff. To some, they consider verbal encouragement for decision-making the equivalent of empowerment. While verbal support is important, structures for providing coaching and encouragement at all levels are essential. In 1997, Harvard business professor and author Rosabeth M. Kanter defined organizational factors influencing employee empowerment as:

- Structures for advancement opportunities;

- Awareness of worker contributions; and

- Access to resources, information, and support.

Amount and types of delegated activities, reward systems, career ladders, committee participation, and job enhancement opportunities are all things organizations can examine to enhance employee empowerment.

Several instruments are available to measure staff empowerment in long-term care at *http://aspe.hhs.gov/ daltcp/reports/dcwguide.htm#empowerment*. Consider gathering this data before you begin to implement changes and after changes have been sustained.

Empowering Frontline Staff

While statements about the importance of empowering staff in long-term care settings are almost universal and almost everyone claims to be doing so, what this means is only vaguely understood. During change, it is important that direct-care staff:

- Understand changes and the reasoning behind them;

- Have numerous opportunities to increase their knowledge about clinical care areas;

- Have numerous opportunities to learn about how the organization operates and how resources are allocated;

- Understand how to apply and be actively involved in implementing best practices at an individual resident level;

- Understand how best practices can be implemented and supported at a unit and facility level;

- Understand how to assess the influence of organizational processes on clinical practice and be actively involved in such assessments;

- Be actively involved in the evaluation of practice intervention at an individual and an organizational level; and

- Be comfortable participating in all of the above activities.

Research on frontline staff tells us that most nursing homes do not have an environment where these eight things are likely to occur. Instead, frontline staff are often excluded from important opportunities to learn about clinical care, information sharing, and problem-solving activities at both an individual resident and organizational level, and they are generally not comfortable offering their opinions. Organizational change can be designed to change that. Frontline staff empowerment can create an expectation that frontline staff can achieve fairly high levels of clinical knowledge and that they will be encouraged and supported to do so. In addition, empowerment assumes that frontline staff will be allowed—and encouraged—to use the information, participating in clinical practice changes. While acquiring and using the information are related, they involve separate processes. This is an important distinction since, in many instances, frontline staff have an opportunity to acquire the new clinical information, but have little or no opportunity to use it (the organizational structure to do so is often lacking).

I. Providing Support for Employees

Leaders can sometimes become distanced from actual change implementation. They often see themselves as "big picture" people who are only there to generate the big idea, oversee architectural changes, or work on the budget. This distancing can be detrimental to the success of change implementation and can deeply color employee perception of support for change.

Listening

There is a desperate need in management across industries to move beyond "I tell staff my door is always open," and "I tell them I'll provide resources." No matter how close to the frontline managers are, there is still a power relationship that exists and needs to be addressed. Management will need to create clear mechanisms for soliciting ideas, input, and requests for resources. In addition, managers will need to consider all requests and input, being careful not to provide the answer to staff before considering options. For example, unit nurses often feel they should be part of staffing decisions. Management sees that as a budget issue and often thinks they know the request will be, "We need more staff." Providing clear information on how resources are being allocated and budget realities can often produce creative thinking by unit staff. They might have ideas for redesigning their work that wouldn't have occurred to you, or even to the director of nursing. Sometimes it's not just providing more money, but rather encouraging staff to use information to come up with creative solutions.

Providing resources

The changes you desire to implement will result in a variety of resource needs. Some examples of items often mentioned by staff and management during change implementation:

- More or redesigned space for facility operations;

- Incentive programs for employees;

- Career ladders;

- Redesign of resident living and social environments;

- Staff training or education in primary areas of concern;

- Technology to help staff do jobs efficiently; and

- Alternate staffing models that create efficiency.

Remember, a variety of staff can help address these issues. Leaders need not approach these in isolation. Teams using systems thinking are great ways to begin to look at these issues. Teams can also function to identify resource needs in advance by critically thinking and soliciting input from staff. Anticipating needs can create smoother implementation of change.

J. Making Communication a Priority

Throughout this guide, there are suggestions for enhancing communication in your organization. It cannot be emphasized enough that clear, constant communication at all levels will help implement any changes you might be considering. Consider having a team examine current information flow in the facility and pull together a new communication plan that encompasses communication at multiple levels. Look at an accurate organizational chart for your facility and consider all the places within and outside of the organizational chart that information flows:

- All departments and staff;

- Residents;

- Families;

- Board of directors;

- Corporate staff;

- Public and potential consumers; and

- Trade associations.

Look at how information currently flows to each of these facets. Consider how you might improve the consistency of information and encourage it to flow in both directions.

Encouraging two-way communication between management and staff

Most managers will say they wish employees would bring up issues and discuss solutions more often. Getting employees to give constructive feedback or raise issues can be challenging. It may take trial and error to have workable systems in place.

Planning forums for regular two-way communication with staff can be useful. Many staff report that meetings with leadership are "intimidating" or "unwelcoming of their comments." The environment often doesn't feel safe for employees to share concerns or even positive updates. They are unsure what management wants to hear and sometimes feel uncomfortable speaking in front of other staff. There are a few ways to approach this, and you may develop ideas of your own. Some suggestions:

- **Provide a clear venue for all staff to share their positive works.**
  Unit meetings can be a time for those staff to develop a three-minute presentation for the monthly "all staff meeting" where time will be set aside for everyone to share. Staff can take turns being the presenters. Make it an expectation that everyone shares something at each all-staff meeting. Encouraging staff to celebrate accomplishments can help avoid the perception of meetings being complaint sessions and can help increase communication and morale.

- **Consider systems that can safely solicit concerns before the staff meetings.**
  Secure boxes for anonymous topic suggestions can sometimes work, if management pays careful consideration to items submitted, and staff feel very safe inserting their comments. However, staff

often forget about the box or feel wary of being the only one with something to say. Enlisting the help of supervisors to discuss the issues in a smaller group or soliciting concerns on a one-on-one basis can sometimes lead to a better picture of what is going on in the frontlines. Supervisors need to build trust with the employees and assure anonymity. This may take some significant work with supervisory staff and will often take time to see the system working. Management should take care to not push supervisors to use names and will sometimes need to stop supervisors from accidentally providing names. Managers will also need to be ready to respond to all concerns. Consider whether it is most appropriate to respond at all-staff meetings, in writing (via a newsletter or memo), or in meetings with a small group of affected staff.

K. Addressing Stumbling Blocks During Implementation

It is essential for leaders to engage in understanding the issues faced by staff and to help them solve problems during implementation. Truly seeing firsthand the daily work of staff is important at all levels. Only then can everyone understand each other's jobs and how their own actions impact others. It will also help each unit consider implications for other units of implementing new processes.

As a leader, it is your job to help evaluate failures and turn them into learning opportunities. Disseminating this philosophy throughout the facility begins at the top. Being careful to practice this philosophy along the way is key to moving forward in the implementation process.

When implementation activities hit a stumbling block, it's useful to assemble a team of involved individuals (consider including others as "outside perspective") or to invite involved individuals to work with the team that generated the new idea and implementation process. Guide them through systems thinking (see section D, above) to problem solve. Remember to use the stumbling block as a learning opportunity and evaluate the solution.

Suggested Readings and Tools: Leadership

Barry, T., Brannon, D, and Mor, V. (2005). Nurse aide empowerment strategies and staff stability: Effects on nursing home resident outcomes. *The Gerontologist*, 45(3), 309-317.

Buckingham, M., and Coffman, C. (1999). *First, Break All the Rules: What the World's Greatest Managers Do Differently*. New York: Simon & Schuster.

Collins, J. (2001). *Good to Great: Why Some Companies Make the Leap … and Others Don't*. New York: Collins.

Communications Leadership Institute (2006). *Discovering the activation point: Smart strategies to make people act.* Retrieved August 30, 2007, from ***http://www.activationpoint.org/***

Jervis, L. L. (2002). Working in and around the "chain of command": Power relations among nursing staff in an urban nursing home. *Nursing Inquiry*, 9(1), 12-23.

Pfeffer, J., and Sutton, R. I. (2000). *The Knowing-Doing Gap: How Smart Companies Turn Knowledge into Action*. Boston: Harvard Business School Press.

Rogers, E. M. (2003). *Diffusion of Innovations*. New York: Free Press.

Senge, P. M. (1994). *The Fifth Discipline: The Art and Practice of the Learning Organization*. New York: Currency Doubleday.

Senge, P. M., Kleiner, A., Roberts, C., Ross, R. B., and Smith, B. J. (1994). *The Fifth Discipline Fieldbook: Strategies and Tools for Building a Learning Organization*. New York: Doubleday.

Smith, D. K. (1996). *Taking Charge of Change: Ten Principles for Managing People and Performance*. Reading, MA: Addison-Wesley.

Sullivan, E., and Decker, P. (2004). *Effective Leadership & Management in Nursing.* Prentice Hall.

Leadership assessment Web sites:

http://salesacademy.ca/sites/sales/files/leadership_assessments/Leadership_Self_Assessments.pdf
http://www.optimalthinking.com/leader-assessment.asp
http://www.pib.net/assessment.php

Leading Through Change

- Engaging in strategic planning and systems thinking

- Constantly assessing the environment—internal and external

- Surrounding yourself with the right people for the job

- Building trust among staff and management

- Making communication a priority

- Engaging staff, families, and residents in key decision-making

- Empowering staff

- Providing tangible support to staff when needed

Systems Thinking

1. Define the problem

2. Explore the "Five Whys"

3. List key factors

4. Gather information

5. Brainstorm solutions

6. Identify key players

7. Communicate results and changes

Strategic Planning

Steps

✔ Assess the current state of the organization or unit

✔ Develop a vision (purpose) of where to go

✔ Determine the "gap" between current state and the vision

✔ Set a direction, including baseline goals, to close the "gap"

✔ Implement the strategic plan

✔ Evaluate the strategic plan periodically

Action Guidelines*

1. Address the "why" before the "how"

2. Knowing comes from doing and teaching

3. Actions speak louder than plans and concepts

4. There will be mistakes

5. Drive out fear

6. Avoid fighting within

7. Measure what matters

8. Spend your time wisely and provide resources

*Based on *The Knowing-Doing Gap* by Pfeffer and Sutton

Strategic Planning: Employees

The Right People

Skill match

Job match

Organizational match

The Right Hiring Plan

Plan for the hire

Network with others

Consider your needs carefully

Consider new ways of screening

Rely on others' feedback

Carefully appraise applicants

Building Trust Between Management and Employees

Be credible

Show respect

Be fair

Employee Empowerment

✔ Clear advancement opportunities

✔ Awareness of worker contributions

✔ Access to resources, information, and support

A Practical Guide to Transformation

V. Developing Teams

Changes in work practices, even when focused on a limited area, generally affect the work routines and information requirements of many workers. A common mistake in implementing change is to overlook the effects of change on the people who are indirectly involved. For example, when residents are given choices about the time they get up in the morning, there may be an impact on the schedules and work routines of housekeeping staff, nurses, nurse aides, therapy staff, and others. An important thing to remember is that workers are often affected by changes in ways that others cannot anticipate. It is always preferable to include affected departments or staff as the changes are implemented. Finding out after the decisions have been made put employees in a reactive position, often leading to resentment, making future collaboration more difficult. Creating teams to plan for change and to communicate these plans to their coworkers is an effective way to improve your chances of success and prevent problems. Keep in mind that significant practice and organizational change does not simply disseminate itself through an organization. Organizational uptake of change relies on concerted, skillful, and sustained effort. This section will help guide formation of teams and shape team missions.

Teams come in many forms. Teams can be formal or informal, permanent or only in operation to complete a particular project. The membership of a team might vary or remain constant over time. Sometimes membership is mandated by statute or policy, and sometimes you are free to select membership. Teams should be created for a purpose and designed to serve that purpose. For example, nurses and CNAs might see themselves as a "team" to organize and provide direct care to residents. An informal team might convene each day, at each shift change, to transfer important information about residents to the incoming staff. A team might be specifically formed to do such things as: 1) recommend which new bathtub the facility should purchase for residents; 2) decide how to reduce falls on a unit; or 3) plan the annual Christmas party. In each case, the composition, longevity, meeting frequency, time and place, and level of formality is guided by the particular purpose. If you decide to form a new team or teams to assist you in implementing the change you are planning, you might hear staff say, "We already have teams. We don't need another one." This may reflect a lack of understanding about how important it is to design teams for a particular purpose.

The following section addresses the development of teams specifically created to assist you in implementing change. These teams will guide planning and implementation throughout the change process. A useful way to think about formal teams created for a specific purpose is:

"A team is a small number of consistent people with a relevant, shared purpose, common performance goals, complementary and overlapping skills and a common approach to its collective work. Team members hold themselves mutually accountable for the team's results and outcomes."

—Katzenbach and Smith (1993)

Consider teams you've been part of in the past. Did they succeed or fail? Why do you think they succeeded or failed?

You might think about people on the teams who were a driving or detrimental force. Did they keep things going and make others feel good about participating? Were timelines too rigorous or slow, or maybe the mission of the team was unclear? Thoughtful preparation needs to occur in choosing which teams to introduce and when, choosing participants for those teams, setting goals and expectations for the teams, and providing information and resources for teams. The following pages will help guide you through this process.

Note: Your facility will no doubt already have teams with specific functions. If they are well-established, well-functioning teams, and are working on issues that are relevant to the change you are planning to implement, you might think about ways to link those teams explicitly to the planning and change implementation process. A few questions to ask about existing teams are:

• Has this team functioned well in the past?

• Will the change affect the work that this team has been doing? If so, how can the work be integrated?

• What contribution can this team make toward our new goal?

• What changes will need to occur within this team to fit with our new expectations?

• How does this team fit in the overall structure of other proposed teams?

A. The Basics of Teams

Care should be put into deciding how teams will be formed and into creating the right environment for teams to practice in.

Forming Teams

Depending on the purpose of the team, there may be certain people who are pivotal to the team's work and should be included. These may be appointed by the organization's leadership. Other members might be included because they can represent parts of the organization that should be represented. These members might be volunteers, nominated by their coworkers, or selected and invited by leaders in the organization. Others may be included because they are personally excited about the change, are respected by their peers, have expertise in a relevant area, or are interested in developing their skills or expanding their roles within the organization.

A common concern of managers is whether to select members or ask for volunteers. As a manager or leader in the organization, you may have a good idea about which of your staff have the most potential to develop into leaders or experts. Some of these individuals may be reluctant to join the team, not yet having the confidence to see how they can contribute. Encouraging these people to join the team may be just the opportunity they need to develop their skills, expand their roles, and become important resources for the organization. There will be others with potential who may not have come to your attention. Sometimes these people express interest in participating, but they may also need encouragement to join the team. Sometimes managers select staff who have been "restless" or have agitated for change, even seen as troublemakers. While this is sometimes a wonderful way to channel negative energy in a productive way, it should be done with caution. Most importantly, consider the perceptions of coworkers and their response to such a person on a planning and implementation team. Regardless of what you decide, staff who are accustomed to being in a role of agitator may need some direction in channeling their energy and efforts in a more positive direction. Whatever you decide as a strategy to select team members, be sure to bring diversity in staff type, location, and perspective.

Ways to Enlist Participants	Pros	Cons
Solicit volunteers	• Members bring enthusiasm to the team • Members will likely be prepared to commit to the work and mission • Anyone can participate; less chance of peer hostility • Diversity among representation • Uncovering hidden talent • Fresh ideas	• Most vocal may be the only ones to volunteer • May not have enough volunteers • May have too many volunteers • Participant group skills may be lacking (communication, conflict resolution, focus) • Some departments may not be represented
Appoint members	• Selecting those with the right skills set • Encouraging those with potential to expand their roles • Assuring diversity	• Might be viewed as "more work" • Tendency to rely on the same people who have succeeded in the past; can lead to feeling overburdened, stale ideas • Others' resentment of not being chosen
Nominations and voting	• Assures fairness • Can require a nomination from each department, ensuring diversity	• Tension between those voted in and those not chosen • Those not chosen might fight implementation of team recommendations or plans • Cumbersome, time- consuming process

Consider your organization's stages of planning and implementation and which method would best fit the needs of the organization and the staff. Be prepared to deal with any of the cons that may arise during the process.

How many members?
Literature on the subject generally agrees that 6 to 10 members is an ideal number of team participants. Too few members and each will feel overwhelmed, and tasks will take longer. Too many members and it becomes more difficult to reach consensus and run effective meetings.

You will want to consider the number of departments your facility has and worker levels you would like to involve in your teams. If you have eight departments and would like a manager and frontline staff from each to participate, you can justify a larger group.

Integrating members from across the organization and ensuring management participation
Think broadly because it is valuable to include perspectives from across the organization, across shifts, and at multiple levels. A common decision when creating work teams is to put managers only on teams that deal with management decisions. This effectively isolates managers from important conversations with staff as they consider alternatives, discuss how the change will affect their work, and design their approach. Having managers on teams at all levels also increases the access that teams have to information that is relevant to their work. At the same time, it may become clear to managers and staff on the team what new information they will need to continue their work and to develop ways to gain ongoing access to that information.

Management Recommendations to the Team: Mission, goals, timelines
Management must walk a careful line between dictating the direction of the team and making recommendations. While a team's mission will largely be dictated by management's charge, there might be room for the team to help further shape the mission. Team input can be very valuable and potentially essential to the team's commitment to success.

Goals may also be partially shaped by management, but this can be a collaborative process. Management may have a few concrete goals that must be accomplished as part of a facility-wide project. However, the team will certainly want to understand why those goals are important and may have more goals to add to the list.

It is generally recommended that the team create most of its own deadlines and timelines, though there may be certain timelines for projects that have little room for negotiation. It is important for management to be clear up front why those are firm dates and carefully consider how much leeway they are able to give the group. Management can collaborate with the team to ensure enough time is allotted for activities and that timelines are reasonable. A common problem for new teams is being overly ambitious or allowing insufficient time to achieve goals. If the team suggests a timeline that seems too ambitious or too slow, it's important to refrain from judgment until you understand the team's rationale. Then you may suggest they give themselves a bit of flexibility. A conversation with the team can sometimes lead to both sides negotiating the most reasonable outcome. Working backward from goals, through all the changes that need to be made, the time for education and communication, meetings with different staff that will have input, and the need to develop new ways of working, will yield a more reasonable timeline.

Skills of team members

Regardless of how teams are formed, it's important to reflect on skills present in the team. If management is selecting team members, these skills can be sought when scanning the field. If the team is volunteer or election based, the team can still assess itself and discover areas of weakness. A guide to these skills is found in Appendix B.

Participation policies

It may be useful for management to create formal team policies that would apply to all teams in the facility. Uniform policies can lead to less uncertainty and more time spent on productive work, rather than figuring out what to do when something troublesome occurs within the team. It can also minimize potential pitfalls, such as lack of communication throughout the organization and tension among members. The issues policies might address are:

- **Attendance:** Is this a requirement? What are the acceptable reasons for missing meetings and how do you inform the team of absences? How will formal policies support the expectations?

- **Rewards or incentives:** Are there rewards or incentives? How will those be implemented?

- **Tracking work of the team:** Are progress reports expected? When, to whom, and in what form?

- **Communication expectations:** Will the team have a mechanism to communicate to everyone at the facility, including families of residents? What is the expectation of how often this will occur and in what form?

- **Length of service:** A one-year commitment is ideal. Will members be asked to continue longer if they wish or will there automatically be replacement at one year (or other determined date)?

- **Consensus versus unanimous decisions:** Consensus is a good method to make decisions when time dictates moving forward with plans, however, there can be "buy-in" benefits from making sure everyone agrees with a decision.

- **Resignation of team members:** What will happen when a team member resigns or quits the facility? How will a replacement be chosen?

- **Dismissal of team members:** What are the reasons a team member may be asked to resign? Who participates in that decision and is there a formal process to follow? How will a replacement be chosen?

Creating the Right Environment

- **Define and model norms and acceptable behavior**
  Teams also might need assistance from management in outlining acceptable behaviors and norms for the team. For example, discussing how conflicts will be handled within the team before they arise and creating a system to ensure all voices will be heard will increase the effectiveness of the team.

- **Develop the skills your staff will need**

  Many employees will have little or no experience running or even participating on teams and may need training or coaching in things such as running meetings, taking minutes, resolving conflict, or managing projects. There are many books and resources available for staff to learn these things (see list at the end of this section).

