

# **KANSAS NURSING FACILITY PROJECT EVALUATION YEAR 3**

**For the Kansas Department on Aging**

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**September 21, 2006**

## Preface

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This report was prepared under contract for the Kansas Department on Aging. The investigators want to thank the Department on Aging for the substantial assistance provided to the study by many state staff. In particular, Mr. Bob Parker, our contract manager, gave us access to several data sets maintained by the state and coordinated comments and advice from state program managers and policy staff. We would also like to thank Bill McDaniel and George Dugger for their assistance in providing data, documentation, and background information on state data sets.

We also wish to thank our project consultants, Marilyn Rantz, RN, PhD and Greg Petroski, MS from the University of Missouri, School of Nursing, who provided guidance, advice, and data.

We also thank the nursing homes that participated in our on-site data collection and in the falls consortium.

Under subcontract, Myers & Stauffer, provided the project with extracts from the Minimum Data Set, including quality indicator and case mix adjustment files.

For any questions or comments concerning this report, please contact the Principal Investigator, Sarah Thompson, at (913) 588-1624 or at **sthompson2@kumc.edu**.

## **Communication, Leadership, and Teamwork**

# Communication, Leadership, and Teamwork

## Executive Summary

**Objectives:** The aim of this study was to examine nursing home working conditions, specifically staff perceptions of communication, leadership, and teamwork, using both qualitative and quantitative evaluation methods.

The research question for the qualitative approach included:

- Using a qualitative case study approach, what are the differences in staff perceptions of communication, leadership, and teamwork in high and low performing homes?

The research questions for the quantitative approach included:

- Are there differences between better and poorer performing homes on staff perceptions of communication, leadership, and teamwork?
- What is the relationship between staff perceptions of communication, leadership, and teamwork and nursing home staff turnover, deficiencies, and quality indicators?

### **Methods:**

For the qualitative approach: 4 nursing homes, 2 high performing and 2 low performing, were purposefully selected for an in-depth exploration of working conditions using participant observation, formal and informal interviews, and document review. High performing was defined as: 0 to 3 deficiencies on the most recent survey, no deficiencies above a scope and severity level of "D", and no deficiencies in the category "quality of care"; and low performing as: 10 or more total deficiencies on most recent survey, one or more "G" level or higher deficiencies, and deficiencies in the category "quality of care".

For the quantitative approach: staff in 100 randomly selected nursing homes completed questionnaires regarding communication, leadership, and teamwork.

### **Results**

- Resident centered values were explicitly and implicitly different between high and low performing homes.
- Leaders in high performing homes set clear expectations and role modeled trust, openness to new ideas, and flexibility.
- In low performing homes, staff worked more in silos, cross discipline teamwork was lacking, and CNAs expressed feelings of disempowerment.
- In high performing homes, trust, appreciation, and resident-centered values promoted numerous informal and formal communication channels. In low performing homes, conflict and a lack of trust eroded formal communication processes and little informal communication was witnessed.
- Staff perceptions of communication and teamwork were significantly related to turnover, total deficiencies, and quality indicators.

### **Implications**

- Communication, leadership, and teamwork are important organizational characteristics related to nursing home performance as measured by turnover,

deficiencies, and quality indicators. Our qualitative work suggests that the organizational mission (resident-centered values) combined with more effective leadership/management skills, are important to improving resident care. Findings from this study suggest that leadership/management development would be a highly important area worthy of future effort.

- Provider organizations must bear some of the responsibility in promoting organizational development in the areas of communication, leadership, and teamwork in their respective nursing homes.
- The leadership survey items may need to be revised. Insights, gained from the case studies, suggest that items on this measure may require revision to be more sensitive to the nursing home context.
- Nursing homes may wish to invest in training that teaches all levels of leadership in the home basic communication, problem-solving, and conflict resolution skills. The leaders, in turn, would become role models for other staff members.

## Introduction

Efforts to improve nursing home care have been met with mixed results. Interventions aimed at improving care, successful initially, are frequently not maintained over time. Researchers have turned their attention to the evaluation of organizational characteristics in an effort to understand what factors facilitate or impede improvements to care.

In Year 2, 2004-2005, we examined 3 organizational characteristics: staff communication, leadership, and teamwork using both qualitative and quantitative methods. Qualitative approaches included 4 case studies; 2 of the 4 case studies were presented in last year's report. Quantitative methods included collecting data from staff in 100 randomly selected nursing homes regarding staff perceptions of communication, leadership, and teamwork; descriptive statistics were generated and reported last year.