- **Ensure a nonhostile environment for teams**

  Teams may encounter hostility for their mission, their role as change agents, or even just time spent in meetings and working on projects. It is not enough for managers to verbalize support for teams. It is likely that team members will also need support finding time for meetings and project work. This support is generally more forthcoming from coworkers when they understand what the team is doing, see the staff member as their representative on the team, and appreciate the importance of the outcome the team is working toward. Understanding the goal and the work involved will also help alleviate feelings by coworkers that team members are "getting out of work" by joining the team. Little is more important to team members than the support of their peers. Even if coworkers understand and appreciate the team and its work, there are times when the staff member's absence from their usual work may create a hardship for coworkers. Finding a way to help "pick up the slack" will be appreciated by everyone and is a clear message about the importance of the team.

- **Creating templates**

  There are many ways an organization can help decrease team uncertainty and prevent chaos. Creating templates or guides for each team to use can help organize the work and increase the efficiency of the team. Suggested templates include:

  - Mission, goals, and tasks;
  - Agendas and meeting minutes*; and
  - Project outlines, including how it will impact various departments, residents, and families.

*Samples can be found in Appendix B.

Team Empowerment

Just like individual employees, teams work best when they are empowered to do their work. Managers often express concern that teams might make the "wrong" decision, come up with "unreasonable" solutions to problems, and create problems for the organization. Some things to keep in mind to support your teams:

- Grant the team some decision-making authority. You might start small to see how they are doing, increasing their authority as they grow into their role.

- Act as a coach to the team, not as a manager. One way to quickly undermine the effectiveness of teams is to usurp their authority, direct them in their discussions and decision-making, and worst of all, take the position of approving or disapproving all of their decisions.

- Allocate resources of time and money. Help team members find the time they need to attend meetings. Help them identify the resources they need and determine how to manage resources they control.

- Support and coach the team to become more effective, rather than instructing them or telling them how to proceed.

Occasionally, managers may feel they are able to support a decision made by a team. Making it clear from the beginning just what decisions the team has authority over and the extent of resources available to them will often prevent this from occurring. Even when the manager has reservations about the decision, they should carefully consider the options and thoughtfully (and supportively) respond to the suggestions. Consider the following distinctions between managing and coaching, between "bossing" and "guiding."

Coaching	Managing
Exploring	Telling
Facilitating	Directing
Partnering	Keeping the authority
Focusing on long-term improvement	Focusing on the short term
Being open to many possible outcomes	Seeking or forcing a specific outcome
Seeing the team as a unit, as colleagues	Sees members as subordinates rather than colleagues

Derived from: Harvard Business School. (2004). *Harvard business essentials: Creating teams with an edge: The complete skill set to build powerful and influential teams*. Boston, MA: Harvard Business School Press.

Team Success

When setting up a team, there are several factors to consider that will increase the likelihood of team success:

- The right people to do the job are involved; consider skills necessary and additional training, such as "how to run meetings";

- The mission and tasks are clearly understood by the group;

- The team must combine their abilities to complete tasks;

- The organization, including peers, must be supportive of the team's work; and

- The team will have a sponsor at the administration level to act as an advisor and advocate.

There are several characteristics team members should have to increase team success:

- **Embracing change.** This doesn't mean everything must change, but it means the team members will need to have open minds about changes that may occur and challenge themselves to think about the positive aspects of change.

- **Becoming communicators in the organization.** Teams are key to disseminating information about activities, plans, and progress across the facility, thus it is important to tailor their communication to various audiences. For example, the amount of information and language used can be quite different when speaking to families versus CNAs or activity assistants versus administrators.

- **Choosing a good leader and creating clear roles for team members.** Voting on a leader and deciding who will be responsible for tasks such as taking meeting minutes and reserving meeting space are important. Assuming someone will become the natural leader and that the team will be happy with that outcome doesn't always work. Using a democratic process during the first meeting or having a leader appointed before the first team meeting sometimes helps prevent tension among team members and might result in the best person taking the leadership role. Team leadership also can be done on a rotating basis. This can help spread the workload and help staff develop "on the job." For staff who might be initially uncomfortable in a leadership role, this can be a valuable opportunity for them to see behaviors modeled and give them time to boost their confidence as a participating group member. It is important to avoid the pitfall of having the lowest paid or ranked employee take meeting minutes each time. Sharing this task is as important as sharing the leadership. Using a template, this tedious task can easily be rotated each meeting.

Developing Team Mission and Functions

While each team will have a different mission, there are elements that will be important for every team to consider as part of its charge.

- Teams will agree to evaluate their successes and failures and have clear parameters to do so,

- Teams will solicit input outside of the team when appropriate.

- Teams will reflect effective communication.

There are several ingredients that will need to be generally defined by leaders in the organization and will then be further refined by each team. Leaders should be ready to have a core set of expectations in each of these areas and work with teams to connect team mission, goals, and objectives to each:

- **Values** What are the core organizational values related to residents, families, staff and   community? How does management expect each team to connect to these values?

- **Mission** What is the mission of the organization? What does it broadly hope to achieve? How will each team reflect the mission and form a connection to the larger mission of the organization?

- **Vision** What are the overall goals of the organization? How do they relate to the values of the organization and of the team? How is each team expected to contribute to the goals?

- **Philosophy** The philosophy is the organization's connection of values, mission, and vision. Teams may wish to develop their own philosophy in line with the organization's, yet related directly to their charge.

- **Goals** What the organization wishes to achieve should result in an extensive list of specific goals. The goals of teams should very carefully relate to the goals of the organization.

- **Objectives** The organization may not have specific objectives related to the team goals, as those may all rest within teams. If the use of teams is minimal, more work on objectives may need to come from the top. Teams will need guidance on creation of objectives, however, the team will need relative autonomy in shaping those objectives, which should be carefully crafted. More on objectives is presented   later in this chapter.

B. Which Teams Are of Primary Importance?

Two types of teams can impact the likelihood of successful implementation of change in organization:

- **A team of leaders to shape the direction** of the projects or change within the facility, be a primary information source, and establish a firm link to administration; and

- **A team connected to frontline care**, linking initiatives directly to resident care.

Although there is not a cookie-cutter approach to what these teams should look like in each facility, there are a few important ingredients and processes you'll wish to consider. For the ease of consistent terminology in this guide, the two suggested teams have been titled the "Implementation Leadership Team" and "Care Team." **These are not to suggest a "model" of implementation with specific terminology, but rather names that are reflective of their general activities.**

Implementation Leadership Team (LT)

The role of upper management, and in particular, the role of the facility CEO or administrator, has been one of the least understood and least formally developed roles in some change models. Administrators have sometimes had a difficult time figuring out how to support implementation efforts. Many administrators have seen their role as primarily providing the resources for frontline staff to improve their skills and alter some of the direct care processes. For example, when asked about their role in change implementation, a typical response from an administrator might be:

> "My role is to support the staff to go to the trainings, and to provide resources that the staff asks for."

Providing resources and verbally expressing support for the program is important, but that alone is not sufficient for successful and sustainable implementation. Comprehensive knowledge about current organizational structures, processes, and information flow within the facility, and whether and how these are compatible with implementing a best-practice or staff empowerment program are imperative for the administrator to have.

The administrator and other management staff (director of nursing, maintenance director, dietary director, etc.), must be directly involved with implementation if change is to succeed. This greater involvement often requires altering communication systems and information flow, decision-making processes, and accountability systems. Additionally, the top management team members, including the administrator, will likely need to learn more about direct-care processes to assist supervisors in becoming leaders in the implementation effort in their specific areas and to alter authority structures to be more consistent with an empowered staff model.

When asked to reflect on what they might do differently or how they might advise another administrator just starting out with culture-change implementation, top management staff from the Wellspring Charter alliance suggested that administrators need to be involved in every level and facet of change implementation efforts. Their comments included:

> *"One of the biggest mistakes I have made, and continue to make as an administrator, is assuming that by talking to managers … and the changes our home needs to make—that they understand what it is I want to do. When they don't ask questions, I assume they understand. I assume they will ask questions if they don't understand!"*

> *"I think you have to have the climate for improvement and making changes, even if it's just a matter of getting to the point of saying, 'We have to change things,' without knowing what it is you're going to change—I see a role for the administrator in doing that."*

> *"Administrators have to be familiar enough with the details to know what it is people are trying to change.…"*

> *"(You) have to remember it's not just nursing … (the) administrator has to pull together social services and dietary and whoever else and say, 'whatever we're changing, it cuts across all systems here.'"*

Who Is Involved on the Leadership Team?

Membership of the leadership team should include, at a minimum:

- Facility administrator;

- Director of nursing;

- Department heads;

- Frontline care workers (CNAs, activity aides, etc.);

- Mid-level managers and supervisors;

- Unit nurses;

- Change facilitator (see below); and

- Both new staff and those that bring years of experience in the facility.

The makeup of the LT is purposeful and important. Membership is designed to include employees with authority to access and distribute resources and who have knowledge about the organization, direct care practices, and the work environment. LT membership is also designed to encourage commitment from all corners of the organization. Consider the following: If the implementation team only includes representatives from management, how will frontline staff be empowered? If the LT is only representative of nursing, how can cross-discipline collaboration occur? If the LT includes only long-term, experienced staff, how can new ideas and energy in your organization be tapped? If the LT includes only frontline workers, how can organizational change be expected?

A Useful Member: The Change Facilitator

Facilities should consider designating a change facilitator to oversee implementation activities. This person is at the hub of the action, staying connected on a daily basis to every aspect of the change initiative by linking all teams in the facility. The change facilitator assists with creating and sustaining teams, working with members of teams to identify and prepare for carrying out pre- and post-module implementation plans, and assisting teams to work effectively with each unit. The facilitator also will work with department and management representatives to develop support and accountability systems for implementation purposes. The facilitator requires an individual who is a savvy organizational worker. Consider seeking someone with many of the skills listed in Appendix B. Some of the activities the change facilitator may be engaged in include:

1. Identifying the skills and knowledge that teams and individual team members need to be successful;

2. Arranging for opportunities to gain any missing skills and knowledge;

3. Promoting a supportive environment for team activities;

4. Preparing staff with clear information from the LT;

5. Serving as a liaison between the LT and other teams; and

6. Managing the logistics of staffing teams.

The most successful facilitators will possess sophisticated organizational knowledge; interact effectively with staff at all levels of the organization including leadership and garner respect from staff. Successful facilitators also remain vigilant for ways to support implementation of plans; carefully anticipate how implementation plans will impact all levels of staff in the facility; and be able to assist staff in their implementation efforts rather than doing it for them.

If you designate a current employee to be the facilitator, consider how they will manage other duties. You will want to assure this person has time to do an adequate job of coordinating activities across the facility. While some facilities have joined together to hire a new position to undertake these duties, it may not be necessary or feasible in every facility. Consider your staff resources and how you can reallocate work to allow for the asset of a facilitator.

Mission

The LT will, at minimum:

• Set the strategic direction for change at the facility;

• Be a strong resource for staff;

• Define a uniform stance on how they envision change taking shape at the facility;

• Assure clear communication of implementation vision, tasks, and progress to all staff in the facility;

• Listen to staff comments and concerns, taking time to consider all feedback and respond;

- Perform assessments and gather necessary data related to the proposed changes, such as performing surveys, interviews, and staffing trends; looking at MDS data; and reviewing budget structures;

- Set benchmarks for the organization as a whole in meeting change goals;

- Define imperative support structures (teams, information sources) that need to be in place for change implementation; and

- Create formal accountability systems for implementation of changes.

A facility LT could address several common barriers or challenges to change implementation including:

- Insufficient awareness across the facility about the change in philosophy or practice;

- Uncertainty of administrative and supervisory staff about their roles in the operation and implementation of new philosophy or practices;

- Inconsistent implementation across units and departments;

- Difficulty in creating and sustaining teams;

- Lack of accountability;

- Challenges related to team implementation ideas (too costly, unrealistic, etc.);

- Inability of team members to access or understand facility data sources; and

- Communication and information flow that is inconsistent with the needs of teams, staff, families, and residents.

If you are planning to join or have joined a culture-change network, you will have access to expertise and experience that will help guide you through the implementation process. However, it is critically important to understand that no organization can be transformed by outsiders. When organizations rely only on outside consultants, educational programs, and/or the introduction of specific structures to change their organization, the implementation is less likely to be successful. The facility LT will have a lead role in preparing an assessment of the organization and identifying things to be done to make the organization fertile ground for the changes being implemented.

Assessment work by the LT will include:

- Ease of staff access to relevant data;

- Effectiveness of communication and targeted information flow;

- Focus of performance evaluations and link to desired behaviors;

- Link between staff development activities and care outcomes;

- Work environment quality; and

- Resident quality of life.

Time Commitment

Many have underestimated the importance of regular, prescheduled meetings in implementing major changes within organizations. LT members are seen as the primary staff resource for all change information, as well as role models. Having consistent, frequent meetings will assure the LT has current information at their fingertips and energy is sustained. Frequent meetings will help "keep the ball rolling" and will serve as a model to other teams in your facility. You will want to set up meetings well in advance to avoid scheduling conflicts. Decide early in the process how you will support attendance via backup staff or possibly a reward system. If conflicts should arise, it is important to decide how to handle those. If one person is absent, consider passing on careful notes, with tailored messages to that individual. If multiple people are absent, decide how to update other members of the LT about change activities in each department over the recent time period and any pressing issues that need to be dealt with immediately. One barrier that teams frequently encounter is pushing off starting tasks because all team members are not present. A suggested strategy: Get the absent team members' input before the meeting if possible. If you cannot obtain that input prior to the meeting: 1) Create a plan to start the task without that team member's input, but do not yet move ahead with that plan; 2) Engage one present LT member as a liaison for the absent member; 3) Have that person meet privately with the absent member as soon as possible to discuss the task and proposed plan and gather input; 4) Require immediate report of the results of that communication to the whole LT; 5) Decide if, given the input, you can all move forward with the plan or if you will need to revisit it at the next LT meeting.

Care Team: Linking Change to the Frontline

The care team (CT), again, is a generic term used to describe any team that is primarily concerned with linking project implementation directly to the frontline. It is not indicative of a particular model but is a team to consider assembling for the purpose of engaging important staff and assuring projects link to resident care.

The prominent industry trends of person-centered care and culture change is primarily about increasing:

- Care quality and consistency;

- The degree of collaboration across departments;

- The participation of workers across levels of the organization; and

- Organizational development to promote greater collaboration and follow-through.

As a consequence, workers at all levels become much more adept organizational workers. This extensive involvement of workers at all levels of the organization addresses one of the most significant causes of frontline worker turnover: the inability to participate in planning of resident care. It is not surprising that promoting such collaboration has resulted in a reduction of frontline staff turnover in many nursing homes.

The collaboration that is required for change implementation across organizational levels and creating a decision-making structure that engages frontline workers, mid-level managers, and upper management is what leads to a sense of worker empowerment. As collaborative decision-making proceeds, it becomes apparent that each worker has a vital part to play in both identifying the problems and devising solutions to those problems. This will clearly help link change activities to frontline work.

Mission

The purpose of the CT is to work collaboratively to:

- Identify problems in a particular area of resident care;

- Determine the source(s) of these problems;

- Select problems to address;

- Define the problems clearly;

- Identify the people who need to be involved;

- Develop a plan to address the problem (you may want to create a separate team to work on the issue);

- Mobilize the resources needed to carry out the plans;

- Anticipate and address any organizational challenges to implementing the plans; and

- Evaluate whether and how well the plans ultimately worked.

The efforts required to manage a facility's CT and its effective engagement in the organization are considerable. The change facilitator (described under "Leadership Team" above) could be designated to manage the CT.

Who Is Involved?

Because most clinical problems experienced in long-term care involve multiple worker types, multiple levels of the organization, multiple departments, and cross shifts, teams must model and direct the practice changes in the organization that will allow each organization to enhance clinical outcomes and improve the work environment. As such, an effective CT will include representatives from all the worker groups that will be involved in implementing practice changes. This will necessarily include: frontline workers, department heads, and professional staff from nursing, dietary, the therapies, maintenance, human resources, purchasing, housekeeping, activities staff, and management/administration.

Time Commitment

The CT should allow ample time for communication via meetings, yet also have time to progress with projects. Many have found that a biweekly meeting structure can accomplish these two goals. Meeting less frequently often dilutes the impact of the team and puts them in a position to catch up or put out fires, rather than being proactive. This also allows time to for the change facilitator to share and disseminate

communication between the LT and CT. You will want to set clear expectations for participation because floor staff might find it difficult to get away from their work. Try scheduling meetings when team members are not expected to be on the floor and work to minimize interruptions. Given that many CT members do not have an administrative component to their jobs, administration may need to clarify to the team member and their colleagues the necessary time commitment and provide support to colleagues who might be short- staffed. Additionally, the team member participating in the CT might feel guilt or fear of not being on the floor. Verbal support to that person from administration and other CT members and the support their colleagues remaining on the floor cannot be overlooked.

C. Linking the Care Team to the Leadership Team

It is important to integrate change structures and processes with the rest of the organization. A change facilitator plays a significant role in linking all the teams, however, leadership team (LT) members need to engage in other team membership within the facility. This achieves two things. First, it keeps managers informed about and connected to the changes that are taking place, preventing managers from unknowingly undermining what CT members are attempting to do. It is important to move forward together, not at odds. In some culture-change initiatives, managers were making decisions that were counter to what a CT had decided to move forward with. This can result in frustration of the CT members and create needless tension between managers and staff. This is most likely to occur when managers make decisions in the complete absence of knowledge about what the CTs are doing and how the managers' decisions might affect the team's plans. This can be avoided when the managers are familiar with the CT's plans and the logic and thinking behind the plans.

Note: Managers involved in culture change expressed concern that any involvement on their part might disempower CT members. To the contrary, evidence supports the importance of ongoing involvement of managers. It is important to remember that empowerment cannot occur when frontline staff are simply left alone to make decisions and carry out plans. This is a mistaken perception that can seriously undermine any change initiative. Empowerment requires information and resources. This will only happen when managers who are knowledgeable about the organization and the systems and processes within the organization are involved.

D. Other Teams

Together, the LT and CT may provide a strong backbone to your organizational change implementation, but these two teams will need more support to successfully research, plan, and roll out initiatives. Once you have chosen key changes and know how you would like to proceed in your facility, the supporting teams you'll need to form will become clearer. If you are undertaking a clinical-care focus, you can consider forming teams based on areas of clinical practice such as pain, incontinence, pressure ulcers, and similar categories. These teams could operate under the CT. Be selective in the number of teams you form, as having too many teams can become unwieldy and too few can be too taxing on each team. It is important to make sure the teams fit within a clear organizational plan and communicate with each other. The key changes, size of your facility, and pace at which you wish to roll out implementation will help you determine the number of teams you need. The change facilitator should be part of each team, assuring smooth operation and communication.

For each team created, it is important to include representatives from the departments that will likely be most affected, those that will be required to make significant changes in their work routines, those that have the most relevant experiential information about the issue, and those most likely to be opposed to the recommended changes. In addition, membership on the CTs offers a great opportunity to promote career advancement. Individuals, who have no obvious vital link to the processes that will need to be altered, but who express an interest in the area, are often very effective CT members. They bring enthusiasm and energy to the process and should be included, nurtured, and supported.

E. Involving Unit Nurses and Department Heads

The unit nurse plays a pivotal role in the success of the change. On units where nurses were involved directly in the implementation of changes and were well-informed and deliberately supportive of changes, implementation was likely to both succeed and be sustained over time. Conversely, on units where nurses were not interested or informed, implementation was likely to be weak and intermittent. In addition to being well- informed about what each of the teams is attempting to achieve, some unit nurses can become coaches and mentors for frontline staff on their units, supporting implementation plans and finding ways to help staff attend resource team meetings. This will increase the level of staff excitement and support for improving practice and a much greater likelihood for success.

Department heads of dietary, housekeeping, activities, and therapies have a similar impact on change implementation. Department heads making an effort to understand how their staff can be involved and actively supporting these efforts and assisting them to integrate the implementation activities into their daily work routines will dramatically increase the effectiveness of implementation. Trying to change without the active and well-informed support of a supervisor consistently led to disappointment and failure. When staff engaged in change attempt to "work around" unsupportive department heads or unit nurses, frontline staff become frustrated and often give up. For many staff, this has long-term consequences. They are unlikely to participate in future quality improvement efforts, and lose their excitement for practice change. They are also more likely to leave a facility.