This year, we concluded our data collection and analysis for the remaining 2 case studies and evaluated the relationship between staff perceptions of communication, leadership, and teamwork (from the 100 randomly selected homes) and 3 important organizational variables: turnover, deficiencies, and quality indicators. First we report the findings from the final 2 case studies followed by the quantitative analyses. To provide a context for the reader, we begin by repeating the findings from the first 2 case studies. Nursing home #3 (NH3) and nursing home #4 (NH4) comprise new findings.

## Case Studies

In order to analyze working conditions, we conducted case studies in 4 nursing homes: 2 historically, well-performing and 2 historically, poor-performing. This approach provided a more in-depth evaluation of the interaction of complex factors for example, the use of problem solving strategies in dynamic interaction with leadership skills and staff teamwork. This information can be used to help KDOA identify additional factors that influence resident care and provide the industry with insights regarding organizational improvements.

- High performing was defined as: 0 to 3 deficiencies on most recent survey, no deficiencies above a scope and severity level of "D", **and** no deficiencies in the category "quality of care".
- Poor performing was defined as: 10 or more total deficiencies on most recent survey, one or more "G" level or higher deficiencies, **and** deficiencies in the category "quality of care".

### Data collection activities for case studies:

Two to three project staff were on-site over a 4-to-8 week period. These visits were intermittent and spontaneous in nature and occurred over different shifts and days of the week. Qualitative data collection methods such as participant observation, formal and informal interviews, and document review were used. Participant observation occurred in common areas of the nursing home – not private areas such as resident rooms.

Examples of common areas included hallways, dining rooms, parlor, sitting areas, staff break rooms, activity rooms, and courtyards. Examples of observations included:

- Environmental: smells, sounds such as loud noises, residents yelling or absence of, presence of plants or live animals
- Staffing levels
- Length of time to answer call lights
- Staff to resident interactions such as hugging, touching, smiling, eye contact
- Number of residents up and out of rooms and actively engaged
- Cleanliness of nursing home and appearance of residents
- Interactions during meal times
- Number of community contacts such as programs, volunteers, family visitors
- Meetings: we attended numerous meetings such as care planning, Medicare, nutrition, falls, and the like to observe staff interaction.
- Direct resident care **was not** observed

Examples of document review included:

- Policies and procedures for care processes such as pain management, weight management, skin care, fall prevention. We looked for evidence of the assessment of risk and systems to check, evaluate, and prevent adverse outcomes.
- Resident medical records **were not** viewed.

Examples of interviews:

- Formal one-on-one interviews with staff were conducted to elicit perceptions of communication, teamwork, leadership, care planning, and the like. Staff had the choice to participate or not. Interviews included administrative staff (e.g., administrator, director of nursing (DON), MDS nurse, department heads), direct care staff such as LPNs, CNAs, CMAs, therapists, and ancillary staff such as dietary and maintenance personnel.
- Informal interviews, spontaneous and naturally occurring conversations while data collectors were on-sight, occurred also. These types of conversations provide insights into activities that are naturally occurring.
- Residents **were not** interviewed or included in this study.

A brief overview the four homes follows. Little information about the characteristics (bed-size, location, etc.) is provided in order to preserve anonymity of these nursing homes.

## **Nursing Home #1**

Not-for-profit

> 80 beds

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**Purpose:** To describe the nursing home as an organization with a specific focus on three major areas: leadership, communication, and teamwork.

### **Data collection:**

- Observations of daily activities on 5 occasions.
- Observations of following meetings (8 total): Culture change, behavior, restorative, team leaders, fall review, palliative care, supervisor mentor, and Medicare.
- Formal interviews with staff (11 total): administrative, RNs, CNAs, and ancillary.

### **Leadership**

Leadership promoted the following values:

- “Teach people to see themselves and others in their most positive light; this is where people give their best.”
- “To improve the lives of older adults by providing exceptional services, housing, and health care within a faith-based community.”
- Focus on the good in others.
- The reason for existence is the resident. Leaders were perceived to value staff and to provide staff with the resources necessary to put the resident first.

Words and phrases used to describe leaders or their leadership style: delegate, listen, open door, mentor, train, educate, coach, flexible, creative, “management provides the tools we need,” open to new ideas, future thinking, supportive, growing, reward positive behavior, embrace new ideas.

The leadership team focuses on empowerment. Staff are given an opportunity to and encouraged to participate in decision making. Opinions are valued. There is a strong emphasis on growing and rewarding positive behavior. New ideas are embraced. Trust is a key element in the empowerment of staff. Learning and growing are valued at all staff levels.

Staff share and embrace the same vision for the organization “To create a real home for the residents.”

### **Teamwork**

Teamwork was evident on a daily basis. Working together as a team was emphasized and encouraged. During observations, members of the management team were seen helping out on the floor, answering call lights, assisting in the dining room; staff from housekeeping was observed answering call lights; and RNs assisted with hands-on direct care. One participant stated, “Good teamwork is fostered by mutual respect for one another.” The management team worked hard at being a role model and

staff described a commitment to their role, “everyone seems to take pride in the job that they do.”

Respect and concern for one another was often displayed. For example, a staff member described how the night staff started to empty trash cans for the housekeeping staff on a particular neighborhood without being asked. This was described as an effort to help out the day shift. Staff demonstrated appreciation for each other through spontaneous verbal praise, thank-you notes, an appreciation board, and use of tokens. Furthermore, staff described providing emotional support for team members, “When someone passes away, we grieve together. We are all a family, it feels like home. We provide each other with a support system for personal problems as well.”

In summary, there was a high level of teamwork and trust between staff and between management and staff.

### **Communication**

Staff described communication as “Communication is very open, people talk to one another.” Numerous formal and informal methods of communication were noted. Examples include:

- Bulletin boards
- Newsletters attached to paychecks
- 20-minute flat meetings
- Neighborhood newsletter
- Numerous meetings

Meetings were an important avenue for communication. The following dynamics were observed:

- Inclusion of multi-disciplinary team members
- Started on time
- Circle seating
- Expectations, purpose, agenda clearly articulated
- Meetings brief and to the point
- Validation and acceptance of everyone’s opinion
- Comfort with differing opinions
- Brainstorming encouraged
- Solutions followed-up on in timely manner
- Respect demonstrated
- Meeting goals were met

A formal/informal rule is used to guide problem solving and conflict resolution. This is described by staff as:

- Problems are resolved within teams first through brainstorming. Solutions are shared with management.
- Conflicts are discussed within 24 hours of the incident; this is in accordance with the 24-hour rule.
- Respect and praise are commonly displayed.

### **Residents are the priority.**

Good staffing, positive attitudes, and respect for others are displayed throughout the organization. Staff know residents by name, their likes and dislikes, and answer call lights quickly. The staff show genuine interest in residents. Resident input into care decisions is valued. Laughter, touching, eye contact, and verbal interaction are openly displayed.

### **Summary**

Formal and informal leadership was demonstrated at all staff levels. CNAs were empowered. The organizational values and mission were embraced by all staff. The organization itself was dynamic, growing, and thriving. The dynamic nature of this organization was fostered by investing in staff who in turn invested in the residents. Communication and teamwork were nurtured and well developed.

Most important to note: No one ever covertly or overtly expressed that economic efficiency or state/federal regulations were the guiding values for this organization.

## **Nursing Home #2**

For-profit  
> 80 beds

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**Purpose:** To describe the nursing home as an organization with a specific focus on three major areas: leadership, communication, and teamwork.

### **Data collection:**

- Observations of daily activities on 14 occasions. These included general observations of activities as well as shadowing personnel such as CNAs or charge nurses.
- Observations of following meetings (3 observations): AM administrative meeting on two occasions and one care planning meeting.
- Formal interviews with staff (9 total): administrator, DON, Social work, dietary, rehab, Charge nurses, and CNAs.

### **Chaos**

Chaos is the best term to characterize this nursing home.

During the course of the study there were major changes.

- Administrator at the beginning of the 6 week study was the 3<sup>rd</sup> in the previous 8 months. Administrator was fired during the 6 week study and a new one hired.
- MDS nurses (2) had been there 3 months and 2 months each. One fired/left during study.
- Social worker had been there 4 months, left/fired during study.
- Rehab manager had worked at nursing home for 2 years, but only as a manager for 6 months. Three of the current therapists had been there for only 3 months.
- DON was the 3<sup>rd</sup> since 2000; she quit during 6 week study.
- Business administrator fired/quit 2 weeks prior to beginning study.
- Maintenance manager quit.
- Staff development person was ill when we began study; quit during course of study.
- Several CNAs were hired during course of study and quit. As DON commented, "Two weeks ago I hired 4 people, they have all quit."