It is important to include supervisory and mentoring activities in the performance evaluations of unit nurses, other supervisors, and department heads. Specific training in leadership, coaching, and mentoring is also recommended for this same group. Several nursing homes are now engaged in such training. Often the unit nurses, supervisors, and department heads who participate in these training programs express surprise at how helpful the programs are in their daily work.

F. Evaluating Team Progress

Think about what happens when a staff person goes to a training seminar. The person gathers new ideas, get excited, and returns to work, eager to share those ideas. A few hours into the day and those plans have been forgotten or dismissed by the person. The folder of information often goes on the bookshelf, and as the days get busier, nothing is put into action. What would help change that?

Any number of factors can influence the likelihood of moving from an idea to an outcome. Things that can assist teams and individuals moving forward include:

- Removing barriers;

- Creating precise objectives;

- Measuring outcomes; and

- Providing direct, tangible, visible support for the change.

Removing barriers

As has been discussed in this section and the section on leadership, it is important for leaders to do more than just verbalize commitment. Removing barriers to participation in change initiatives and assisting teams in removing barriers to implementation are vital. For example:

> A team has decided CNAs on the night shift can assist housekeeping staff by doing residents' laundry during the overnight hours. There can be a number of barriers to consider. The CNAs might reject the idea as "not their job." How can you help encourage CNAs to see this as their job? Are you prepared to adjust job descriptions and enforce the new duty? Where is the laundry facility? Will it take CNAs off the unit if they do laundry? Can laundry facilities be moved so CNAs can stay on the unit? If washers and dryers are on the unit, will there be a noise problem? How can you eliminate that problem? The team and leadership will need to consider problems and clarify where management will need to take action to support the implementation.

Creating precise objectives

Team objectives should be carefully stated in writing. When a team is clear on a specific task they must accomplish, the likelihood of planning and implementation will increase. The team should develop its own goals, with management acting in a consultant role.

While team goals might be broad, objectives should be something that can be easily measured. For example, a broad goal for a care team might be to decrease staff turnover, leading to more consistent caregivers for residents. While facility data can measure this, over the long term it doesn't necessarily reflect why turnover happened or the work of the team in the short term. Objectives should clearly reflect steps the team is taking to reduce turnover. For example:

Objective 1: Create and administer a survey for staff to share reasons they might consider leaving their jobs.

Objective 2: Work with human resources to compile and review exit-interview data from staff who have left in the last 24 months. If exit interviews do not exist, perhaps the team objective could be to work with human resources to implement an exit interview process.

Objective 3: Identify the most common factors related to turnover and create a plan to address those factors. Create new team objectives based on the collected data and analysis.

These three objectives have identified short-term steps for the team to take, and progress on those objectives can be easily tracked by administration, peers, and the team itself. Broad team goals will be less overwhelming when objectives are precise and measurable.

Measuring Outcomes

If team objectives have been carefully identified and progress has been clearly tracked, it can be a relatively easy task to measure outcomes. The LT should develop clear and consistent criteria for how team success will be measured. Consider creating a measurement template. The items you address will be specific to initiatives and priorities in your facility and might include:

- Has the team created goals relevant to change initiatives?

- Has the team created goals relevant to resident quality of life?

- Has the team met consistently?

- Has the team maintained a diverse membership?

- Has the team communicated its mission, goals, and objectives to all facility staff, residents, and family?

- Has the team communicated plans and progress to all facility staff, residents, and family as appropriate?

- Has the team developed specific, measurable objectives?

- Has the team completed any of its objectives?

- Is the team making satisfactory progress in completing its objectives and identifying new objectives?

- Has the team's mission been completed, or is it addressing an ongoing need?

- Are there reasons to revisit the team's mission, goals, objectives, composition, or work plans?

Measuring outcomes can often be less daunting than interpreting and acting on outcome data. Each issue many not be best captured in a "yes" or "no" answer format. Measuring a team's success is complex and should incorporate the "big picture." The LT should carefully review team progress and discuss any action it would like to take regarding the team. The LT should work with teams to assure these reviews are not punitive, but are a tool to assure initiatives stay focused and continue moving forward at a reasonable pace. The LT should remember to treat the reviews as such. Outcomes of the team reviews should be discussed with the team in a nonthreatening manner, soliciting feedback on barriers that may be issues for the team. Consider developing plans for addressing LT concerns with the team. This may decrease team frustration and increase team buy-in.

A Practical Guide to Transformation

Suggested Readings: Teams

Harvard Business School. (2004). *Harvard Business Essentials: Creating Teams with an Edge: The Complete Skill Set to Build Powerful and Influential Teams*. Boston, MA: Harvard Business School Press.

Katzenbach, J. R., and Smith, D. K. (1993). The discipline of teams. *Harvard Business Review*, 71(2), 111-120.

Katzenbach, J. R., and Smith, D. K. (1993). *The Wisdom of Teams: Creating the High-Performance Organization.* Boston: Harvard Business School Press.

Levi, D. (2001) *Group Dynamics for Teams*. California: Sage Publications, Inc.

Building Skills of Team Members:

Bens, I. (2005). *Facilitating with Ease! Core Skills for Facilitators, Team Leaders and Members, Managers, Consultants, and Trainer*s. San Francisco: Jossey-Bass.

George, J. A., and Wilson, J. M. (1997). *The Team Member's Survival Guide.* New York: McGraw-Hill.

SUGGESTED TEAMS AND POSSIBLE MEMBERS

Leadership Team (LT)

Leading the Change

CEO/Administrator

Director of Nursing

Director of Dietary

Human Resources

Director of Staff Development/Education

Director of Housekeeping

Director of Maintenance/Engineering

Change Facilitator

Medical Director

Care Team:

Bringing Organizational Change to the Frontline

Change Facilitator

Director of Staff Development/Education

Director of Nursing

Dietary Aide

Housekeeper

Unit Nurse

CNA

Social Worker

Activities Facilitator

Pharmacist

*Consider adding family members and residents to all teams in your facility.

Other Teams?

Fill in the blanks with other teams you might desire or need:

_____

_____

_____

_____

_____

_____

_____

Setting Up Teams for Success

- The right people to do the job are involved; consider skills necessary and additional training, such as "how to run meetings."

- The mission and tasks are appropriate to the group.

- The team must combine its abilities to complete tasks.

- The organization, including peers, must be supportive of the team's work.

- The team will have a sponsor at the administration level to act as an advisor and advocate.

Organizational Support of Teamwork

- Encourage employee participation.

- Integrate members from across the organization and ensure management participation.

- Define and model norms and acceptable behavior.

- Believe people are assets and should be developed.

- Ensure a nonhostile environment for teams.

- Create templates of tools for your teams.

Team Empowerment

- Grant the team decision-making authority.

- Act as a coach to the team, not as a manager.

- Allocate resources of time and money.

VI. Staff Education and Development

A. Effective Staff Development

All culture-change initiatives rely on change occurring at multiple levels of the organization to be successful. This requires staff to learn new things and to go about their work in new ways. As we all know, changing the way we work is not easy. The most common strategy to achieve this involves training, education, or staff development. Unfortunately, the degree of change that results from staff education or training programs is often disappointing. Despite well-planned and skillfully delivered training programs, real practice change has been difficult to achieve and even more difficult to sustain. This can be quite frustrating and can also cause conflicts and bad feelings among staff. When staff attend training programs and then seem to ignore what they have learned, continuing to work as they had in the past, we often interpret this as not caring or as deliberately undermining the effort. Typical responses to this lack of change or lack of sustained change include: reminding people of the change they agreed to implement; becoming angry that they are not cooperative; and finding ways to keep reeducating staff about the same things.

What's wrong with this? Research on continuing education and practice change in long-term care suggests that much of the current effort is destined to fail, that current staff development efforts are not consistent with what we know about how adults learn and how work practices change.

First, it is important to understand the difference between learning something new and using that new knowledge to change the way we do something. Clearly, not all new knowledge leads to change (new practice). We all have knowledge that we don't use, often to our own detriment (we all know that we would be healthier if we exercised every day, but most of us don't). The relationship between acquisition (acquiring new knowledge) and knowledge implementation (or practice change) is complex. Many things can prevent people from using knowledge they have, even when they want to use it and intend to use it. Fortunately, we know quite a bit about the things that promote (or block) knowledge use.

Experts in staff development and adult learning generally break down learning into three areas. These are:

• characteristics of the learn he knowledge is intended to be used.

• characteristics of the educational program; and

• characteristics of the work environment where the knowledge is intended to be used.

B. Learner Characteristics

Learner characteristics include: demographic characteristics such as age or gender, motivation, and intelligence or ability. For many years, it was believed that these were the most important determinants of how well people learned. We know now that, while these have some influence on learning, they are not the most important. Research has demonstrated that, although there may be differences in how people learn, demographic characteristics do not affect someone's ability to learn. It is well established, for example, that adults learn differently from (but not generally less than) children and that older adults learn somewhat differently than younger adults, although they are still highly capable of learning new things. The important thing is to match the way people learn best with the learning environment. (More will be said about this match in the discussion about the learning environment.)

Personal motivation has also been seen as a very important personal characteristic that influences whether or how well someone learns. When someone attends a training program and doesn't seem to have learned much or isn't using what they learned, we often believe they are simply "not very motivated." If only they were more motivated, they would have learned what they needed and put it into practice. Two things are important to understand about motivation. First, many people who are highly motivated, who really want to make improvements in their work, do not actually change much of their practice. To say that again, people who are highly motivated, who learn well and intend to use that knowledge, often continue to practice the "old way." This is frustrating for everyone.

There are some important things to know about motivation. We generally think of motivation as something within a person. She or he is motivated or not. We know from research that motivation is more influenced by the environment than it is by a personal characteristic of the learner. This means that someone who seems unmotivated will become quite motivated under the right circumstances. One of the most important influences on personal motivation for learning is the attitude of the learner's direct supervisor. A supervisor's interest in the learner, explicit recognition of the efforts made by the learner, and encouragement to learn new things and bring them back to the unit all have quite an impact on the motivation of the learner to attend educational sessions and to use what is learned. Recognition encouragement and support from peers and subordinates also affect motivation to learn. Workers who feel they will be chided or ridiculed or simply not appreciated for what they have learned and what they can bring back to the work setting are unlikely to feel very motivated about attending an educational session. These issues are all related to the work setting, not the learner or even the educational program.

It seems that personal confidence is one characteristic of a person that can influence learning. Sometimes this is a long-standing personal trait and does not respond significantly to the work environment. However, it has been shown that personal confidence can be maintained, increased, or undermined by the work environment, particularly by the direct supervisor. Therefore, finding ways to bolster a learner's confidence about learning the new material and being able to share it and use it upon return will increase motivation to learn.

Obviously, the supervisor and others in the work environment are important determinants in whether the staff learn, how well they learn, and whether they are able to make the desired practice improvements. Let's look at some ways that supervisors, in particular, influence workers' ability to learn. Supervisors can

identify staff who they believe will be able to take a lead role, or an important supporting role, in practice change. Hearing that your supervisor believes you would be good at something and would like you to help the unit make some changes can be both confidence-building and motivating. Supportive supervisors can also anticipate negative reactions from peers or other obstacles to implementing new practice or using new knowledge, heading off disappointments. Supervisors play an important role in assessing whether work routines will be disrupted by implementing a new practice and can work with the learner and other staff to prevent this—to find ways the environment can adapt to be supportive of the change.

C. Training or Educational Environment

The method of delivery and the educational setting also are very important for effective learning. Environment includes both the physical setting and the way the program is conducted. For example, the physical environment must be comfortable and free from distractions and competing demands for the staff attending an educational program. In terms of the teaching methods used with adults, we know a considerable amount about how adults learn best, assuming they are in an environment conducive to learning. Some things to remember about adult learning are: Adults learn best when the relevance of what they are learning is clear or is made clear. Information that is assessed as not relevant is unlikely to be retained. Adults are generally very goal directed, especially in work-related learning experiences. This is similar to the requirement for relevance because adults learn best when they know why they are learning something and can see a clear goal that might result from using the new information or skill. Adults are also likely to come to an educational situation with a wealth of experience and often a familiarity with the topic of instruction. As adults learn, they are constantly thinking about the new information in the context of what they already know, in the context of their own experiences. Acknowledging what adult learners bring to an educational program, what they already know, and what they are concerned about, and relating these things explicitly to what they are learning will increase their ability to integrate the new information effectively.

D. Supporting Learning in the Work Environment

Probably most important and certainly most often ignored is the impact of the work climate that the worker will return to after the training session. Very often there is little or no explicit mention of what the staff member learned or even acknowledgment that they attended an educational program. What happens when the worker returns to the work setting determines, to a large extent, whether the new information will be used at all, used temporarily, or will actually lead to sustained change. There are several things that influence the use and sustainability of new learning. One of the most important factors is recognition (preferably by supervisor and peers) that the staff member attended a program and that the new information is valuable to everyone. In addition to recognition, providing opportunities for the staff member to use the new learning and to have opportunities to practice what they have learned is an extremely important factor in sustaining practice change. Practice opportunities help to integrate the new knowledge with old routines, allowing the learner to figure out how to change the way they work most effectively. Practice opportunities, ideally with oversight from the supervisor, allow the learner to identify how to adapt what they have learned to the many varying circumstances encountered in daily practice. It is discouraging to try out new ways of doing things only to find that the situation is different from that discussed during the

educational session, and it is not clear how to proceed. Supervisors can help immensely in this situation. Together the supervisor and the learner can determine how the knowledge might be adapted to each situation until the learner is comfortable doing that on his or her own.

Effective staff development requires careful planning, attention to the needs of the learner, and a high level of integration between the training and everyday practice. Learning that takes place in isolation from the daily work or that is not supported by organizational policy, access to information, and acceptance from peers and supervisors is destined to fade away.

E. Mentoring

Recent data places the turnover rate for direct-care workers in Wisconsin nursing facilities between 99 percent and 127 percent (Dresser et al. 1999), and the Governor's Health Care Worker Shortage Committee reported a turnover rate of 72 percent in 2000. A study by Sager (2002) estimated that it costs approximately $2,500 to replace one certified nursing assistant while a study by Dawson and Surpin (2001) placed the estimate at between $1,400 and $4,300 when the increased managerial expenses, lost productivity, and recruitment and training costs are figured in.

High staff turnover has been associated with higher levels of federal deficiencies, more resident pressure sores, and increased complaints filed against facilities—all of which translate into negative quality of life for residents (Dresser et al. 1999). High turnover also affects the employees who remain with a facility. As less staff is available, those who stay are often moved from one unit to another to provide necessary coverage. Many CNAs feel that they need to establish and maintain relationships with residents to provide "good caregiving" (Bowers, Esmond, and Jacobson, 2002). When CNAs are moved from unit to unit, establishing and maintaining any relationships with residents is difficult, if not impossible.

Reasons for Turnover

A number of studies have tried to identify the primary reasons for turnover of direct-care workers in all settings, including nursing homes, assisted living, and home health care settings (Banaszak-Holl and Hines, 1996; Dawson and Surpin, 2000; Dresser et al. 1999; Wilner and Wyatt, 1998; Bowers, Esmond, and Jacobson, 2003). Primary sources of staff dissatisfaction and turnover include:

- Lack of opportunity for career advancement;

- Lack of respect and support from administrators and direct supervisors;

- Lack of permanent and predictable client assignments;

- Lack of autonomy or involvement in decision-making;

- Unreasonable work loads;

- Inadequate or poor training;

- Low pay; and

- Limited benefits.

Though low pay has been identified as a primary reason for job dissatisfaction among CNAs, issues that are related to what the Wisconsin Governor's Health Care Workforce Shortage Committee (2002) referred to as "the internal employment culture" appear to influence the decision to seek other employment. One of the recommendations outlined in the committee's report was to "transform the internal employment culture to a culture where health care staff are valued." Initial attention, it further stated, was to be given to such "internal culture" elements as: creating mentoring programs; increasing employee satisfaction; improving internal employee relationships; developing collaborative work models; and increasing leadership, professional, and occupational development opportunities. The Certified Nursing Assistant Recruitment and Retention Pilot Project in Iowa in 2000 surveyed CNAs and found inadequate job orientation and levels of training as the top CNA concerns. Nurse supervisors, in the same study, reported having similar concerns, citing a lack of authority to see that CNAs get the training they need.

F. What Is Mentoring?

A mentor is defined in the dictionary as "a wise, trusted advisor … a teacher or coach." A mentor is someone who helps someone else learn something the learner would otherwise have learned less well, more slowly, or not at all.

Historically, mentoring has been seen as an oftentimes older, more experienced, and wiser person guiding a younger and untested person through a life passage. It is often a long-term relationship in which the protégé is guided, counseled, and assisted in mastering the skills and gathering the knowledge necessary to assure success in a particular endeavor. A healthy and successful mentor/protégé relationship will move from one of relative protégé dependence at the beginning of the relationship, to one of autonomy and self-reliance as the protégé grows into a colleague and peer.

From the mentor's perspective, being identified as a mentor often provides a sense of accomplishment and value. Staff who are chosen or choose to mentor are often respected for their skills and leadership abilities and have a sense of commitment to the career that they have chosen, as well as to the facility where they are employed. Though the mentee or protégé is seen as the main beneficiary of the relationship, the mentor can gain satisfaction knowing that he or she has contributed to and influenced the next generation of workers. Mentors often report a deep sense of fulfillment and accomplishment as a protégé succeeds. The protégé or mentee can look upon this relationship as one that can be beneficial in the long-term and short-term, as skills are honed and helping relationships are established. The protégé can be assisted and supported to understand the informal systems of an organization and receive guidance in how to be successful in the organization.

Benefits to Successful Mentoring
According to Stone (1999), there are 10 benefits to mentoring your own employees:

- Faster learning curves;

- Increased communication of organizational values;

- Reduced turnover at a time when new recruits may be hard to find;

- Increased loyalty;

- Improved one-on-one communication and a sense of team within the work group;

- Increased employee productivity;

- More time for yourself;

- Additional corporate information;

- Creation of an innovative environment; and

- Allies for the future.

G. Successful Mentoring Programs

Several groups have successfully designed and implemented mentoring programs for certified nursing assistants. Though the approaches vary, the goal of addressing inadequate or poor training and a lack of opportunity for career advancement is the focus.

The Certified Nursing Assistant Recruitment and Retention Pilot Project (2000), coordinated by the Iowa Caregivers Association (iowacaregivers.org), was initiated to help with the retention of CNAs, as well as to attract new workers to the field in specific counties in Northwest Iowa. The Iowa Lakes Community College Continuing Education Department developed a CNA Mentor Training curriculum. This was piloted by a qualified CNA instructor to assist current CNAs in developing skills as mentors to new CNAs. The CNA mentor program reported three positive outcomes from this initiative: 1) CNAs report enhanced professionalism; 2) Providers reported retaining workers longer; and 3) Patients and consumers receive increased quality of care provided by a more stable workforce.

A second successful CNA mentoring program was developed in 1997 by Mark S. Noble, the executive director of Luther Manor in Dubuque, Iowa (***www.luthermanor.com***). Train the Mentor: A Training Program for Long-Term Care Workers was designed to reduce CNA turnover rates, establish a CNA career ladder, and improve the training and support of new nursing assistant staff. During the first year, the CNA turnover rate dropped from 102 percent to 39 percent, and this rate has almost consistently remained under 40 percent since then, according to personal correspondence from the retirement community. Train the Mentor has been published (Simon & Kolz Publishing) and is available for purchase for those interested in implementing a complete mentoring program within their own facilities.

Masonic Home of New Jersey implemented a long-term care preceptor program in 1989. This same facility received a 1997 National Gerontological Nursing Association Innovations in Practice Award in recognition of its efforts. "The Preceptor Program" has decreased overall staff turnover from 53.4 percent in 1988 to the current level of 19 to 20 percent. Additional benefits have included: positive new employee comments regarding the program; an increase in morale as turnover rates decreased; and a reported increase in job satisfaction and self-esteem among preceptors, according to Cindy Shemansky, director of education for Masonic Home. New Jersey Department of Health survey results also revealed an increase in

compliance with state and federal regulations since 1989, as well as savings of thousands of dollars each year with decreased expenses related to turnover. See Appendix C for an outline of Masonic Home's "The Preceptor Program."

These three programs have successfully addressed two issues that CNAs have identified as reasons for leaving: 1) A lack of opportunity for career advancement; and 2) Inadequate or poor training. During the development and subsequent implementation of these programs, several additional elements were identified as critical to the success of the mentoring initiatives:

- **Management must believe in the idea and demonstrate support for a mentoring program.**
  Training programs for administrative or management staff and supervisors will ensure that there is a smooth transition for the newly trained mentors and reflect the commitment that the facility has to CNA development.

- **Incentives, such as title changes, wage increases, opportunities for additional training, and increased involvement in care planning and various aspects of staff development are recommended.**
  By creating a mentoring program that offers advancement opportunities and additional pay, employers demonstrate that they value the skills and experience of mentors and frontline workers.

- **A combined process of formal application and interview is suggested for selecting mentor candidates.**
  The application process will allow those with an interest in mentoring to step forward, while the interview process can be flattering and serve as a bonding process between mentors and management. Providing a self-assessment tool such as The Mentor Scale (see Appendix C) will help prospective mentors evaluate their gifts as well as their "blind spots." Knox and McGovern (1988) identified six important characteristics of a mentor:

  - A willingness to share knowledge;
  - Honesty;
  - Competency;
  - A willingness to allow growth;
  - A willingness to give positive and critical feedback; and
  - Directness in dealings with a mentee.

- **Mentors need to receive proper training on how to mentor and train new employees.**
  Whether an in-facility training program is provided, as in Train the Mentor, or training is provided off site, such as that used in the Iowa Caregivers pilot project, guidance must be provided to those who are expected to guide and mentor others. Mentor training skills to build supportive relationships include: leadership skills, interpersonal communication skills, teaching and coaching skills, as well as problem solving skills.

- **Facility leadership must provide opportunities for CNA mentors to meet regularly encourage sharing of experiences during the mentoring process.**
  Creating and supporting a mentor support group will ensure that mentors will have a "safe" environment to verbalize concerns about their positions, as well as to receive advice and emotional support from their colleagues.

- **Effective mentoring programs reflect content that considers the developmental tasks that both the mentor and the protégé are facing.**
  The protégé often is in early adulthood where the primary task is one of initiation into the workplace while dealing with personal developmental issues related to identity and intimacy. The mentor, by comparison, may be addressing professional reappraisal, assessing life accomplishments, and readjusting lifetime goals, while responding to opportunities for passing on accumulated wisdom and skill. Failure to consider the developmental levels of the mentor and the protégé will certainly lessen the effectiveness of the mentoring experience and may even be detrimental (Head, Reiman, and Thies-Sprinthall, 1992).

- **A common pitfall of the mentoring process is the failure of one, or both, of those involved to allow the relationship to evolve or change over time.**
  For example, after a mentor/protégé relationship has been established, encouraging a protégé to develop a "mentor mosaic," or a network of secondary mentors, will lessen dependence on the primary mentor and assist the protégé in developing self-reliance, as the protégé learns to assess needs and utilize multiple resources are available.

- **Care should be taken when matching the mentee with a mentor.**
  Attention should be given not only to a proper skills fit, but also to compatible outlooks between the mentor and mentee. The mentee should understand the mentor's role, expectations, and length of time that the relationship will be formally supported by the facility. This will allow for informal relationships to occur and continue.

The Paraprofessional Healthcare Institute Web site (paraprofessional.org) identified an additional key program design element that needs to be addressed before a mentoring program begins. Workforce Strategies, No. 2, May 2003, issue says that a specific job description should be developed to guide the responsibilities that the new mentor will need to fulfill. Appendix C contains a copy of its recommended Certified Nursing Assistant Peer Mentor job description. Appendix C provides an example of a job description for CNAs participating in a CNA peer mentoring program, provided by the National Direct Clearinghouse on Direct Care Workforce Web site (directcareclearinghouse.org/practices).

Several other tools for mentoring, such as mentor skills, a mentor scale, and sample program can be found in Appendix C.

Selected Readings: Mentoring

Banaszak-Holl, J., and Hines, M. A. (1996). Factors associated with nursing home staff turnover, *The Gerontologist*, 36(4), 512-517.

Bowers, B. J., Esmond, S., and Jacobson, N. (2003). Turnover reinterpreted: CNAs talk about why they leave, *Journal of Gerontological Nursing*, 29(3), 36-43.

Dawson, S. L., and Surpin, R. (2000). *The Home Health Aide: Scarce resource in a competitive marketplace*. Accessed August 18, 2007, at http://www.paraprofessional.org/publications/HHA_scarce_resource.htm.

Dawson, S. L., and Surpin, R. (2001). *Direct-care health workers: The unnecessary crisis in long-term care.* Aspen, Colorado: Aspen Institute.

Dresser, L., Lange, D., and Sirkus, A. (1999). *Improving retention of front-line caregivers in Dane county.* Madison, Wisconsin: Center on Wisconsin Strategy.

Head, F., Reiman, A., and Thies-Sprinthall, L. (1992). The reality of mentoring: Complexity in its process and function. In T. M. Bey and C.T. Holmes (Eds.), *Mentoring: Contemporary Principles and Issues*, (pp. 5-24). Reston, VA.: Association of Teacher Educators.

Iowa Caregivers Association (2000). Certified Nursing Assistant recruitment and retention project "Final report summary." December.

Knox, P. L., and McGovern, T. L. Mentoring women in academia. *Teaching of Psychology*, 15(1), 39-41.

Sager, M. (2002). Wisconsin Alzheimer's Institute. Long-term care symposium, Madison, Wisconsin. November.

Stone, F. M. (1999). Coaching, *Counseling and Mentoring: How to Choose & Use the Right Technique to Boost Employee Performance*. New York: American Management Association.

Wilner, M. A. and Wyatt, A. (1998). *Paraprofessionals on the front-lines: Improving their jobs, improving the quality of long-term care.* AARP Long-term Care Initiative, Executive Summary, September 10-11.

Avoiding Turnover

✔ Provide career advancement opportunities

✔ Show respect

✔ Consider permanent and predictable assignments

✔ Support worker autonomy and involvement in decision-making

✔ Support reasonable workloads

✔ Provide sufficient training and coaching

✔ Consider pay scales

✔ Consider employee benefits

Why Use Mentoring?

- Faster learning curves

- Increased communication of organizational values

- Reduced turnover at a time when new recruits may be hard to find

- Increased loyalty

- Improved one-on-one communication

- Sense of team within the work group

- Increased employee productivity

- More time for yourself

- Additional corporate information

- Creation of an innovative environment

- Allies for the future

Why Become a Mentor?

- Sense of accomplishment

- Sense of value

- Respect

- Develop leadership abilities

- Build relationships

- Potential to impact greater good

VII. Preparing for Change

A. Introducing Change in Your Facility

As an initial step to implementing change in your facility, it is important to create a general awareness about what the key philosophy is and why you have decided to embark on the changes. Based on conversations with many care staff and managers involved in change, this initial step is not always done as carefully as it could be. Reasons for this seem to include lack of clarity on the part of managers about just what the philosophy and changes are and inadequate planning for facility-wide inclusion in the startup process. This has important consequences. When there is insufficient awareness about the program, staff may be left wondering what the new initiative is all about, or worse, not knowing about it at all. Being clear that there is a commitment from the top of the organization, and that the program is neither short-term nor confined to isolated areas of the organization, is necessary for staff in the organization to take change seriously. Unless this is done carefully, there is a risk that most staff will see the program as "someone else's concern" or "just a passing fad."

B. Anticipating Questions from Staff

Successful implementation seems to be dependent on creating a facility-wide belief that organizational change is everyone's concern and that, importantly, there is a role for everyone to play in its implementation. Promoting the belief that everyone has a role to play relies on a clear understanding of just what those roles are. It is crucial for the facility Leadership Team (LT) to have a clear understanding of these roles and to be able to describe them in a way that staff, across the organization, can see themselves in the program. Questions from staff that the LT can expect and must be prepared to respond to include:

- What exactly are we trying to achieve?

- What is wrong with the way we are currently doing things?

- Does this mean I will have additional responsibilities?

- What are the systems that will be used to communicate as the program is implemented?

- What exactly will be different for me?

- Will this ultimately make the care we provide here better? If so, how?

- Will this affect my relationships with coworkers? If so, how?

- What if I don't have the skills or knowledge to do this?

- Will I relate differently to those above and below me in the organization? If so, in what ways?

- Will I or others be held accountable? If so, how?

These are questions that the LT must think carefully about and be prepared to discuss as the changes are initiated. It is assumed that the LT will engage in considerable discussion about these questions before presenting the changes to the organization. It is not necessary that the LT be able to answer each of these questions for every worker in great detail, particularly in the early phase of introducing commitment to change. However, it is vital that these questions be addressed and considered and that the LT understands that, eventually, these questions need to be addressed for all workers in the organization. Otherwise, organizational change will be seen as something "extra" to do, something that is added to—rather than integrated into—daily work. When change is viewed by facility staff, and especially direct-care workers, as something that is "added on," it has little chance of being successfully implemented or sustained.

C. Specific Strategies to Introduce Changes

Some strategies that can be used for introducing new philosophies and changes include:

Public discussions and educational session about the need for changes in care delivery and hoped-for outcomes. Discussions must be held at multiple times and in multiple places to be effective. This means all three shifts, each unit and department, resident and family councils, and any formal gatherings of staff, residents, and family. It might also be helpful to include physicians, medical directors, and nurse practitioners who attend residents in your nursing home. Physicians and nurse practitioners can be an important source of information regarding the impact of implementation on resident outcomes. They can also provide insight into the quality and comprehensiveness of reports and documentation on resident conditions, which should be positively influenced by the implementation of the changes.

Scheduled forums to discuss expected changes in staff roles and relationships. Such forums could be used to make expectations clear, while also allowing staff to ask questions and make suggestions about the evolution of their roles. This will be slightly different in each organization and will likely evolve over time.

Regular reporting from the Leadership Team on findings from its ongoing organizational assessments. Success of implementation relies heavily on the accuracy of data about resident outcomes and staff work environment, the effective use of information about the organization, and how well the staff is able to use data about resident care outcomes. It is important to remember that the work of the LT must be integrated with the evolution of the organizational change. This means the LT's findings must be made available to staff, and the implications of its findings must be discussed, at a minimum, with those who will be using the information.

Examine the systems of communication used in the organization. Assess whether and how these systems will serve the implementation plan, and identify places where these systems need to be modified. In particular, this should include discussions about what information is needed, by whom, and when, so that systems are established that will automatically do what needs to be done (rather than relying on an individual staff to remember). Points at which information flow is blocked or tends to be delayed should be identified and addressed. It is helpful to create a checklist or information flow chart whenever long-established communication systems are being examined or altered.

Create a system to determine whether follow-through on each of the above areas is occurring. There is often a significant difference between perception and reality on how well goals are being achieved and how well staff are following through. This is true for both direct care and organizational practices. Objective accountability systems that provide actual evidence for degree of follow-through are extremely helpful to identify.

Can you identify clear and convincing evidence that what you perceive is occurring in your facility related to communication and follow-through actually is occurring? If you are able to do this, the likelihood of successfully implementing change in your facility increases significantly.

D. Prior to Engaging in Organizational Assessments

Undertaking change requires a careful organizational assessment to be clear about your starting point and create a reference point for later comparison. An organizational assessment will yield crucial information about how your organization works and what structures and processes might need to be altered to reduce frustration during implementation, maximizing your chances of success. Direct-care staff and management staff alike can quickly become impatient with the assessment component of change implementation. In short, there is a tendency to jump to solutions before accurately determining the nature of the problems and to base conclusions on superficial impressions that may or may not be supported by hard evidence. For this reason, a comprehensive assessment, led by the LT and requiring direct observation rather than relying on reporting of others, is suggested as a starting point for change implementation (this manual includes exercises designed to facilitate this process).

Undertaking major organizational change, implementing successfully, and transforming your organization will require your organization and its staff to work hard. Assessing items within your organization will require significant commitment on the part of the LT. Prior to conducting an organizational assessment, your LT members must be familiar with challenges associated with long-term care quality, particularly with regard to the following areas:

- **Ability of CNAs to participate in care planning.** Probably the most consistent research finding is that CNAs feel left out of care planning for the residents they care for. As with other issues already discussed, CNAs and other staff seem to have different views about what it means to "participate in care planning." Nurses often point to the important information that is brought to them by CNAs and how that information is important for care planning. This is viewed as "participation in care planning." CNAs on the other hand do not see this as adequate. Providing information for someone else to make a decision is not the same as being involved in the decision. This is an important distinction that, unfortunately, is often not appreciated by unit nurses and other managers.

A Practical Guide to Transformation

- **Questions for the LT to consider:** In addition to providing information to the nurses, how are the CNAs in your facility participating in the resident care planning process? Do they feel as if they are true participants? How do you know?

- **Effectiveness of communication across shifts.** Cross-shift communication is a challenge in almost every health care environment. In long-term care settings, lack of effective communication across shifts is a source of anxiety and frustration for families and residents and undermines carefully designed clinical interventions. Families and residents frequently report that important information about their loved one, as well as simple requests made to staff, are not transferred from one shift to the next. These "simple" things are often important quality-of-life issues for residents and family members. Vital information about clinical practice interventions frequently suffers the same fate, leading to interruptions and delays in care.

- **Questions for the LT to consider:** What is done to prevent such information from being lost? If information related to a family member or resident request or related to clinical practice change were given to someone on the staff and you tracked what happened to it for three days, what would you expect to find?

- **Care provider access to and use of data about unit level outcomes.** Staff are quite good at describing what has happened to a particular resident in a particular care area. However, most staff would not be able to say how their unit is doing overall or over time in any of several care areas. This would include an inability to describe trends over time on their unit in functional ability, continence, weight gain, or participation in activities. It is important to appreciate the distinction between understanding an individual resident and understanding the resident population on a unit.

  What happens to an individual resident can always be explained by particular circumstances, idiosyncrasies of one resident, or staffing problems that occur during a particular time. When confronted with data indicating a poor outcome for a particular resident, staff often see this situation as "unusual." They will often say (and believe) that the situation has been corrected or that it is so unusual as not to merit any corrective action. Not seeing the proverbial forest leads to inaction, while allowing the staff to maintain the belief that nothing needs to be done. For this reason, it is vital to provide staff with data about how their local environment (unit/shift/department) is doing and how the residents receiving care in that local area are faring. It is quite difficult to dismiss data that shows trends over time, that defies what may appear to be the case, and that cannot be explained away by unusual circumstances or residents.

- **Questions for the LT to consider:** Can staff on a selected unit tell you what trends have been over the last month? Last year? What about trends in weight loss for low-risk residents? What about depression without treatment? What about other care outcomes? Can they tell you how they compare to other units? To the United States as a whole?

- **Unit nurses' supervisory skills.** For 25 years, research in long-term care has suggested that the supervisory skills of the unit nurses are crucial determinants of CNA work life quality. Despite this, there has been little attention paid to this important area. While some nursing homes have attended to the development of supervisory skills in their RNs, most facilities have neither assessed nor promoted this

area of skill development. The collective wisdom of available research would suggest that this may be the single most important factor in frontline staff turnover.

- **Questions for the LT to consider:** What training have nurses in your facility had on supervision, delegation, collaboration, and leadership? How important do nurses think these skills are in the work life quality of CNAs? Do nurses in your facility enjoy supervising? Are they comfortable with it? Are they evaluated, in part, on their effectiveness as supervisors? Do they have mentors to help them develop these skills?

- **Link between actual work and staff development.** Frontline staff have identified their lack of preparation in several areas as a source of frustration and work stress. While in-service programs are often interesting and sometimes helpful, frontline staff often find little or no link between what they are learning and what they need to know to do their work. Sometimes this is as simple as making the link more explicit. Many times, it also involves assisting the frontline worker to develop new care approaches that would allow them to integrate the new learning. Changing approaches to care would, necessarily, involve others who also care for the same resident. Only with collaborative decision-making and a change in the way the group approaches care can new skills and knowledge be put to use. CNAs have identified the inability to use new skills and knowledge as a negative aspect of their work.

- **Questions for the LT to consider:** What happens on each unit or each department when a frontline worker—or other worker—returns from an in-service program? What, if anything, is done beyond information sharing? Are the implications for care delivery routinely discussed? What does the department head or supervisor do, explicitly, to promote the integration of new learning into the care or service? How successful has this been?

Many care quality and work life quality problems can be prevented. Unfortunately, the quality systems necessary to do this are often not in place. The questions above were provided in an effort to get LT members thinking about the quality systems that currently exist, or are lacking, in your facility. Interestingly, research continues to identify the same issues (like those above) as obstacles to quality in long-term care. The good news is that the apparent obstacles are largely limited to a set of issues that is well recognized. The bad news is that we have done little about these issues in the 30 years since they were first documented.

NOTE: Keep in mind that the majority of nursing homes do not have effective quality- improvement systems in place. Consequently, maintaining and sustaining quality- improvement initiatives becomes difficult, if not impossible. As in other health care settings, failure to achieve or sustain desired changes in care practice is often seen as a problem with individual care providers (they forget what they are told; they don't believe that it's important; they become distracted and fail to follow through; they leave and new workers must be taught). The usual remedy, therefore, is to educate and train the staff. Repeatedly, this approach effectively prevents many organizations from making the system-level changes that would lead to improved outcomes. An important departure from this is the appearance of nursing home change initiatives.

Strategies to Introduce Change

- Public discussions and educational sessions about the need for changes in care delivery and hopes for outcomes

- Scheduled forums to discuss expected changes in staff roles and relationships

- Regular reporting from the LT on findings from its ongoing organizational assessments

- Examination of the systems of communication used in the organization

- Creation of a system to determine whether follow-through on each of the above areas is actually occurring

VIII. Conducting Organizational Assessments

Introduction

It is recommended that the LT conduct a number of organizational assessments intended to address overall quality of care and how care practices enhance resident quality of life, overall quality of work life for staff, and the basic clinical knowledge of staff. A number of questions have already been put forth for the LTs consideration (see Preparation Activities, Section IV), to encourage team members to think about how systems and processes in their facility support these important quality areas.

To further explore how your organization is addressing quality assurance and quality improvement, LT members are encouraged to discuss the following questions early in their work, as a group, in an effort to assess their own general understanding of the facility:

- What sort of objective accountability do units have to the next level of management?

- Is there a way to know how each shift/unit/department is doing in a clinical area, or is there only facility-level data available?

- Are there quality-improvement activities occurring in each department? What are these, what have they revealed, and what has been done about them?

- What generally happens to areas identified for quality improvement? How well and how long are corrective interventions usually sustained? Why have they succeeded or failed?

- Are departments or units expected to honor resident preferences? How is this expectation made clear to staff? What happens when resident preferences are not honored?

- How do educational or staff development programs address the needs of frontline staff? What involvement do these staff have in selection of topics? How do unit routines assist staff to use what they have learned?

- Identify three staff development efforts that have come directly out of practice problem areas identified by either staff, families, or the MDS database (or one from each).

- How many of your management staff have participated in trainings related to conflict resolution, coaching and mentoring, delegation, and other areas? Name two ways this training has been utilized in your facility.

- What do present CNAs, as well as those who have left the facility recently, think about the work environment? Do you have systems in place to find this out? What specifically has been done with the information?

- Do you have mechanisms to elicit resident feedback, and what has been done with the feedback? Who has access to this information?

As you review the above questions, ask yourself: Do I know the answers to these? Do I know without looking them up or asking someone else? Does anyone know? What could be done to increase the effectiveness of these processes? If you discover you are unable to respond to these questions, do you know whom in your facility to ask? Do you know how to find the answer? If you don't know the answer and don't know who has the answer, this raises important questions about how well your organization is set up to respond to best-practice changes that come with change implementation. It suggests that systems will need to be created so that, in the future, you and many of your employees will know the answers to questions like these.

These are some areas you may wish to assess:

1. Clinical care quality

2. Resident quality of life

3. Workplace quality

4. Clinical knowledge

Assessment packets for each of these four areas are provided below. Accompanying worksheets (Attachment 2) and reading guides (Attachment 1) can be found as companions with this guide. Keep in mind that conducting assessments in any of these areas provides an opportunity to formally—and organizationally—connect management staff on the LT with CT activities related to implementation.