The general appearance of the hallways contributed to feelings of chaos. Hallways were very cluttered including items such as med carts, supply carts, laundry carts, resident wheelchairs, trash carts, floor buffing machine, scales, and BP monitor. At times it was difficult for staff and residents to navigate the hallways.

Meetings such as behavior or care planning were rarely held. We were provided a schedule, but only one care planning meeting occurred according to schedule. Meetings were cancelled without notice or "just didn't happen" without anyone having an

explanation. For example, when one of the staff attempted to hold a meeting regarding resident nutrition, other staff responded by saying they did not have time to attend. Aside from the AM mandatory administrative meetings, we were able to observe only one meeting.

## **Leadership**

With the tremendous staff turnover, the nursing home has been in a continued state of transition. Staff described each new “leader” (DON and administrator) as having different leadership styles. Varying leadership styles has led to confusion about organizational expectations and goals and has also contributed to a breakdown in communication and trust.

The administrator (that was in-place at the beginning of the study) was described as “he doesn’t have a clue;” and too laid back. Numerous staff described the need for stronger administrative leadership. Staff wanted an administrator that would get his/her “hands dirty,” meaning he/she would get out on the floor and work if necessary. The administrator described himself as a “hands off” person. The DON was described as a great person to talk to and very supportive, but not a strong leader when dealing with problems. Department heads described needing more leadership from the administrator; being in need of a role model.

Staff lacked a clear vision and mission for their organization and their work. The explicit-written corporate mission of resident care was frequently in conflict with verbal messages received from administration and resources provided. This led to confusion and a conflict between values. For example, front line staff, including CNAs, rehab aides, and dietary personnel described their mission as “the residents.” Certainly, the strongest asset of this nursing home was the love and attention given to residents by front line staff. When observing day-to-day activities, numerous exchanges of care, concern, and love were observed. Staff attended to resident personal needs, such as grooming, and answered call lights as quickly as possible.

However, there were conflicting values evident. For example, one department manager was told his staff could no longer work overtime. This mandate was handed down without apparent explanation or evaluation of causes for overtime. The same department manager who was instructed to not have any overtime was reported by staff as one who would “pitch in and help.” Although, his department was dietary, he had been out on the floor making beds when there was not enough nursing staff. Front line staff talked frequently of the need for more staff, yet in the AM department manager’s meetings, there was a primary focus on the balance between Medicaid and Medicare residents, new admissions, and keeping the beds full as well as “getting through” the next survey. Department heads were instructed to conduct checks twice a day for problems that surveyors would notice, to correct the problem immediately, and to confront the staff person responsible. Yet, there was no discussion regarding why these problems were occurring or any long term solutions.

Problems with leadership and mission were evident when meetings were abruptly cancelled due to lack of attendance and other unknown causes. We asked for a list of meetings when beginning the 6 week project. Of the list of meetings provided, the daily department head meeting was the only meeting which occurred on a regular basis. We were told this meeting was mandatory by the corporate office. A formal outline was

used for this meeting; a task sheet was completed, and faxed to the corporate office. There was a lack of communication, leadership, and teamwork that was noted when observing these meetings, for example: 1) when a department manager was absent no one knew where the person was; 2) when problems were discussed there was a conspicuous absence of collaborative communication, generalized brain storming, and problem solving. The administrator or a department head would provide one solution and then the meeting quickly proceeded to another problem or issue. The "solution" was not formally adopted, there was an absence of "who" would be accountable for a solution or follow-through; there was an absence of communication to see if there was agreement or "buy in"; and there were no indicators discussed or established to evaluate if the problem had been solved; and 3) Staff tended to blame others for problems and offered responses such as, "I didn't know we were supposed to be doing that."

There was one department head that demonstrated good leadership and team building skills. He described himself as a "coach" and that his job was to develop a team. He gained respect from his subordinates by working with them when there were shortages. He won the respect of coworkers in other departments by helping make beds when nursing was short-staffed. He believed all of his staff were deserving of respect, but also demanded respect in return. This belief was supported by staff comments. He clearly articulated the mission for his department as being "for the resident." He believed that if his subordinates understood the "reason" behind policies and decisions combined with proper training and resources, the staff were more likely to "get it right." He displayed a personal interest in his staff; he "touched base" with each person every day.