A. How the Organizational Assessment Packets Are Formatted

The following sections provide the LT with the tools to begin an organizational assessment. For each of the four assessment areas (clinical care quality, resident quality of life, workplace quality, and basic clinical knowledge) there are worksheets, a series of questions for consideration, and some recommendations provided in this manual. It is recommended that LT members approach each of the four assessment areas in two distinct phases: Phase I and Phase II. These are described in detail below and are suggested as a means to organize and guide assessment work in the first three assessment areas and to provide an opportunity for management staff on the LT, and others, to take a lead role in collecting and analyzing data related to care quality and in teaching CT members how to do this. The fourth assessment packet, Assessing Basic Clinical Knowledge (C.6), is slightly different in structure.

Phase I:

Guided by worksheets found in the Appendices, LT members are instructed to locate specific sources of data and answer specific questions (included on each worksheet) about the data source. It is important that during Phase I, LT members take note of how difficult or easy the data source information is to obtain. Think about whether staff in your organization will need to access these data, and whether they will be able to do so quickly and easily. If not, what needs to be done in your organization to make these data more accessible and usable? The LT, either on its own or in collaboration with the CT, has two key tasks to keep in mind as part of Phase I:

First, make sure the data needed by the CT are collected and analyzed regularly and are easily accessible to staff; second, act as a resource to the CT by explaining the data and relevant data sources to each CT (that is, this is what this data means, this is where it's kept, this is how it's collected).

Addressing these two tasks up front will make implementation much more enjoyable by ensuring that key data sources are accessible to staff and ready to use (prior to staff trying to use the data during planning). This will prevent needless confusion and frustration for staff trying to make data-based decisions.

What if your facility does not have a database or data source noted on a worksheet? If you do not have a database for this information, it is important for the LT to take the lead in figuring out how to collect, analyze, and make the data available. Experience suggests that a CT without access to relevant data will not make the wisest decisions about problem areas to focus on or strategies to discern whether or not an implementation plan has been successful.

Phase II:

Three of the four assessment packets include a Phase II section with suggested activities that LT members can engage in to learn more about their organization and what needs to be done to prepare for change implementation. These exercises are designed primarily for administrators and management staff to become more familiar with: 1) the frontline staff and their work environment; and 2) with the views of residents and staff that are not generally shared with them. These exercises are intended to guide LT members to see for themselves—rather than relying on others to assess—the state of care and services being provided in the facility. While at first glance, these exercises may seem wide-ranging or too general to be helpful, these suggested activities will not only provide you with firsthand knowledge about your facility, but will also make LT members visible to facility staff. Demonstrating the LT's commitment to changing practice is critically important. In fact, many staff who have engaged in these sorts of exercises have reported learning a great deal of new and surprising information about their facility and staff and actually enjoyed the process as well.

It is not expected that all of the exercises described will be completed as part of the organizational assessment processes. The exercises are intended as suggestions to help you address some of the common problem areas that have been identified in many facilities implementing organizational change. Our recommendation, however, is that every LT member participate in these exercises, sharing the results of their efforts with the rest of the LT at weekly meetings.

A Practical Guide to Transformation

Important Phase II Caveat:

In almost every nursing home we have visited, administrators and managers claim to be intimately familiar with the experiences, views, frustrations, and joys of frontline workers. In these same facilities, we heard repeatedly from frontline workers how frustrated and disappointed they were that they were not listened to, and that organizational policies continued to miss what these staff think is most important about resident care. The exercises proposed under Phase II in each assessment packet are designed to bring you closer to the experiences of your staff and residents. Much of the success of these exercises will depend on how you chose to carry out these exercises and whether you take this as an opportunity to learn more about your organization, your staff, and residents, or whether you see these exercises as not very useful. Whatever you decide will be clearly conveyed to the staff you interact with.

B. Clinical Care Quality Assessment

Introduction

Fieldwork opportunities with culture-change facilities revealed that team members continue to experience difficulties related to accessing, understanding, and utilizing clinical data. It also suggests that some organizations have difficulty seeing the complete picture. That is, some nursing home staff tend to focus on individual residents in their care area assessments, missing the bigger picture of how a care area is approached throughout the facility and how well systems have been developed to maintain organization-wide quality practices for each clinical care area.

Phase I

Review the "Assessing the Clinical Quality of Care" worksheet in Attachment 2. The worksheet is constructed to provide you with both an overview of all the data sources available to a CT to assess clinical quality and guiding questions for use in assessing whether these data sources are being used, and, if so, how effectively, how consistently, and by whom.

Phase II: Unit Exercises to Assess the Quality of Clinical Care

In consultation with the staff who work most closely with the clinical quality data sources noted on the worksheet (MDS, etc.), select a clinical focus area to investigate. Select a clinical area that the data suggest may be a problem in your organization (for example, high levels of incontinence or poor follow-through on turning and repositioning).

The clinical focus area (care problem) you have chosen to investigate is: _____.

Go to two or three units in your facility and explain to staff you are investigating the above care problem. Sit down with staff from that unit and talk about how this problem is being approached. Below, you have been provided with Suggested General Questions for Use with Unit Staff to assist you with exploring any clinical problem area including the one you have noted above. You have also been provided specific follow-up questions for use with the clinical care problem of high incontinence, in an effort to illustrate the nature of information LT members are expected to collect from unit staff for a specific care focus area like incontinence.

Suggested General Questions for Use with Unit Staff

• Is there a perception among the staff that a problem exists?

• Is anything being done to address the problem? If so, what?

• Is the problem defined only at the level of the individual resident?

• Can staff define the problem as a system problem?

• Is the problem being monitored?

• What sort of success have they had addressing this problem?

• What accountability systems are in place to determine whether or not practice plans in this clinical area are being implemented or achieved?

• What assistance have they had in dealing with the problem?

Suggested Follow-Up Questions for Specific Care Problem: High levels of incontinence

If incontinence levels are high, what do staff say about the incidence of incontinence on their unit?

• Do staff think that anything should be changed to address the issue?

• Is there any leadership in addressing the issue?

• Is there a unit plan in place to assess and address the plan, or is it just focused on individual residents?

• Do staff have adequate knowledge about what the plan is and why the plan was developed?

• Can staff tell you how well they have been following the plan?

• If there are barriers to implementation, have they been addressed effectively?

• If the plan was abandoned, what were the precipitating events and how do staff feel about it?

• Do staff have suggestions for what might be tried next?

• Have staff assessed the situation or have they just seized the first idea to come along?

• Should the in-service educator or other staff be involved in resolving the problem?

• Do current documentation systems need to be developed?

• Does the unit nurse know of follow-through on the plans: Worker-to-worker? Shift-to-shift? Across departments?

• Who are the staff involved in making the plans work? What communication system is used to communicate across all of these staff? Do these staff hold one another accountable? If so, how?

One of the common challenges you can anticipate facing is that staff generally focus on solving clinical problems for individual residents. When there is inadequate assessment or follow-through, the solution to this is often focused on fixing a particular problem for a particular resident. This results in very little transfer of learning to new situations. It is helpful to demonstrate this transfer of learning by asking staff explicitly how information and problem solving related to one resident can be used to address a clinical area for the entire unit or facility. Staff will often benefit from discussion that includes carefully walking through what this means for a population of residents with similar care needs. This will help everyone think more about creating systems to improve care. The following case example illustrates this.

Case Example

A resident with continuing skin breakdown has been placed on a high-vigilance program. Each day someone inspects his skin closely. On days when he has a bath, a thorough skin assessment is done. When he is dressed in the morning and undressed at night, his skin is carefully inspected. In the meantime, two more residents are discovered to have a stage II pressure ulcer. They, in turn, are placed on a high-vigilance program.

The CT examined this situation, and noted that pressure ulcers are sometimes not discovered until they reach a stage II. The CT identified a goal of developing a system that would make discovery of pressure ulcers much more likely to occur at stage I. A plan was developed for the entire facility. First, all staff would attend an in-service program on pressure ulcer prevention. Second, a simple form would be developed for pressure ulcer documentation. They decided to use the outline of a human body, front and back, where an X would be placed to indicate the presence of a pressure ulcer and to carefully track progression.

The team spent one meeting describing all the barriers they could anticipate to successful implementation. These included:

- Poor attendance at the in-service program

- High turnover

- Inconsistent staff giving baths

- Lack of involvement from non-nursing staff

- Forgetting to bring the forms into the tub room

- Running out of forms

- Failure to transfer the information into the resident care plan

Each of these barriers was addressed by the CT, and strategies to deal with them were included in the final plan. One CNA on each unit was sought to be in charge of ensuring that forms were always where they could be used. On some units, the same CNA was designated to ensure that the information was transferred to the resident plan of care, and that frequent follow-up was used to track the progression of the pressure ulcer. On other units a second CNA volunteered to do this. A third staff member was selected to evaluate the new program at the end of one week, three weeks, and two months. The CT developed

a standard, but brief, form for each of these CNAs to use in the evaluation. At the same time, a group of therapy and dietary staff was convened to identify what their department staff could do to contribute to the prevention of pressure ulcers. Their recommendations were implemented, and the plan was added to the evaluation. Nurses on each unit were recruited to present the plan to their staff and to encourage questions, discussions, and additional ideas.

C. Resident Quality of Life Assessment

Introduction

Quality of life (QOL) for residents has been addressed in culture-change models through improving care outcomes or focusing on resident participation in care planning and decision-making as a formal component to the culture-change initiative. For example, in a model that focuses on improving care outcomes, increasing resident functioning, increasing continence, and decreasing pain are all considered important quality of life issues. Residents are more likely to go out with family when they are continent. Residents are more mobile and able to engage in activities when they are functioning at higher levels.

One challenge to collecting data on resident quality of life is the reluctance of many residents to appear as though they are making complaints. Another obstacle is that residents (and staff) often come to accept the situations that they live and work in. Residents quickly stop expecting to have interesting lives, to maintain relationships, or to chose the activities they will engage in during the day. Staff often see only the resident clinical outcomes and not the quality of life that might be possible. Once this occurs, it is very difficult to even think about how quality of life can be improved. At the very least, it is important to find out about resident preferences, activities they once enjoyed, and things they would enjoy doing now. At the very least, quality of life requires considerable resident input into determining daily routines, schedules, and activities.

It is important to remember that resident expectations for quality of life may be artificially low. They may have developed a sense of futility, which in turn, greatly decreases expectations for quality of life.

Phase I

Attachment 2 includes the "Assessing Resident Quality of Life" worksheet. It provides a beginning point for developing a quality of life database and a structure for improving resident quality of life. The LT will need to look at whether the data sources necessary to do this work are already being maintained. If these data have been collected, it is likely they are not systematically collated and reviewed as a set of QOL indicators. A system will need to be established that determines:

- Which data are currently available;

- What other data are desirable, but not currently available;

- A mechanism to organize and interpret these multiple databases;

- A process to review the current databases to see if alternatives or additions would be useful;

- How residents and family can participate in the development and use of these databases; and

- What currently available data already reveal.

The worksheet in Attachment 2 contains some ideas for data sources that can be used to assess and promote resident quality of life.

Phase II: Unit Exercises for Assessing Resident Quality of Life

In most facilities, there will not be a system in place to systematically collect data from residents about the quality of their lives, their preferences, and what might be done to improve overall quality of their daily lives. It is often difficult to elicit uncensored input from residents about the quality of their lives. The following recommendations are based on research with nursing home residents and other vulnerable groups. They should assist you in developing a plan for collecting these data from residents in your facility.

Collecting Quality-of-Life Data From Residents

The best way to promote honest feedback from residents about their experiences in your facility is to eliminate the following:

Resident and Family Fear of Retribution. This fear should not be minimized, especially as you go about collecting data on resident perceptions of care. Even in situations where caregivers are seen as kind and caring, there is often some fear about retribution if family or residents are seen as ungrateful or complainers. Families, in particular, express concern that staff may even, unwittingly, neglect or be impatient with residents whose families have complained. Even though staff often have difficulty accepting this, the majority of family members are concerned about staff retribution and are quite careful about what they say.

Hurting the Feelings of the Staff. Residents, in particular, are generally quite concerned about how their comments will be heard by their direct care providers. Despite assurances to the contrary, residents often fear that comments they make could be used against their caregivers, that staff will be reprimanded, treated badly, or even fired if residents express displeasure with some aspect of their work. Acknowledging short staffing, lack of resources for the staff, or inadequate training is much more acceptable to residents than is a negative comment about a particular caregiver's performance. In addition, when responding to questions about care, if the relationship with a particular staff person is important to the resident, he or she will generally focus on the quality of the relationship instead of the quality of the care they receive.

Resident Fear of Being Seen as Ungrateful. Many residents are reluctant to complain for fear of being perceived (by self or others) as ungrateful for the care they receive. This is particularly the case when residents see staff working hard, believe the facility or shift is short-staffed, or see the caregivers as vulnerable or overworked. Many residents prefer to focus on what is done well, avoiding conversations about what is not done well or not done at all.

Given the preceding caveats, quality-of-life data must be very carefully and thoughtfully collected. The following recommendations will help you to collect these data in your facility.

Recommendations for Collecting Quality-of-Life Data from Residents

Resident and Family Interviews: It is a good idea to try several of the following strategies. No single method will work in all instances. It might be a good idea to develop a questionnaire with several questions, using each of the following strategies.

Try a vague, general question. This allows residents to name the issues that are important to them, rather than responding to what someone else has identified as important:

- Can you tell me what it's like to live here?

- Can you tell me about a typical day here?

Craft a few questions that depersonalize the response. That is, ask a question that does not require the resident to comment about *this* place, but rather asks about nursing homes in general:

- If you had a friend who was looking for a nursing home, what advice would you give? What should he or she look for in a nursing home?

- If you were building or planning a nursing home, what would it be like? What would a typical day be like for residents?

- If you had the job of nursing home inspector, what would you look for in the homes you inspected? What sorts of things might suggest that a place is likely to be very good or not very good? Can you tell this with a quick inspection, or is it necessary to look more deeply? What are some of the superficial things to look for? How about some of the deeper things to look for?

Ask directly what the resident would change. What would a resident do if he or she could change anything about the organization, the activities, the staff, the routines, the food, the care, or life in general. Managers and administrators often avoid these questions, fearing that residents will ask for things that are totally unreasonable. However, experience with other programs (including other nursing home culture-change initiatives) suggests that this is not the case. Residents generally ask for very reasonable things that could be provided quite easily and that would make a real difference in the quality of their lives. Some examples include:

- A newspaper in the morning;

- A beer on Saturday night;

- A dinner table companion who can carry on a conversation;

- A later time to get out of bed in the morning;

- A second cup of coffee;

- A cold glass of water every afternoon;

- A chance to attend church services on Sunday morning; and

- A particular type of music.

You might consider combining these approaches by using a combination of very open and very structured questions. It is also important to be sure that the person asking the questions is not a direct caregiver. It is ideal if the person collecting the data is seen to be neutral, but with enough authority to actually use the information to improve resident quality of life. It is also important that the resident be told exactly who will have access to the data, and what will be done with it. It is quite important to follow up with residents and families to let them know what has been learned and what will be done in response. Again, this latter step is often neglected. Sometimes it's because administrators and managers are reluctant to share "negative" information with other residents, family members, or staff. Often there is a fear that the comments of one resident might "get something started," leading to more negative perceptions and comments.

In reality, what usually occurs is nothing like this. Residents and families are often relieved to hear that the staff is interested in learning about things that residents are concerned about and using resident insights to improve care. As well, the feedback is often quite similar to what others are already thinking but have been unwilling to share. In fact, in some instances, residents and family members object to negative comments by others, offering much more positive feedback in response. Often, some combination of these things will occur. Whatever the strategy for sharing comments of residents and family members with staff and other residents, openly acknowledging problems generally leads to greater improvements than does hiding or avoiding discussions about resident perceptions.

Some additional things to keep in mind:

- Ask residents about their experiences.

- Avoid questions that ask residents to directly comment on the adequacy of care.

- Be careful not to ask residents to judge their care providers.

- Consider asking someone who knows the resident well, who has established a close relationship with the resident, to ask the resident for feedback.

- Consider asking a family member for assistance, but make sure the family member is asking the resident for feedback, rather than providing their own opinion of what the resident thinks.

- Consider asking unit staff who care for a resident about the resident. You could ask staff:

  - Are there things this resident has asked for?
  - Are there things this resident has asked for that over time he or she has stopped asking for?
  - Think back over your time caring for this resident. When the resident asks for something, how do you respond? Do you explain why something the resident asks for can or can't be provided? Do you tell the resident you will do something about what they've asked for? How often have you not been able to follow through?
  - Do you know of things the resident would like, or how the resident would like things done, that are different than the way things are?

- Explore the resident care plan: Assess the balance of information related to quality of care versus resident quality of life. For example, if a resident reports a preference about developing relationships with other residents or indicates a favorite activity (reading, writing letters, hobbies), how does the resident care plan in place reflect supporting the resident's ability to do these things?

The team overseeing resident quality of life (the LT, a CT, or some combination of these) can look at both quality of care and quality of life. The team can work directly with other teams, building on the work of the other CTs or choose to work on quality-of-life issues that are not directly related to care practices.

The worksheet in Attachment 2 has identified several sources of data for determining resident quality of life. While most facilities will have some of these data and will use some of these data sources, most organizations do not have a systematic way to use them. The questions listed in the second column are designed to assist you in putting a useful system together.

Note: Family satisfaction and resident satisfaction surveys are useful ways to collect data on quality of life. However, it is important to keep in mind that many of these surveys ask residents to judge the staff who provide their care. It is usual for residents to rate their care as high quality no matter what they really think. The caveat here is not to rely too heavily on these surveys and not to think everything is fine because a resident survey revealed a high level of satisfaction.

Also, letters from families are not a common source of data for quality-improvement initiatives. In fact, they are not generally used in any systematic way. Instead, the issue being written about is usually dealt with only as it relates to a single resident. This is an important missed opportunity for quality improvement and for improving resident quality of life. In combination, family letters, satisfaction surveys, and interviews with residents and family members can provide a valuable source of information for system-level quality-improvement efforts.

D. Workplace Environment Assessment

Introduction
Many culture-change models have their greatest impact on the quality of work experiences for staff. For example, in many Wellspring homes, turnover rates have dropped, and many workers have expressed real excitement over their work, enthusiasm for new roles, and a new appreciation for the importance of their work. The specific (and common) problems in long-term care settings that change has had a positive effect on include:

- Frontline workers' beliefs that they are not respected by the managers of the organization;

- CNAs' beliefs that they are not respected by the unit nurses;

- Nurses' and department heads' lack of interest or lack of skill in supervising and mentoring frontline workers;

A Practical Guide to Transformation

- CNAs' inability to participate in work schedules, work design, care planning, and evaluation for residents;

- Lack of advancement opportunity for staff at many levels; and

- Inability of staff to use what they learn in educational programs.

Phase I

The "Assessing the Quality of the Work Environment" worksheet provided in Attachment 2 is laid out exactly as the other assessment worksheets, providing a starting place for assessing the quality of your work environment. It reflects several important sources of data that can tell you something about the workplace. Some organizations may find that the data sources reflected in Attachment 2 are not systematically collected. If that is the case in your organization, the place to start is creating the systems that will support the collection and review of these data.

Below are a few thoughts and recommendations specific to workplace environment data sources identified in Attachment 2:

Exit interviews are a relatively uncommon source of data in most nursing homes. However, knowing why employees are leaving is vital to any organization that wishes to maintain a stable workforce. It is often wise to hire someone to conduct exit interviews who is not on the staff or, at least, someone on the staff who is seen as relatively neutral or sympathetic. Staff participating in exit interviews also need reassurance that their comments will not be shared with someone who could negatively affect their ability to find work in the future. Exit interviews often dismissed are as unimportant. Administrators often say they don't do them because they already know why staff are leaving. In practice, this has not been borne out. Organizations often learn a great deal about the work environment through carefully conducted exit interviews.

Performance reviews of peers, as well as of the staff being supervised by the person being evaluated, is another source of information that is not often utilized in nursing home settings. While performance evaluation data is standard in many other industries, nursing homes rarely engage in evaluations such as these. As with other types of data, collecting this data must be done carefully. Care should be taken to maximize the usefulness of the evaluations while minimizing any negative impact that could result. Questions should be specific, relevant to the work, and easy to respond to. For example, questions that are vague and highly judgmental will not provide useful information, and worse, can lead to hurt, blame, and generally bad feelings among staff. Consider the distinct wording, for example, of the following common evaluation criteria:

- "Creates opportunities for me to put new learning to use" is preferable to "Is helpful or supportive."

- "Provides the level of feedback that I need" is preferable to "Effectively provides feedback."

While these different approaches may seem minor, it is much more effective to tell a supervisor that her or his staff feel they need more feedback than they are getting rather than to tell the supervisor that she or he does not give feedback effectively. If constructed well, evaluation criteria and survey questions such as these can provide quite detailed information on what staff would like from their supervisors.

Staff advancement programs and how well they are working can also tell you a lot about your organization and what it might be like to work there. Gaining a new title that has little or no practical impact is mostly frustrating for staff. Therefore, it is important to discover how real your staff advancement programs are and whether they lead to personal growth.

Satisfaction surveys come with the same caveat noted above (concerning resident satisfaction surveys), and it is worth repeating here: Satisfaction surveys often suggest a more positive view than is actually the case. On the other hand, anonymous staff satisfaction surveys may tell you quite a bit about how staff are feeling.

Staff focus groups, similarly, are a valuable source of information about the workplace. Focus groups must be done carefully and by someone who is experienced with doing this sort of thing. Without such expertise, focus groups can turn into unproductive gripe sessions, can leave some staff vulnerable to attacks from other staff, or can generate rumors that create problems in the organization. Done well, they can generate valuable insights into the work environment and can assist the organization to take advantage of good ideas that staff members may have about improving the workplace.

In addition to these suggestions, a guide[2] has been developed by the Institute for the Future of Aging Services (IFAS) at the American Association of Homes and Services for the Aging (AAHSA). The guide is intended to help long-term care organizations use tools effectively and appropriately to increase their understanding of the direct-care workforce in their organizations. The introduction to the guide notes:

> "Research has shown that employees' feelings about certain aspects of their jobs often affect their commitment, their overall job satisfaction, and the likelihood that they'll remain with their employer."[3]

The guide is available for anyone to use and can be accessed at: ***http://aspe.hhs.gov/daltcp/reports/ dcwguide.htm***.

Phase II: Unit Level Exercises for Assessing Workplace Environment
The unit-level exercises for assessing the quality of your workplace have been organized around a number of elements (for example, communication flow, decision-making processes, and leadership and supervision). Together, they make up the workplace environment. The exercises were designed primarily for the LT to learn about how staff experience the organization, and what it is like to be an employee there. These exercises are suggestions for strategies you might use to take a closer look at how your organization operates and how that influences the work environment. As with the other unit-level exercises

---

[2] Measuring Long-Term Care Work: A Guide to Selected Instruments to Examine Direct Care Worker Experience and Outcome, April 2005; Institute for the Future of Aging Services: Washington, DC.

[3] Measuring Long-Term Care Work: A Guide to Selected Instruments to Examine Direct Care Worker Experience and Outcomes, April 2005; Institute for the Future of Aging Services: Washington, DC, p. 1.

A Practical Guide to Transformation

provided, there are many other ways to approach these as well. Whatever strategies you choose to use, it is important for the LT to collect the data on its own and to remain as close as possible to the processes it is exploring (don't rely on others to assess for you).

Assessing Communication Flow

Understanding how communication flows within units, across units, across shifts, and across departments is vital to any practice changes. You might explore what mechanism nurses use to share information across shifts. It is easy to make unwarranted assumptions about the nature or effectiveness of communications. When practice change plans are based on these assumptions, they are very likely to fail.

- Pick a unit, listen to report, review the charts of three residents on that unit, and talk to the residents and/or their families. Identify something about the residents that you think needs to be carried through to all staff. Provide this information to a staff member, and see whether it shows up during report.

  1. Does the information stay with the resident and the resident plan of care? Or is it lost along the way?
  2. How are decisions made about what information is important enough to pass on?
  3. What communication strategies are used that are not working well?
  4. What seems to prevent these strategies from working well? (Avoid personalizing this, such as, "It's Mary's fault.") Look at systems that promote communication and how they can be enhanced.

Assessing Decision-Making Processes

- Identify a decision that the director of nursing or a department head has recently made. Find something that directly affects care practices (for example, everyone out of bed by 9 a.m.; all residents who are able, will walk to the dining room, etc.). Pick a couple of units, and talk with staff to find out what's been done since the decision was made.

  1. Looking back, can you think of people who should have been involved in that decision and weren't? Are there things that could have been anticipated that weren't?
  2. Identify two or three aspects of the decision-making and communication process that could have been done more effectively. (Involve the director of nursing or department head in this process.) What prevented this from being more effective? Is it likely that decision-making or communication will be any different in the future? Will differences result from this experience?

- Ask one of the department directors to identify a recent decision that affects the department in general, as opposed to a single worker.

  1. What was the decision in response to (for example, a family complaint, a citation on a survey, a need for new equipment, or other)?
  2. What was the problem being addressed?
  3. What leads you to believe the problem will not recur?
  4. What information was needed to make the decision?
  5. Who participated in the decision-making, and how did each person participate?
  6. Does the solution rely on people remembering, or is there a system change to support the new way of doing things? How exactly will the system support the desired change?

7. Describe in detail how this decision directly affected the daily routines of two workers.
8. Looking over your responses to questions one through seven, were you surprised by any aspect of this assessment process?

Assessing Support for Staff Development

- Locate three staff in your organization who have participated in a continuing education program sometime during the past year. Ask them the following questions:

  1. What was their reason for attending the program (personal interest, requirement, or other)?
  2. Was the program one they would have chosen if they could choose anything to attend?
  3. Did they return to the organization with any ideas about new ways to provide care?
  4. Were they able to implement new care practices? If not, what prevented this? If yes, what did they find helpful?
  5. Have they been able to follow up with other educational programs? What specifically? Have follow-up programs built on the previous programs?
  6. Have these staff shared this program and what they learned with anyone else in the organization? What was the consequence? What else could have been done?

- Ask unit staff: Can you share two examples of how your immediate supervisor demonstrates support for you and your work, the promotion of your skills, or your education? If the staff member can't think of anything, report that.

Assessing Supervisory and Leadership Skills

- Investigate the following: Do all nurses on staff have skills or formal training in mentoring, delegation, and supervision of frontline staff? Are these skills assessed as part of nurse performance reviews? If so, what evidence is collected to make this assessment? If not, what might be done to make this

- Think about your own style as a leader. What development do you need? Ask two peers what areas they would suggest you focus on. (Some organizations bring in consultants for this. If resources are available, it is quite helpful to bring in someone who is an experienced management coach.)

- Either individually or within the LT, name three reasons why you think a CNA would want to work here or continue working here. Be sure that identify things related to the environment rather than to characteristics of the CNAs. For example, you might believe that CNAs work here because they feel like they are part of a team or that they have opportunities to learn or that their coworkers are good friends. Find two CNAs who you believe will speak openly. Ask them why they continue to work here. Try to find a CNA who has been with the organization for a long time and someone who is newer. Ask them to comment on what you have identified as reasons to stay.

- Either individually or within the LT, try to identify two reasons why you think a nurse and someone from another department would want to work here or continue working here. Ask these staff members directly why they continue to work here and whether your assumptions match their perspectives. Following your conversation with each of these individuals:

  - Describe something you plan to do that will alter working conditions in your facility, in response to what you have learned.

- Meet with the LT and compare what you have each learned and whether there are some common themes. What organizational changes are in order, and how will you evaluate the effectiveness of the changes?

Note: It is not adequate for anyone on the LT to delegate these exercises or to simply accept someone else's view. It is crucial that each member of the LT talk directly with staff at every level to collect the information needed. Each team member must find his or her own evidence for any conclusions. This evidence should include specific details on how systems and individuals operate, what works and what doesn't work, and who (focus on position rather than person) is following through and who is not.

Assessing Accountability

- Pick two departments. What has each department head done to promote the following:

- Quality of work life and workplace for the staff. Find specific examples in each department. Examine how the department heads have identified workplace problems, how they have thought about the nature of the problems, what information they have collected to learn more about the problems, what has been done to address the problems, and how the effectiveness of the solutions have been evaluated.

- In each department, look for any examples of how systems have been altered in response to the problems identified. Look at whether system problems are addressed as individual staff problems.

- Look at how these problems and the solutions arrived at have been communicated across shifts and with other departments.

- In each of the same departments, collect information from both department heads and staff regarding how performance is evaluated and how staff are rewarded. Do rewards seem to be related to performance? Are staff clear about what is expected of them?

- Do staff who are promoted to supervisory positions receive the supervisory training they need?

- In each of these departments, what happens when workers are not performing adequately? Is substandard work or performance accepted or ignored? What are the consequences of inadequate performance? Be specific.

As the LT meets to discuss what each member has discovered, it is important to identify what organizational issues the LT will focus on and to think about how the implementation of change will be affected by the organizational context. Are there themes across the organization? Can you think of any organization-wide training or staff development programs that need to be supported? For example, what have you learned about information flow that may influence how staff learn about the new program, how practice changes will be communicated throughout the organization, and how staff will access the information they need?

E. Basic Clinical Knowledge Assessment

Introduction

Another important component of the implementation team's organizational assessment work is to determine the level of basic clinical knowledge in the organization. From available research, it is clear that many organizations overestimate the level of clinical knowledge achieved by staff. In fact, managers in long-term care organizations often believe that their staff are better informed about clinical care than they actually are. Additionally, organizational practices in many long-term care facilities prevent staff from effectively using at least some of the clinical knowledge they possess. Previous sections in this manual have addressed the organizational processes related to implementing best practices. This section focuses on the assessment and development of clinical knowledge and skills.

Much of what is contained in this "Assessing Basic Clinical Knowledge" section is based on the Wellspring Evaluation and the follow-up data collection that occurred as part of the program development initiative.

Key Assumptions:

- For clinical changes to succeed, all staff must have basic clinical proficiency. This means that any training or implementation program must include some plan for the entire organization to be clinically proficient at a basic level. In other words, clinical change cannot be "carried" by a few individuals.

- It is assumed that all clinical staff need basic, up-to-date, technical knowledge about the clinical care areas that the change focuses on. Further, it is not reasonable to expect a few designated staff to acquire such knowledge at a seminar or be responsible for raising the clinical knowledge level of the entire organization. An important role for the CT, therefore, could be to provide a leadership role in addressing any deficiencies after the assessment.

- Educational programs are most effective when they simulate the situation that staff will face when carrying out their daily work. Therefore, the exercises suggested in the "Assessing Basic Clinical Knowledge Tools" attachment (No. 1) following this section are designed to model real-life scenarios. For example, they are designed to foster collaborative problem solving, to examine both individual care practices and the systems created to support these, and to promote both staff quality of work life and resident quality of care.

- Making staff aware that clinical practice needs some improvement is not sufficient. Staff need to be guided in their problem-solving efforts, and individuals need to develop a range of skills (not just clinical) to be effective.

- Similar to any other quality-improvement program, effective staff development work proceeds based on information about what is needed and what is already in place.

Educational Materials for Addressing Clinical Knowledge

Some organizations will wish to incorporate increased clinical expertise in their facilities. While some culture-change models address this quite in-depth (See Appendix A for a description of models), you may wish to focus on other changes, but don't want to leave out a clinical piece. There are tools in this guide that may be useful as templates for addressing clinical areas of:

- Pain;

- Skin problems;

- Elimination;

- Psychosocial well-being;

- Falls and restorative care; and

- Nutrition.

Using the Assessing Basic Clinical Knowledge Materials

In many service industries, including long-term care, where the education and training of staff is critical to good performance, there is often a great deal of attention paid to the information staff need, while principles of adult learning are not well integrated into the processes of transmitting that information. Both of these must be attended to for educational programs to result in effective learning and practice change. Ineffective learning strategies and programs lead to frustration among staff and rarely achieve any sustained behavior changes. Following this logic, it is not sufficient for facility staff involved in staff education or development efforts to be knowledgeable only in clinical content areas. They must also have knowledge in adult education and be effective educators, coaches, and mentors.

The materials contained in this section can be used to assess clinical knowledge in the organization prior to or early on during culture-change implementation. However, they can also be used any time during implementation to examine the level of clinical knowledge in a particular area. In addition, the materials contained here are intended to serve as templates for culture-change homes to use in developing their own educational materials. This is a place to begin.

The Assessing Basic Clinical Knowledge section includes the following information:

1. An explanation of how the materials were developed and organized;

2. Reading questions or quizzes in each culture-change clinical area designed specifically for basic, intermediate, and advanced levels of readers;

3. Options for using the reading guides; and

4. Logistical considerations when using the guides.

Development of These Materials

Materials to assess basic clinical knowledge were developed to accommodate a wide range of staff abilities. These materials acknowledge that: staff in all organizations have achieved various levels of competence; staff come with a range of skills, knowledge and experience; and effective educational programs acknowledge these differences. First, literature in each of the targeted clinical areas was carefully reviewed. Articles were then selected for inclusion in clinical reading guides reflecting basic, intermediate, and advanced reading levels. For example, in each clinical area there are some very basic articles, some more advanced articles, and some articles that only experienced clinicians would likely find useful.

Rationale. Leveling of clinical reading is rarely done. In most educational programs, all staff are given the same materials. Inevitably, some staff find the materials too difficult, while others find the same materials too simple. This experience tends to discourage both these groups from continued participation. This issue is particularly relevant in a program such as culture change, where there is a sincere effort to support collaboration across levels and staff types.

It has also become clear that nonclinical staff must be actively included in the educational processes to create facility-wide awareness surrounding clinical-care changes. For this reason, articles were included that are appropriate for administrative and other nonclinical staff.[4] Some of these articles provide basic insights into the reasons for specific clinical practices, the organizational benefits that may accrue from such practice changes, and financial implications of clinical practice changes. Meeting learners at their own levels and in ways that seems relevant to their work is an important starting place and should be continued as culture-change staff take over the development of further educational materials. Research points to the frustration that occurs when staff are given materials that are not at the appropriate level.

Reading Guides and Quizzes

A series of reading guides and quizzes were developed from each of the articles included in the reading packets. The reading guides are intended to assess the general knowledge of staff throughout the organization and to provide a sense of whether there are particular groups of staff who are more in need of staff development than others (specific options for using the reading questions are provided below).

The reading guides are intended to be used with groups—to assess the knowledge levels of groups— rather than to target individual staff. However, you may wish to ask staff using the reading guides to identify their unit, shift, or department to better assess and target educational interventions.

Each reading guide includes a "Basic Questions" section and a section labeled "Specialty/Discussion Questions." The Basic Questions were designed to test the readers' knowledge about article content at a basic level. The Specialty/Discussion Questions were created to be applicable to particular groups of staff who might team up with a reader to answer these questions or to participate in a larger discussion group with colleagues. **Note:** Following each Specialty/Discussion Question, in parenthesis, is a page number on

---

[4] Basic readings for all modules are appropriate for any reader (clinical care providers or administrative support staff); the skin module reading packet includes articles specifically selected for administrative staff and are marked as such.

A Practical Guide to Transformation

which the answer to the question can be found in the article. and, also, suggested facility staff who might team up with a reader to explore these questions or take part in a discussion group focused on these questions (see "Options for Using the Reading Guides," below, where this is discussed in more detail).

The reading guides can be used to monitor the success of targeted clinical staff-development programs. For example, when a new care practice is implemented and a facility-wide educational program is developed, how will an organization determine if staff are learning what they need to learn to carry out the new plan? Using the reading guide questions, you can start to assess whether staff have benefited or if educational programs have affected staff differently.

No matter how you choose to utilize the reading guides, the following questions are important to keep in mind:

- Through using the reading guides, do data suggest a lack of competence in some specific clinical area? Has a plan been developed to address this?

- Do the quizzes suggest that the problem is a lack of knowledge? Is the knowledge deficit with any particular staff? It is the continual integration of multiple data sources that will lead to the best results.

Every attempt should be made to avoid compartmentalizing efforts. For example, in many nursing homes there is no link between these various forms of feedback and staff development programs. It is the responsibility of the LT to ensure that these efforts are carefully linked. Are survey results considered when plans are developed? Are turnover data and exit interviews used in decisions about work environment?

Options for Using the Reading Guides

Option A: Staff will be asked to read one or two articles (leveled appropriately) and respond, individually, to 5 to 10 questions. This could be used to provide staff with feedback on their own knowledge level. Some staff might want to read several of the articles, increasing the level of difficulty as a self-directed learning program. Some staff might simply be curious about where they stand. The quiz results could be compiled to provide an overall assessment of specific types of staff or the organization as a whole.

Option B: Staff will be asked to read one or two articles (leveled appropriately) and answer the quiz questions as a group of four or five. This option will not provide you with an assessment of knowledge level achieved by individual staff or groups of staff. However, it is an effective way to begin to model collaborative problem solving. In this scenario, different staff bring different knowledge that must be used to answer quiz questions. It becomes clear from this exercise that all staff are necessary, all have important input, and working together is the only way to solve clinical problems. This option requires some instruction in how to work collaboratively.

Option C: Staff will be asked to read one or two articles (leveled appropriately) and answer the quiz questions as a team of two (nurse and CNA, for example). There is some evidence that frontline staff (as well as others) learn best from individual mentoring. This might be seen as a logical precursor to option B, a way to prepare frontline staff to participate more actively in group problem solving. In this option, it is important to prepare nurses or other supervisors for mentoring, teaching, and collaborative

problem solving. One recommendation is that the supervisor/mentor relationship be established only after completing a training program in mentoring.

Option D: Examine the data sources available to see whether there is a correspondence between problems identified through other means and the answers to reading guides and quizzes. For example, do citations from surveyors or complaints from family members correspond to an area where staff have not scored well? If this is not the case, it is important to think about why the organization would perform poorly in an area that staff have adequate knowledge about. This suggests some organizational-level problems that might need to be addressed.

Option E: CT members read suggested articles (leveled appropriately) and pull "Top Ten" important elements that staff need to know. This is seen as the least useful option and is not recommended. It is included here primarily because it is the strategy that is most often used in homes that are not successful at achieving or sustaining successful implementation of culture change. Use of this option should be carefully targeted for very specific goals that, for some clearly identified reason, cannot be achieved by any of the options noted above.

Whichever of the above options are selected, the results can be used by the LT when developing an implementation plan. Additionally, whenever available, it would be quite useful for the results to be shared with the facilitator of the related module. In this way, a facilitator can assist the CT members attending a module to think about how the data can be most effectively used. Another important use of quiz data, either before or after reading the leveled articles, is to share quiz results with the in-service educator in the facility. Again, it is vital to ensure that these assessments and implementation processes are all integrated with each other. That will clearly yield the best results. Consider developing a network of colleagues available to assist with problem solving. Sharing the quiz results with your network will make it clear where there are common challenges that the entire alliance might wish to address. It will also reveal organizations that have been able to solve problems that others are struggling with, creating a useful cross-network collaboration.

Logistical Considerations When Using the Guides
Staff in culture-change homes will be able to identify questions of their own that can guide the use of the reading guides and other knowledge-assessment efforts. Some additional questions that are important to consider include logistics related to reading guide use:

- Will you quiz all staff in the organization at one time? Or by unit? Or by worker type? Think carefully about your purpose in using the guide. The answer to these questions should be directly in service of some particular goal. What are you trying to achieve? What will give you the information you need?

- What will you do with the assessment of management staff knowledge about the clinical area? Think about what managers need to know. Is this only knowledge related to organizational processes? Is it important for managers to know basic clinical knowledge? What do managers need to know to be sufficiently supportive of interventions developed by the Care Teams?

- How will the quizzes be administered? By whom and how will the quizzes be explained to staff? Some staff will be anxious about taking a quiz. Some will not be able to complete a quiz without assistance. Staff who think the quiz will be used to assess their personal performance might also be quite anxious about taking the quiz. Staff could be frightened about a quiz administered by their direct supervisor or embarrassed over having a peer administering the quiz. All of these questions need to be considered when administering the quizzes.

- How will you raise awareness in the facility about the competency effort? Will this be a mandatory activity for all staff? Will there be a timeline in which the readings and quizzes will be expected to be completed?

- How will you know whether staff have taken part? Are there consequences for staff who do not take part? What are these?