Leadership from the corporate office was viewed as both a strength and a weakness. Each department manager had a corresponding regional representative that could provide guidance and support for their department's needs. This was seen as a strength. However, staff also viewed the corporate office as having "tight control," allowing little flexibility and individualized decision making that would be beneficial to the more specific needs of this nursing home. Decision making was described as hierarchical, "from the top - down."

## **Teamwork**

The continual change of leadership combined with staff turnover has had an impact on how the employees work together and the manner in which resident care matters are communicated and solved. Trust was lacking within most departments and across departments. Staff also expressed mistrust of the corporate office. The individuals interviewed felt that the change within numerous roles had a direct impact on how the teams worked together. For example several times when asked whether or not the care plan meeting was going to be held, the response received was "I don't know"; when asked "who might know," the response was the same, "I don't know". No one seemed to know who was directly responsible for scheduling meetings. The lack of leadership and teamwork influenced resident care planning.

Staff described "cliques" as thwarting development of teamwork. Older staff described newer CNAs as "less likely to work as a team." Training for new CNAs was only one week and as described by staff "if they were not accepted by a more senior person, they will quit." There were a couple of examples of new hires being teased by other staff, probably contributing to their rapid turnover. Cliques among CNAs made consistent communication regarding resident care difficult. This lack of teamwork

coupled with heavy workloads was believed to be a primary cause of staff turnover, especially with newly hired staff. Some staff described work as “every man for himself.” Examples of poor teamwork include: the night staff didn’t help the day shift housekeeping crew by completing small cleaning chores, resident needs were ignored by staff not assigned to particular resident, lack of attendance at resident care meetings, lack of input from CNAs at care plan meetings (they were not included when meetings occurred), and by a lack of validation of CNAs opinions regarding resident problems when reported to charge nurses.

During the course of our study, there was a lot of concern expressed about the upcoming survey. The staff we interviewed believed there was a direct relationship between the continual turnover and teamwork. The lack of teamwork contributed to communication problems regarding resident care which fueled concerns about the pending survey. For example, one resident had not been bathed in three weeks and the MDS nurse did not know a resident was receiving hospice care. We also documented little teamwork during our observations.

Many nursing homes have implemented numerous methods for positive reinforcement and signs of appreciation for staff. Other than a corporate reward program, a monthly reward for staff who demonstrate positive concern for client relations, there were no other formal or informal tokens of staff appreciation observed.

Formal or informal mechanisms for problem solving, conflict resolution, and team building were not evident. Except for the dietary manager, this did not seem to be occurring on a systematic basis. The dietary manager described staff meetings where problems were addressed. He reported that he required his staff to identify problems and to suggest a solution.

## **Communication**

Problems with leadership and teamwork affected communication. Examples of breakdowns in communication were numerous. Decisions decided in the AM management meetings were supposed to filter down from department heads to staff. There was little evidence that this occurred except for informal channels that were not detected during our observations and interviews. There were numerous examples of areas where problems could result from unstructured formal or informal communication. For example, the lack of attendance at care plan meetings made the translation of resident information difficult. MDS nurses placed care plans on chart, but there was no evidence that CNAs read the information. Information was communicated in a “communication book” for CNAs; however, CNAs admitted to rarely using this communication mechanism.

Staff described the DON as a person they approached with problems and concerns. However, when observing staff interactions problem resolutions and accountability remained unclear.

## Nursing Home #3

For-profit  
> 80 beds

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**Purpose:** To describe the nursing home as an organization with a specific focus on three major areas: leadership, communication, and teamwork.

**Data collection:** We used several data collection methods commonly used in organizational evaluation. These included observing the setting and day-to-day activities, formal interviews with staff, and informal interactions with staff when observing naturally occurring activities.

- Observations of daily activities for a total of 19 hours.
- Observations of scheduled meetings, such as utilization review.
- Formal interviews with staff (13 total).