Role of the Leadership Team

The LT plays a very important role in overseeing the above processes. The CTs can benefit significantly from the LTs experience and authority as it develops facility plans to enhance performance in a specific clinical area. Specifically, the LT oversees how all the components discussed in the manual come together. Remember, the questions that the LT will need to address in the beginning of implementation, as well as during the ongoing implementation, include the following:

1. Do staff have access to the information they need to do their work?

2. Does this organization respond appropriately to challenges or problematic issues, or are our interventions not clearly linked to the problems we have?

3. Do we train staff on what they need to know?

4. Do we build systems that work toward improving staff skill and capacity?

5. Do we have systems of correction that work at odds to one another?

6. Are staff at all levels encouraged to take initiative?

7. Do we use the data we have effectively?

8. Do we need additional data?

9. Are we accountable for what we say we're doing?

10. Are we accountable for what we say we're going to do?

11. Based on your assessments, what do LT members see as the needs of staff in this facility?

12. Where are places that decisions are being made without appropriate amounts of relevant data?

13. Where does practice seem to be institutionalized, and where does it rely on individuals to follow through?

14. Where is there insufficient follow-through?

15. Is there an adequate transition for new employees? Do orientation activities prepare staff for actual work or tasks associated with the position?

16. Is there follow-up to orientation sessions?

17. Does ongoing, learning occur on the job? If so, how?

18. What is the role of other unit staff in relationship to a new employee?

For each of the above questions, the LT must be able to provide clear evidence for the conclusions arrived at. Impressions and hearsay must be carefully avoided. It is generally a good idea to follow each answer with, "How do I (you) know this?"

To address clinical problem areas, a facility might choose to focus on:

• Improving linkages between a clinical problem area and staff development;

• Improving mechanisms to access and use clinical data to enhance care and improve decision–making;

• Developing accountability systems at unit and shift levels; and/or

• Creating staff-development opportunities to increase ability of staff to advance, specialize, and develop skills and competencies in care areas of particular interest.

Another outcome might be to focus on strategies for improving the quality of the work environment. The CT and LT plans could focus on:

• Improving linkages between work quality environment problems and work structure or processes;

• Establishing mechanisms to access and use reliable information about work quality (performance reviews that reflect facility goals, exit interviews, quality indicators of positive work environment); and/or

• Creating an internal mentoring system to increase worker skill and capacity.

Please see Attachment 1 for materials related to Assessing Basic Clinical Knowledge.

IX. Sustaining Practice Change and Developing Accountability Systems

Introduction

Many of the preceding sections have dealt with sustaining change. In particular, there has been considerable attention paid to the organizational structure and systems that are required to alter care practices and sustain the changes that have been made. This section is a brief summary of how change can be implemented so that sustained change is likely to occur. Some of this has already been stated elsewhere, and some of this is new.

A. Data Systems

It should be clear from preceding discussions that successful change implementation is dependent on data systems that are:

- Current;

- Reliable;

- Relevant to resident care;

- Useful for planning and evaluating care;

- Accessible; and

- Provided in a useful form.

The more current the data, the more useful. Data that are three months old or older (which is the case with MDS quarterly data) are not always taken seriously by the staff and can be easily dismissed as "no longer a problem." Data from last week, however, is typically taken much more seriously. It is quite useful, consequently, to design your system so that data are compiled, analyzed, and provided to those who can use it as often as possible. Facilities that were able to do this on a weekly basis had the greatest success with staff taking ownership of the outcomes. This is vital for accountability.

B. Accountability Systems

Units, departments, or homes that used clear accountability systems are much more likely to be successful than those that relied only on monthly or quarterly reports. The most successful implementation can be facilitated by an accountability system that is *integrated into the unit or department's routine*. For example, in one culture-change evaluation, units that integrated daily assignment sheets with the new toileting plan or new walking program and also integrated documentation that the plan had been carried out with daily reporting were considerably more likely to follow through. Another important outcome of building accountability systems at this level is that lack of follow-through or lack of desired results from follow-through become quickly apparent and can therefore be addressed sooner. Seeing at the end of the shift or the end of the day that a plan was not carried through has a much stronger impact on changing behavior than did discoveries that follow-through had not been done over the past month. This also allows staff to more clearly see the relationship between their actions and resident outcomes.

Another advantage is that data collected at the level of the unit, department, or shift is much more useful in determining the source of a problem with implementation. For example, in one evaluation, discovering that "toileting is not being done" or that "incontinence has not changed much" had little impact on individual staff and the way they went about their work. On the other hand, specifying that Unit C evening shift did not seem to be toileting residents and that incontinence figures were significantly affected by this led to a different approach to addressing the problem and much greater accountability. In such cases, it was quite difficult for staff to dismiss undesirable resident outcomes as someone else's problem or as not related to their actions.

Another obstacle to maximizing accountability can be the willingness of staff and their supervisors to accept impressions as evidence of follow-through (or achievement of outcomes) rather than insisting on data. For example, administrators can sometimes suggest that a change is being implemented throughout the facility because the director of nursing assures the administrator that it was being implemented. In turn, the nursing director is willing to accept the impressions and assurances of the unit nurses and other staff that implementation is being carried out. In most instances, everyone involved actually believed that this was the case. Evidence collected to confirm these impressions can surprise everyone. Staff can discover their impressions were not correct. Insisting on evidence, importantly, provides objective data for everyone to refer to and does not require supervisors to question what staff are reporting to them. Such questioning might be construed as a lack of trust when, in fact, the issue is more often a misperception that was never intended to deceive.

Effective accountability systems, ideally, contain the following elements:

1. Specificity at the unit, shift, and department level. For example:
   a. A data collection system that can distinguish one unit from another;
   b. A data collection system that includes data from departments involved in the implementation plan; and
   c. A data collection system that can distinguish processes and/or outcomes by shift.

2. Specificity to the daily or weekly level. For example:

   a. A data collection system that can provide data noted in No. 1 at weekly intervals where relevant; and

   b. A data collection system that can provide data noted in No. 1 at daily intervals when appropriate.

3. Objective outcome or process indicators. For example:

   a. Each implementation plan should have expected outcomes clearly specified in advance, the more discrete the more useful (number of incontinence episodes per shift).

   b. Each implementation plan should have clearly defined process indicators to monitor implementation. These will be obvious prior to changes in resident outcomes. Both process and outcome indicators must be easily identified with a high level of agreement among data collectors (inter-rater reliability).

4. Clear links between indicators and practice initiatives. For example:

   a. Careful thought should go into the identification of process and outcome indicators that are reliably linked to the implementation being initiated. (Staff sometimes become frustrated over selecting indicators that are not necessarily, or reliably, linked to the implementation.)

5. Clear designation of responsibilities. For example:

   a. Responsibilities for each aspect of implementation should be carefully spelled out so everyone knows who is expected to do what.

   b. Responsibilities for implementation can vary by departments and units but should be very clear and recorded and communicated in a way that is clear to all staff. Monitoring and evaluation responsibilities should also be clearly specified.

6. Systematic data and evidence collection on a regular basis. Specifically:

   a. Data collection systems should be used at predetermined intervals.

   b. Data collection for evidence of successful implementation should be collected as part of daily work, not added on.

   c. A predetermined plan should be developed to guide use of data collected (who will use it, when, and how).

   d. Clear link to Quality Improvement systems should be established from the onset.

A team could be constructed to deal with many of these issues. The team could provide the mechanism by which practice improvements are institutionalized, supported, and sustained. The responsibilities of this team suggest a high level and a broad range of skills among the members.

Appendix

Appendix A: Culture-Change Models

	CLINICAL APPROACH	
	Wellspring	**Eden**
Why it got started	Initially a proactive response to an increasingly competitive environment of managed care and consumer demand for quality	In direct response to the loneliness, boredom, and helplessness that elders experience in the institutional setting of a nursing home
Principles	Clinical focus that seeks to improve the quality of care for residents and quality of work life for staff resulting in reduced turnover Uses interdisciplinary clinical modules to improve knowledge of best-care practices for all staff, especially frontline workers Empowers frontline staff to use knowledge to create practice change that will improve care Relies on collaboration within and across facilities for improved care	Attending to the social needs of an individual will improve physical health Creates a community that encourages the development of meaningful relationships, spontaneous interactions, and variety in life Medical treatment is a supplement to genuine caring
Implementation	Has at the heart of the model interdisciplinary care resource teams based on clinical modules for problem solving Use of evidenced-based best practices CNAs put in position of authority in decision-making about work practice Nurse practitioner serves as a consultant to alliance and individual facilities at a systems level; also acts as a liaison between frontline staff and management staff	Creation of small groups of residents into neighborhoods to encourage relationships Inclusion of plants, animals, and children in everyday practices to foster spontaneity Staff are encouraged to get to know residents' likes and dislikes and allow residents to direct their own care needs Trained Eden Associates teach staff principles of the Eden Alternative
Outcomes	Facilities have shown improved clinical outcomes and higher staff retention rates than comparison facilities	Enhanced staff retention rates Reduction in number of resident medications and infections Anecdotal evidence suggests residents and staff are more highly satisfied with their environment after implementation of the Eden Alternative
For more information	*www.wellspringis.org*	*www.edenalt.org*

HOUSEHOLD APPROACHES		ORGANIZATIONS
Greenhouse	**PersonFirst**	**Pioneer Network**
Created to further deinstitutionalize care Realization of Eden in design	Started in order to train staff to understand how to know and care for a person with dementia	Umbrella organization for the culture-change movement Transformation of the current culture of aging in which elders experience loss of control, loss of choice, and loss of relationships to a culture that is life-affirming, satisfying, humane, and meaningful
Focuses on social settings and relationships rather than assistance with activities of daily living and clinical care Changes facility size, interior design, staffing patterns, and delivery of skilled services Houses 6–10 elders in a home that blends with neighboring houses Houses are smart, warm, and green with inclusion of computers, wireless, paging, fireplaces, private baths, and outdoor spaces	Focuses on allowing control in daily care by accepting risk as a part of everyday life and allowing residents to direct routines Believes honoring a person through the physical, social, and psychological environment may allow the resident to regain a sense of self otherwise lost Create a meaningful life for residents by getting to know the person's values no matter what their abilities are	Value knowing each person and putting the person before the task Accept risk as a normal part of life Emphasize community living and promote household living environments Anyone is eligible to join the Pioneer Network regardless of facility, position, or person-centered care approach. The Pioneer Network provides resources and information about change as well as serves as a networking outlet
Professional nurses, physical therapy, and other skilled services are visiting services at the home Direct-care staff called Shahbazim carry out day-to- day activities including cooking meals, laundry, and light maintenance tasks Construction has been funded for some facilities using tax credits or grants	Staff training emphasizes learning about the resident and getting to know daily habits, practices, and routines Daily pleasures interviews are used to understand residents' habits, and care cards include information about residents' preferences	Staff members develop personal relationships with residents Community meetings offer opportunity for developing relationships and exploring common interests and goals Routines are individualized
In one study, residents reported a higher quality of life, were more satisfied, and had a better emotional well-being than residents in a comparison nursing home. QIs that are as good or better than comparison homes with fewer declines in late-loss activities of daily living (ADLs) as a notable finding in the study	Residents described a better quality of life and an increase in meaningful activities in an evaluation of PersonFirst. Turnover for CNAs and RNs reduced significantly Data on QIs is mixed	An unpublished study found Pioneer nursing homes have better quality-of-care outcomes than nonparticipant homes
www.ncbcapitalimpact.org/default.aspx?id=146	**www.actionpact.com**	**www.pioneernetwork.net**

It is important that the organizational culture and the culture-change model are compatible. When organizations attempt to implement culture change without carefully considering how their organization operates and whether that is compatible with the operation of the culture-change model, frustration and failure can result. In particular, it is important to examine the culture-change requirements for information flow, decision-making, resource utilization, staffing, scheduling, promotions, access to data, problem solving, and disciplinary actions to determine whether these are consistent or inconsistent with how the organization operates. Maintaining a reward system for frontline staff that is entirely based on absenteeism, for example, is incompatible with sustaining culture-change models. It is too narrow and will undermine the implementation. Avoiding corrective action and possibly dismissal when department heads or unit nurses actively undermine culture change or simply refuse to support it will also undermine the program.

Based on interviews with culture-change staff, the following areas are some of the organizational and program compatibilities that deserve scrutiny:

1. Is culture-change participation included in performance evaluations?

2. Is there enough staff and enough staff consistency to carry out implementation plans?

3. Is turnover too high to implement programs requiring follow-through?

4. Are staff nurses able to participate in the program?

5. Do department heads and charge nurses integrate CT plans into their decision-making about their areas?

6. Are staff throughout the organization supported to attend CT and other meetings related to culture change?

7. Is necessary information shared easily?

8. Are problems addressed quickly or left to simmer?

9. Do staff feel appreciated?

10. Does each level of the organization have a clear view of what the level just above and just below is doing?

11. Is staff development clearly related to the work and what the staff need?

Appendix B: Tools for Teams

Conducting Effective Meetings

Meeting Minutes Template

Skills for Team Members

Conducting Effective Meetings

Many common implementation challenges surround meetings. Those described by culture-change facilities include:

- Invited team members did not respond or attend;

- Team members attended meetings but didn't participate much in the meeting discussions; and

- Team members attended and participated in meetings, but follow-through on meeting decisions or work plans varied significantly.

Each of these challenges, and certainly any combination of them, left some people carrying the weight of the team, or lead to team ineffectiveness.

There are several strategies that can assist teams in keeping organized and on task. These strategies are described in this section.

A. Create a Meeting Statement

A meeting statement is a clear statement of purpose drafted before a meeting takes place. Writing a meeting statement may sound like an unnecessary or excessive step in the direction of more productive meeting time but preparing a meeting statement can help a meeting facilitator and meeting participants focus and prepare for targeted meeting discussions. An effective meeting statement will include the following information:

a. Any materials (including data) needed for a meeting;

b. The location and the length of time of the meeting; and

c. The identification of the participants taking part in the meeting.

Meeting statements should be very specific. See the examples below.

Sample Meeting Statements

Appropriate: The Care Team on Activities will meet on September 21, 2007, from 1 to 2:30 p.m. in meeting room XX to: 1) report back on work assignments from the August 18 meeting; 2) discuss activity participation data collected during July and August; 3) discuss this data and link it to our next implementation steps; 4) identify work assignments for each team member; and 5) schedule our next meeting.

Inappropriate: The purpose of the September 21, 2007, the Care Team on Activities meeting is to discuss an implementation plan.

In addition to bringing focus to a meeting, creating and using meeting statements can assist with tracking the progression of a team in their efforts, since meeting purpose statements often appear on meeting agendas and meeting minutes.

A meeting statement can assist some participants with determining what type of meeting will occur. For example:

- **Information-giving,** in which the meeting facilitator or a guest speaker presents to the group about a particular topic. The purpose of an information-giving meeting is to provide clear and complete information to meeting participants. These meetings are characterized by opportunities to ask short, clarifying questions with very brief discussion time allocated.

- **Information-taking,** in which there is open discussion among participants. The meeting facilitator in this type of meeting is expected to facilitate discussion or information sharing, returning the discussion back to main ideas, as needed. The facilitator may also ask open-ended questions of participants. In an information-taking meeting, the meeting participants are initiating most of the discussion, with one person facilitating the discussion.

- **Problem solving,** in which communication occurs between the facilitator and participants. The meeting facilitator or guest speaker typically provided background information (the question or problem to be addressed at the meeting) to meeting participants, and team members provide suggestions and generate ideas toward problem solving. Like an information-taking meeting, the meeting facilitator keeps the meeting discussion moving toward the goal of identifying solutions to a particular problem.

Many times these different meeting types or focus areas are blended in a single meeting agenda. However, appreciating the distinctions between the types of discussion is important when considering what to address in a meeting and how to direct participants with regard to preparation. For example, for a meeting or discussion on problem solving, you may want to consider posing the question at hand to meeting attendants for their thoughtful consideration ahead of the actual meeting time. If it's an information-providing meeting, you may want to solicit requests from the meeting participants for particular content areas they wish to be covered.

B. Creating an Agenda

Creating an agenda is a key element of a productive meeting. The agenda reflects essential information of importance to meeting attendees (including topics for discussion, identification of facilitators who will lead a discussion or topic area, and the time allotted for each topic); provides an outline for the meeting time (how much time will be spent on each topic); provides a checklist to ensure all information is covered; gives meeting participants an opportunity to prepare for discussions or decisions; and lastly, but importantly, provides a focus for the meeting.

It is recommended that the meeting facilitator request agenda items from participants well in advance of the meeting date. Make sure each person indicates how much time he or she expects to use for the agenda item. Make sure you are clear on what each presenter (those leading a discussion or presenting information to the group) will be presenting on. This latter point is critically important for two reasons: 1) it is your responsibility to make sure each agenda item directly relates to the goals of the meeting (the goals

laid out in your meeting statement), and 2) it will allow you to set realistic amounts of time for each person who will be presenting. In other words, don't schedule more than 50 minutes worth of material in an hour-long meeting—if you end a meeting early, participants will be pleased!

A template for a meeting agenda is included at the end of this section.

C. Notifying Meeting Participants

Meeting participants should be reminded of the time, duration, and place of an upcoming meeting in advance. To determine an appropriate amount of advanced notice, consider how much time is needed by participants to prepare for the meeting (Do they need to review relevant materials? Create documents? Brainstorm or conduct research to prepare?). Advance notice could range from three days to two weeks or longer. It is recommended that "same day" meetings only be called in the case of an emergency.

Ask those invited to the meeting to accept or decline the meeting invitation. It should be clear that once an invitee has accepted the invitation, the person will be expected to be there.

Consider how to most effectively deliver meeting information to colleagues ahead of time. Is a meeting announcement posted somewhere in your facility likely to be seen by all meeting invitees? If you consider using staff mailboxes, have you allowed enough time to ensure that mailboxes will be checked by staff prior to the meeting date? If the meeting involves a small group, is it possible to hand-deliver the meeting materials to each participant? This provides an opportunity for you to provide any additional information and answer questions personally.

It is also useful when you are sharing meeting materials with participants to have sorted out and identified ahead of time any specific roles meeting attendees will have. For example, whose turn is it to take minutes? Does this person know that he or she will be expected to do that?

D. Selecting a Meeting Setting

The meeting setting should be determined by the purpose of your meeting. Selection of the meeting space requires consideration of several important environmental factors. For example, is the room you have chosen appropriate for the size group you expect? Are all participants who are attending able to sit together at the meeting table? It is also important that the function of the room doesn't interfere with purpose of the meeting. For example, meeting in a board room or an administrator's office may be intimidating or anxiety inducing to some participants. By the same token, meeting in a lunchroom or employee break room may be too informal a setting, or may allow interruptions from visitors.

Think about the room arrangement as well. Rows of seats with the facilitator or guest speaker in the front of the room works well for information-giving meetings, although it is a bit formal. U-shaped chair arrangements around a table works well for problem-solving meetings, particularly if the ideas being generated need to be noted for view by meeting participants.

E. Conducting the Meeting

This next section describes several aspects of meeting coordination that are recommended to occur at the meeting being held.

Starting a Meeting

a. Inform the building receptionist and/or overhead speaker operator of the meeting start and end time and provide that person with a list of the meeting participants, so that messages can be taken for these individuals.

b. Arrive in the meeting room early to arrange the space and to greet and introduce new participants.

c. Ask participants to turn off their pagers and phones for the duration of the meeting.

d. Start the meeting on time. This sets an expectation about timeliness and the value of an individual's time in the organization (don't punish those who are punctual).

e. Some facilitators are successful with starting meetings with a statement or story that is dramatic, novel, or humorous to get the attention of the group and focus participants on the purpose of the gathering. At a minimum, welcome everyone, thank them for coming, recognize special guests, and identify the meeting minutes taker.

f. Update participants: refer to the meeting statement of purpose and briefly fill in any background information necessary so all participants are on the same page to start.

g. Remember to remind participants what time the meeting will end

Facilitating a Meeting

To facilitate participation in the meeting discussion, try these techniques:

a. State your need for others' opinions on the meeting topic.

b. Don't be afraid to ask for help; state that you can't solve the problem alone: *"I have some thoughts on this, but I'm wondering what others are thinking."*

c. Call on experience; recognize those who have been through similar problems: *"Everyone here brings a unique perspective on this, so I'm excited to hear what each of you think about this."*

d. Compliment people on work or achievements so far: *"You've done some excellent work on this topic. Thank you for bringing the information you have to this meeting."*

e. Use prior information, such as earlier discussions about the topic with participants: *"If you recall, the last time we met, we determined A. Can you help me to understand how A relates to what we're currently discussing?"*

f. Question the need for other sources of data:

- *"Has everyone we need to hear from on this subject weighed in? Who are we forgetting?"*
- *"Are there other data sources we need to be considering at this point?"*
- *"Who is most likely to be affected by what we're concluding?"*

To keep the meeting discussion flowing, try to listen supportively to all opinions, encouraging those who speak to finish their thoughts. Avoid asking for too many details at the beginning of any discussion. Let the group decide how the conversation will flow and encourage participation (see tips above to facilitate participation).