## Results

Several strong values were demonstrated by the formal leadership [we defined this as administrator, DON, ADON] and the mid-level management [we defined as department heads] and are embraced by charge nurses and informal leaders. The primary value of this organization is resident-centered care and mission; the resident is the reason for being for this nursing home. The more common, implied nursing home values of economic efficiency and compliance with survey regulations were rarely discussed and when discussed were in the context of a specific event. A resident-centered mission creates and drives the secondary values found in this home: a sense of community and home-like environment as well as the importance placed on individual staff. A strong value was placed on staff as *invaluable to reaching* the overarching mission: the resident. These values were demonstrated by the formal leadership in day-to-day activities and their management style as well as by front line staff in their daily relationships with residents and each other. These values are embedded in our findings related to leadership, teamwork, and communication. A discussion of each of these organizational attributes follows.

## Leadership

The formal leaders such as administrator, DON, ADON, and mid-level leaders such as department heads were asked to describe their leadership style. Their answers shared a consistent belief expressed through different examples: that for a nursing home to do a good job taking care of residents, the staff must feel valued. These leaders discussed the different ways they “took an interest in the lives” of the staff that worked in the facility. They cared about what was going on in someone’s personal life, including life circumstances, children or spouses, and acknowledged occasions such as birthdays. One person expressed, “staff feel valued here because of the way they are treated.” Another person shared, “I make it a point to have a relationship with my staff.” As one CNA shared, “I’ve worked in other facilities where the administrator never acknowledges you.” This is not the case here. Core leadership values of trust, respect, teamwork, and a resident focus have been transmitted to all staff levels. For example, department heads, charge nurses, and even direct care staff are encouraged to solve problems at

the level they occur instead of bringing them up the “chain of command” unless absolutely necessary.

Leaders were described as firm and fair, plus they led by example. Staff noted that the administrator, DON, and department heads would work “on the floor” if necessary. No one was “too good” to pitch in and help reach the organizational mission. Leaders were also described as open. Department heads were given flexibility and authority, based in trust, to address their own issues before bringing problems to the administrator. The leadership was focused on developing good staff and getting rid of the ones that did not embrace the same organizational mission.

The leadership benefits from being a cohesive group and several members of the more formal leadership network have been there a number of years. When asked about leadership, staff also spoke about a previous administrator. Although previous administration was not the focus of our study, we found that staff spoke highly of the current and previous administrator. Staff spoke of some differences between the two; however, the resident centered mission remained the same and provided a sense of cohesiveness between two different leaders. This speaks to the more enduring effects of values when embraced by both formal leadership and staff.

### **Teamwork**

Teamwork was evident by staff assisting each other with daily activities and the numerous ways staff demonstrated appreciation for each other. Two bonds created a sense of family and fostered strong teams in this home: 1) the resident centered mission and 2) a genuine appreciation for each other. One staff member captured the sentiment, “I could go somewhere else and make a couple of dollars more an hour, but this is where I am supposed to be.” Other quotes demonstrated the sense of family and commitment to the residents and this organization:

- “We work well together, we are like a family. If you are short, people will jump in and help you.”
- “This is the residents’ home. We have the pleasure of working here.”
- “We work well together; this is a great place to work.”
- “Just because I am a RN, doesn’t mean that I am any better than the rest of the staff. We are all equal.”
- “Its not about a job, it’s not about a paycheck. The residents are not just warm bodies. The staff really tries to take care of their needs. This is their home and it needs to be safe.”

Staff demonstrated appreciation for each other by helping each other, and also through tangible awards for good care. These awards included things such as gift certificates, candy bars, movie passes, and verbal acknowledgement. Staff looked for ways to appreciate each other. The direct care staff noted that teamwork was role modeled by the administration and it permeated other staff levels.

Teamwork was enhanced by a core group of individuals that had worked together a number of years and had the opportunity to develop trust and community. People were focused on what the meaning of their job was. When discussing the low turnover, one person shared that staff were committed to the residents and felt as if they were part of a family. Although there were new staff who had only been there a year or so, many staff noted they had been at this facility for 3 years, 12 years, 7 years, and 18 years!

Of course, no organizational system is perfect and there were staff that made some negative comments. However, these were minimal and that is especially noteworthy.

It is evident that this facility has developed a sense of family, community, and commitment to the organizational mission – the resident. Trust is necessary for teams to function and this is enhanced by the positive behaviors role modeled by formal leaders and good communication.

### **Communication**

There are numerous ways that staff communicates with each other. Most of these communication mechanisms are informal in nature. For informal mechanisms to work in a complex organization such as a nursing home, they have to be embedded in trust. Open communication was demonstrated up and down the more formal levels of management as well as horizontally within departments and on units. Most important to the delivery of resident care is that CNAs perceived an open communication with their charge nurses and perceived the charge nurses listened and acted when they brought resident concerns/issues to their attention. CNAs described feelings of being respected by most licensed nurses and that their opinion was valued. Interesting to note is that CNAs did not participate directly in resident care plan meetings; however they felt their opinion was important, elicited, listened to, and valued. This is noteworthy, since recent nursing home organizational research has highlighted the need for CNAs to have a “voice” in resident care planning.

The charge nurses appear to be the pivotal link in the horizontal or vertical communications. They send important information to superiors and are the ones who most directly impact CNAs perceptions of feeling valued. As one person shared, “The charge nurses really hold this place together.”

More formal communication takes place through regularly scheduled across department meetings. Department heads take the responsibility for communicating information directly with their staff and staying in touch with their staffs’ needs. Other communication methods included reports at shift change, communication books, and facility newsletters.

## Nursing Home #4

Not-for-profit

> 80 beds

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**Purpose:** To describe the nursing home as an organization with a specific focus on three major areas: leadership, communication, and teamwork.

**Data collection:** We used several data collection methods commonly used in organizational evaluation. These include observing the setting and day-to-day activities, formal interviews with staff, observing meetings, and informal interactions with staff when observing naturally occurring activities.

- Observations of daily activities for a total of 30 hours.
- Observations of 10 regularly scheduled meetings, such as unit meetings.
- Formal interviews with staff (37 total).

### Results:

Every aspect of this evaluation has to be interpreted through a historical lens. Almost every person that we spoke to brought up what this nursing home has been through the past two years. Staff used the following words or expressions repeatedly -- the dark days, living in fear, chaos, no trust, living in fear of losing their job, the unknown, too much growth too fast -- to describe the last two years. One person summed up the expressions of many, "we have been in crisis mode for two years." Even in light of this historical perspective and *feeling*, many staff were very positive about the new administration. Staff recognized that there was a need for time and the development of trust, but made positive comments such as, "better administration, you can trust them now;" "the management team is approachable;" "management is taking time to build trust;" and "optimistic".

The administrators (implying more than one upper level management person) had accurate perceptions of staff and consistent visions. Both saw the need to empower front line staff, to have front line staff involved in communication and decision making, and to improve staff morale. Both spoke of the desire to create a stronger resident centered focus through participatory leadership, communication, and greater teamwork. It is interesting that they both spoke of the need to use positive reinforcement with staff or to use staff problems as opportunities for development as opposed to disciplinary action such as firing. This attitude has clear implications because staff that we spoke to made numerous references to the use of negative reinforcement such as "being written up," "fired," or "taken care of" as opposed to references to positive reinforcement or staff growth.

Silo is probably the best term to describe working relations in this home. Departments, such as nursing, social service, housekeeping, and activities have very defined territories that foster a lack of problem solving, communication, and teamwork *at the unit level*. Problems are described by numerous staff as being solved by their own boss, that they "go up the chain of command" to have an issue dealt with. Especially noteworthy is the lack of problem solving or communication that occurs *within units across disciplines*. This probably began with the previous administration and is fostered by the size of the

facility, the current lack of trust, and inability of front-line staff to not only know how to solve problems but feeling unempowered to do so. Maintenance is the star and the one department that everyone speaks highly of. The director of maintenance is described as a person who recognizes problems and gets them solved.

### **Leadership**

The management team has been turned upside down over the last four years. Many at the management level share a common core value, residents and family are first. The management team sees the need to foster greater teamwork, communication, and to empower the front-line staff, however this vision has not been put into practice yet. Many describe the upper management as working together as a team. This view, however, is not shared by all. There is conflict between departments and a lack of trust. The value, we are all here for the resident, breaks down when departments protect their territories. Undoubtedly, this has been fostered by the facility's history of fear and constant change. In general, people are very positive about the future with the new administration, but this has not changed feelings and perceptions yet.

Unit managers are the leaders for the front line staff and there has been great turnover in these roles as well. Some staff are uncertain about who to turn to for assistance and advice, for example some describe going to their social service unit director for some issues, but seeking out a nurse manager for clinical issues. This seemed to lead to some confusion and lack of clarity. For others such as ward clerks, there was some confusion about who they reported to. Good unit managers are described as ones who are positive with staff, create positive working environments, are "not afraid of getting his/her hands dirty", are willing to help in the dining room or wherever the need is, and/or have strong nursing knowledge.