Here are five strategies (initiate, orient, clarify, integrate, and test possibilities) for a facilitator to guide and unify the meeting discussion:

1. **To initiate**, start conversation by stating the problems for the group to address or solve, suggest new ideas, and/or state new activities:
   "I heard from Sue in education that they're planning a new in-service on X. Is this something we might want to ask about getting involved with?"

2. **To orient**, keep participants focused on the meeting purpose by restating it, as needed, and reminding participants of their role at the meeting. Don't hesitate to question whether a goal or objective has been identified:
   "In an effort to orient myself and the group, I believe we've identified several ideas to this point and raised several questions including a, b, c. Is that an accurate assessment of where we are?

   If the goal has been identified, have specific strategies to address the goal been identified?
   "We've decided as a group that our goal is X. Have we identified how we anticipate meeting this goal? What strategies will we use to reach X? How will we know if or when we've succeeded?"

   Remember to use data as a resource. Encourage the group to clarify how the discussion or suggested plans for implementation reflect data-based conclusions.

3. **To clarify**, make sure meeting participants understand the information that has been covered.
   "We've covered a lot of ground here today. Does anyone have questions about what's being presented or the data that's been shared?"

   Also make certain that timelines and assignments that are being discussed eventually get linked to individuals for completion and that this information is being recorded in the minutes.

4. **To inform**, provide facts or information to facilitate decision-making while also noting facts or information that still needs to be gathered.
   "It seems we have a clear understanding of rates of falls on unit X, but are we in agreement that we still need to gather data on where and how these fall are occurring and if there are any variations across shifts?"

5. **To test possible solutions**, raise questions about the areas or issues being suggested that could potentially be problematic, identifying implications for others (residents, other staff, the organization in general). Central questions for the facilitator to stay focused around include:

- What is our timeline?
- Who will be doing what?
- Will residents or other staff be affected by our proceeding with this? If so, how?
- How will we assess our progress? What evidence will we use to know whether we're making progress?

Ending a Meeting

- Watch the meeting time so the purpose of meeting is addressed during the time allocated.

- **Ten minutes out from the meeting end time:** Remind the group that the meeting is about to end, and encourage participants to vocalize any final important thoughts.

- **Five minutes out:** Summarize points addressed at the meeting, including what was accomplished. Provide specific instructions for any action that is to occur before the next meeting. Review the group's work plan and work assignments and deadlines. Confirm that the minutes taker has documented this information in the minutes.

- Inform participants when the minutes or summary document of the meeting will be sent out and how this will occur, such as e-mail, hard copies posted, or copies in mailboxes.

- Announce future meeting date, time, and location, and thank participants for coming.

- Try to close your meetings with strong, positive statements:
  "I know we can solve this problem together."

F. Meeting Challenges

This next section provides information in several common challenge areas associated with meeting participants.

Challenge: People who talk too much

Suggestion: Try to interrupt the participant without offending him or her:
"Excuse me, Sarah, I was still speaking. Will you hold your comments for just a minute? Thank you."

Suggestion: Summarize what the person has said, then ask others for opinions:
"I'm sorry to interrupt you. It sounds like you're frustrated with this situation, but we need to be sure the perspectives of all team members get addressed on this topic. How does someone else feel about this issue?"

Challenge: People who don't participate

Suggestion: Individuals may be nervous about speaking in front of others. Assure the person that it's a friendly group, and participation get easier each time. Inquire about any specific needs.

Suggestion: Individual may not be prepared for the meeting discussion. Try to check ahead of time that meeting materials have been received and reviewed.

A Practical Guide to Transformation

Challenge: People who stray from the meeting purpose

Suggestion: Remind the person of the meeting purpose.

Suggestion: Use the agenda items to refocus discussion:
"I apologize for interrupting this discussion, but it seems we're a bit off topic. According to the agenda, I think we've designated this time for discussion about X."

Suggestion: State that all new items of interest will be addressed at the end of the meeting, if time allows.

Care Team on Activities
Meeting Agenda
September 21, 2007
1–2:30 p.m.

Conference Room, 3rd Floor, Room 318
Meeting Purpose: 1) report back on work assignments from the August 18 meeting; 2) discuss activity participation data collected during July and August; 3) discuss this data and link it to our next implementation steps; 4) identify work assignments for each team member; and 5) schedule our next meeting.

Invited: Participants:	Facilitator: Anne Calloway; Minutes: Jenni Klein, Terry Lever, Mary Troy, Kim Jensen, Chris Temple, Stacie Newman	
TIME	**ITEM**	**LEADER(S)**
1:00	Attendance and Restatement of Meeting Purpose	Anne
1:05	Review of Work Assignments from August 18 Meeting	Anne
1:10	Individual Reports from Work Assignments	Terry Mary Stacie
1:40	Discussion of Data from Work Assignments	All
2:15	Discussion of Next Steps	All
2:20	Work Assignments and Issues for Next Meeting Next Meeting Facilitator and Minute Taker	Anne Jenni
2:30	Adjourn	Anne

Meeting Minutes Template

1. Meeting Information
Team Name:
Date of Meeting:
Minutes Prepared By:
Purpose of Meeting:

2. Attendance at Meeting	
Name	Department

3. Agenda/Discussion Items

I. Old Business (Be sure to follow up on previous action items.)
 	
    Notes:
 	
    Outcomes

II. Agenda Item
 	
    Notes:
 	
    Outcomes

III. Agenda Item
 	
    Notes:
 	
    Outcomes

4. Action Items			
Action	*Assigned to*	*Due Date*	*Status*
Item 1:			
Item 2:			
Item 3:			

5. Nest Meeting		
Target Date:	Time:	Location:
Objectives:		
Send Agenda Items to:		

Skills for Team Members

It is not important for each team member to have all of these skills. Collectively, a team must bring or cultivate all of these skills and abilities in order to develop, implement, and sustain their practice improvements. It is important, consequently, that management and teams make the effort to assess the capacity of their team and team members and that they quickly identify which skills are missing and which are present but may need further development. It is important that this assessment be done early and repeatedly. This assessment can be used to inform the selection of new committee members and to determine where committee development needs to be done. This clearly has implications for staff development activities at the individual and alliance levels. Given the level of staff turnover in most long-term care settings, it is important to have some depth in the above skills. That is, it would be unwise for only one team member to be skilled in any particular area. Many of these skills can be developed over time:

- Knowledge about accessing, interpreting, and using multiple types of data;

- Familiarity with the work routines of multiple groups, departments, units, and shifts;

- An understanding of information flow, lines of authority, and decision-making processes in the organization;

- An understanding of the quality improvement systems in the organization;

- Familiarity with staff development and orientation programs;

- An understanding of employee performance evaluation processes;

- Familiarity with the usual problem-solving mechanisms used throughout the organization;

- An ability to assess organizational aspects of or contributions to events or incidents that occur;

- The ability to develop a detailed plan with a timeline;

- The ability to collaborate;

- The ability to participate in and run effective and efficient meetings;

- The ability to hear, appreciate, and consider multiple perspectives;

- The ability to generate multiple approaches to each problem identified, anticipate the likely outcomes of each approach, and make decisions based on such an assessment;

- The ability to identify resources needed;

- The ability to identify learning needs of self and other committee members; and

- The ability to work with others to develop the above skills in new team members.

Skills and Characteristics of the Change Facilitator

For cost-effectiveness, you may wish to look internally and consider work reallocation for the change facilitator position. No single person brings all of these skills. Different staff will bring very different levels of confidence, skills, and experiences in each of these areas, however, it is recommended that when interviewing and selecting a staff person for the facilitator position, discussion about skills and experiences with these areas are included:

- Problem identification;

- Problem solving;

- Collaboration;

- Listening;

- Facilitating the development of others;

- Locating resources;

- Coaching and mentoring;

- Analyzing organizational challenges;

- Negotiating;

- Willingness to ask for help or delegate;

- Assertiveness;

- Critical, creative thinking;

- Teaching skills (taking advantage of teachable moments); and

- Clinical knowledge.

Appendix C: Tools for Mentoring

New Staff Orientation Program: Preceptor Model

Mentor Scale

Recommended Job Description: Certified Nursing Assistant Peer Mentor

New Staff Orientation Program: Preceptor Model

The Masonic Home of New Jersey has published one example of how a Preceptor Program might work. This program was specifically designed to increase the effectiveness of orientation programs for new staff. It is included here to provide an example of how such a program might work and what it could include.

A. Purpose

The Preceptor Program provides increased effectiveness in the orientation of new nursing staff.

B. Definition

A preceptor is a registered nurse, licensed practical nurse, or certified nursing assistant, who has been judged experienced enough to assist in the orientation of new nursing personnel to our organization, policies, and procedures. The preceptor is responsible for providing orientees with an environment conducive to learning and growth. The preceptor assists orientees during the transition to our nursing service roles. The preceptor serves as a clinical role model following the orientation given by the education directors.

C. Preceptor Selection and Qualifications

Selection of the preceptors will be performed by Nursing Administration and Education. Selection will be based on the following criteria:

1. Minimum of one year employment;
2. An above-average or outstanding performance evaluation;
3. Demonstrated knowledge of our policies and procedures; and
4. Active participation in continuing education.

The preceptor must attend a one-day orientation program with the Education Department prior to the beginning of preceptor duties.

The preceptor position will be offered for a 12-month period. The preceptor will be evaluated for overall effectiveness and may or may not be reinstated for an additional year.

D. Preceptor Responsibilities

1. Performs regular staff duties as assigned.
2. Orients new nursing staff to the unit:
   a. Identifies and meets learning needs;
   b. Acts as a clinical resource;
   c. Aids in the socialization of the new staff member;
   d. Makes educational opportunities available (in-service programs, unit in-service training, staff meetings); and
   e. Assures that policies and procedures of the home are followed.
1. Ensures quality resident care during orientation.
2. Assesses performance by providing positive feedback as well as suggestions for improvement.
3. Reviews skills checklist and orientation sheets and reports progress by orientees to education directors.
4. Meets with education directors as required.
5. Assists in the operation of the Geriatric Nurse Extern Pr ogram.

E. Evaluations

1. The preceptor will be evaluated by each new staff member at the end of orientation.
2. The preceptor will receive one yearly performance evaluation rated by the nursing supervisors and education director.
3. The Preceptor Program will be evaluated by each preceptor and the education director on a yearly basis.

F. Termination of Preceptor Position

Termination of a preceptor position will occur if the employee:

1. Fails to maintain preceptor responsibilities; and/or
2. Violates Masonic Home policies and procedures; and/or
3. Has excessive absenteeism.

G. Compensation

1. During the period of time that the employee is a designated preceptor, he or she will be compensated at the extra rate of $0.50 per hour.

Mentor Scale

Source: *Managers as Mentors: Building Partnerships for Learning*
by Chip R. Bell

1. People probably see me as	a. a soft touch	b. hard-nosed
2. Workdays I like the most are	a. unpredictable	b. planned
3. When it comes to celebrations, most organizations need	a. fewer	b. more
4. When I evaluate people, my decisions are based on	a. mercy	b. justice
5. My approach to planning my personal activities is	a. easygoing	b. orderly
6. People generally see me as a person who is	a. formal	b. personable
7. When it comes to social situations, I tend to	a. hold back	b. jump in
8. I like to spend my leisure time in ways that are fairly	a. spontaneous	b. routine
9. I believe leaders should be more concerned about employee	a. rights	b. feelings
10. When I encounter people in need of help, I'm more likely to	a. avoid	b. pitch in
11. When I am in a group, I typically	a. follow	b. lead
12. Most people see me as	a. private	b. open
13. My friends know that I am	a. gentle	b. firm
14. If I were in a group of strangers, people would most likely remember me as a	a. listener	b. leader
15. When it comes to expressing my feelings, most people probably see me as	a. guarded	b. comfortable
16. When people I depend on make mistakes, I am typically	a. patient	b. impatient
17. When I eat out, I generally order food that	a. sounds unique	b. I know I like
18. In general, I prefer	a. the theater	b. a party
19. In a conflict, when anger is involved, my emotional fuse is usually	a. long	b. short
20. In an emergency situation, I would likely be	a. calm	b. anxious
21. I prefer to express myself to others in ways that are	a. indirect	b. direct
22. I am likely to be ruled by	a. emotion	b. logic
23. When in new and unfamiliar situations, I am usually	a. carefree	b. careful
24. In a festive social situation, I am usually	a. passive	b. active
25. When I am blamed for something I did not cause, my initial reaction is to	a. listen	b. defend
26. If I am in a situation in which I lose or am left disappointed, I get	a. sad	b. mad
27. If someone came to me in tears, I would probably feel	a. awkward	b. at home
28. Most people see me as	a. an optimist	b. a pessimist
29. People usually see me as	a. uncritical	b. critical
30. If people were given a forced choice, they would say I was	a. too quiet	b. too loud
31. At the end of a long party, I usually find myself	a. exhausted	b. energized
32. When I work on projects, I am best at getting them	a. started	b. completed
33. I believe people should approach their work with	a. dedication	b. inspiration
34. My social blunders typically leave me	a. embarrassed	b. amused
35. When my organization announces a major change, I get	a. excited	b. concerned
36. People are likely to see me as	a. firm	b. warm
37. After a tough day, I like to unwind	a. alone	b. with others
38. Change is most often your	a. friend	b. adversary
39. My work and social life	a. are separate	b. often overlap

THE SCORING FORM

Sociability

Using simple hash marks, tally your A's and B's for the 13 sociability items.

		As	**B**s
1, 4, 7, 10, 13, 16, 19,			
22, 25, 28, 31, 34, 37	Totals	_____	_____

Dominance

Do the same for the 13 dominance items.

		As	**B**s
2, 5, 8, 11, 14, 17, 20,			
23, 26, 29, 32, 35, 38	Totals	_____	_____

Openness

Do the same for the 13 openness items.

		As	**B**s
3, 6, 9, 12, 15, 18, 21			
24, 27, 30, 33, 36, 39	Totals	_____	_____

A Practical Guide to Transformation

Interpretation

The Mentor Scale measures—at one point in time—a mentor's need for sociability, dominance, and openness, all crucial components of an effective mentoring relationship.

Sociability has to do with your preference for being with or apart from others. People with high column-A scores in sociability tend to be reserved loners; those with high column-B scores tend to be outgoing joiners. People with similar numbers of As and Bs are neither highly sociable nor highly reserved; they can be moderately sociable or moderately reserved, depending on the situation.

What does sociability have to do with mentoring? People who have high sociability scores will find the rapport-building and dialogue-leading dimensions of mentoring easier. They will have to work hard to avoid dominating discussions. Low sociability scores are found among people whose reserve may make them a bit unapproachable. These people will need to work harder at helping protégés open up and communicate.

Dominance is about your preference regarding being in charge. People with high column-A scores are comfortable having someone else do the leading and often prefer it. People with high column-B scores tend to like being in control and often assert that need. Low dominance scores can also indicate a high need for independence. People with balanced scores are neither highly dominant nor highly submissive. They can control moderately or not at all, depending on the situation.

Dominance is a major issue in mentoring with a partnering philosophy. The whole concept of mentoring today is based on a relationship of shared power. High dominance scorers are reluctant either to give up control or to share control of the relationship; they have to work hard to listen rather than talk. Low dominance scorers, on the other hand, may need to work to assume leadership of the relationship. They may take such a low-key, laissez-faire approach that the protégé feels insecure and without guidance.

Openness refers to how easily you trust others. High column-A scores are found among people who are cautious, guarded, and reluctant to show feelings. High column-B scores are typical of people with many close relationships, who are comfortable being vulnerable and tend to express their feelings easily. People with similar A and B scores are moderately open or moderately cautious, depending on the situation.

High openness scorers will find it easy to reveal themselves in a mentoring relationship. In fact, their challenge is to be candid and open enough to encourage the protégé to do likewise, while not being so aggressive as to overwhelm or intimidate the protégé. Low openness scorers, however, will need to work at overcoming their caution in order to take early emotional and interpersonal risks with the protégé; their instinctive guardedness can make the protégé feel that mistakes might have dire consequences.

Remember, the Mentor Scale gives you a reading at a moment in time, one that may change with the circumstances. Keep in mind also that the scale assesses only three aspects of your leadership personality. Don't generalize the results beyond their intent.

Recommended Job Description:
Certified Nursing Assistant Peer Mentor

Purpose:

- To reduce turnover in the direct-care workforce by giving new employees a personal introduction to the work and the role of the nursing assistant;

- To support newly hired nursing assistants to become a caring member of the team; and

- To serve as a resource to other nursing assistants in the organization.

Job responsibilities:

- Provide on-the-job training for new, rehired, and existing employees.

- Support newly hired aides for a minimum of five shifts, increasing the mentees' caseloads as their progress and experiences allow.

- Train or educate all newly hired or existing staff regarding departmental procedures, safety and health issues, and other information.

- Complete an orientation check on all new hires upon the completion of the orientation period and a competency evaluation within two weeks of hire.

- Provide constructive feedback to the new aide.

- Serve as a liaison to the administrative staff and the new employee.

- Participate in the interviewing of nursing assistant applicants.

- Be an active member of the peer mentor team.

Skills, abilities, and qualities pertinent to the position:

- Strong connection to the work of direct-care service
    * Demonstrates an ability to do the work of a CNA
    * Shows a positive attitude about being a CNA

- Good assessment and observation skills
    * Demonstrates ability to be nonjudgmental of staff and other aides
    * Sees many sides of a situation

- Good interpersonal, relational, and communication skills
    * Shows ability to learn and use problem-solving skills
    * Displays good listening skills
    * Asks for help or assistance
    * Demonstrates the ability to be self-reflective

- Ability to work as a member of a team
    * Maintains a good relationship with other staff and other aides
    * Receives positive feedback from residents and/or family members
    * Understands confidentiality and will discuss issues only with those who have a "need to know"

- Flexibility
  - * Able to respond in emergency situations
  - * Willing to be on call

- Knowledge of company policy, procedures, and culture
  - * Has exemplary work history
  - * Demonstrates knowledge of policies and procedures
  - * Understands how to access resources and explore options

- Ability to work independently and in potentially stressful situations
  - * Able to handle self in a calm manner in stressful situations
  - * Self-directed and able to follow directions
  - * Demonstrates good organizational and time-management skills

Minimum qualifications:

- Six months experience
- Familiarity with agency policies and procedures
- Ability to speak, read, and write functional English

Appendix D: Tools for Leaders

SWOT Analysis

Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis

SWOT Questions	Answers
Strengths What do you do well? What unique resources do you have? What do others see as your strengths?	
Weaknesses What could you improve? What resources do you lack? What might others see as a weakness?	
Opportunities What opportunities are open to you? What upcoming changes could you take advantage of? What trends can you take advantage of? How can you turn your strengths into opportunities?	
Threats What trends, or upcoming changes, could harm you? What is your competition doing? What do your weaknesses expose you to?	

Based on SWOT tool at *http://www.mindtools.com/pages/article/newTMC_05.htm*
Mind Tools is an excellent resource for leadership tools and short articles.

Authors and Contributors

Authors

Barbara Bowers, R.N., Ph.D., professor with the University of Wisconsin–Madison School of Nursing and Center for Excellence in Long-Term Care at the School of Nursing.

Kim Nolet, B.S., outreach specialist with the University of Wisconsin–Madison School of Nursing and Center for Excellence in Long-Term Care at the School of Nursing.

Tonya Roberts, B.S., R.N., doctoral student at the University of Wisconsin–Madison School of Nursing.

Sarah Esmond, M.S., former research coordinator at the University of Wisconsin–Madison School of Nursing and current project manager at the Center for the Study of Cultural Diversity in Healthcare.

Contributors

Brenda Ryther and Donna Kopp, Researchers with the Center for Health Services Research and Analysis.

Shiela Tunison, R.N., and Lucy Olson, R.N.