Few people were acknowledged or described as role models.

### **Communication/problem solving**

Communication is described as fragmented within and across departments. Looking at the language people use to describe their perceptions offers valuable insights. When interviewed, staff described communication in the following ways: fragmented; the greatest weakness; secretive; hush-hush; "don't know something 'til you done it wrong;" "too many sheets [paper forms to be filled out], too many people;" and the use of the words "up and down." Communication is perceived as a hierarchical process which has implications for teamwork, problem solving, and decision making. Noteworthy is that communication is not described in terms of a lateral process within units. Within smaller departments, such as activities or social work, these individuals perceive their intra-departmental communication to be good; however, this breaks down at the unit level across disciplines.

Other descriptions of communication included: "we don't have a good system in place that includes the front line staff in communication and decision making"; communication from one shift to another is sketchy; communication on the units is very weak, many staff do not feel listened to – they bring problems to the unit manager and then staff don't know what happens after that; we need to build bridges; taking an issue up the chain of command to get it solved; staff don't get the information unless someone tells them; things are hush-hush and stay within departments; communication is the biggest problem; why don't they ask us [CNA] we are the ones with the resident; and if you don't pay attention it will be a long time before you know what is going on.

Communication has a historical perspective also. Several individuals noted the way things used to be. One staff member shared, “we used to have care plan meetings with the LPN, social worker, activities person, dietary, and MDS coordinator. That really helped us to know what was going on. We don’t do that anymore.” Another staff member compared the present to the way things were: “staff are resentful. When we were smaller, staff felt part of decisions. We had input. People saw the DON and ADON out on the floor, helping, we felt part of a team. Now people are disconnected. We never see the DON and ADON on the floor; I don’t even know what they do.”

One unit is perceived to be the “better unit” with regards to teamwork and communication. The majority of staff agrees with this perception. This unit has many positive attributes such as a smaller unit, less turnover of staff, and better teamwork for most staff. In fact one staff member reported, “the LPNs work well together on this unit, we don’t stab each other in the back.” However, perceptions of communication and problem solving are not consistent even on this unit. There are differences across disciplines and within levels of nursing personnel.

Weekly unit meetings are described by staff as the primary mode of communication for staff within units. As a general practice, policies and memos were communicated to staff in these meetings. However, when issues or concerns were raised by individual staff there was little evidence of problem solving, leaving staff unempowered. Examples include a concern raised about a unit being dirty on the weekend. The reply that the staff member received was that there was less housekeeping staff on the weekend. At another unit meeting a staff member raised the issue of shift report and rounds saying that staff don’t hang around. The reply to the staff member’s concern was, “absolute rounds, no questions, the end.” Another example includes a CNA who raised a resident care issue that was communicated to the charge nurse but the resident did not receive appropriate nursing intervention. The CNA was told to document, leave a paper trail, and that her job was to advocate for the resident. The CNA responded, “how am I supposed to cover my butt when it gets thrown in my face later?” When told to speak up for residents, another staff member muttered under his/her breath, “why don’t we get a rope and hang ourselves.” In summary, basic information is being provided in unit meetings and some concerns are being raised by the front-line staff. However, there is a lack of problem solving – identifying the core issue, identifying possible solutions, adopting a solution, and following up to see if the solution is addressing the problem. One person succinctly summarized this issue, “problems and solutions are lost after unit meetings.” This lack of problem solving erodes morale and disempowers staff.

Besides the unit meetings, communication processes included communication books, posted notices, notices in mail boxes, and notices with pay checks. Most staff described the dominant mode of communication as verbal and “just telling people.” Most acknowledged that the current system of paper notices did not work. That staff were informed of information at unit meetings, through the grapevine, or when they did something wrong. It is not clear from our interviews why the existing paper mechanisms are not being used effectively. However, the comment “too many sheets, too many people” may shed some light. The staff member was referring to a lot of documentation going to too many different people and not knowing what is happening to it all.

When analyzing our data, the use of the term “written-up” was used frequently to describe how personnel problems were addressed. It is important to draw attention to

this because of the number of times this expression was used and the negative feelings it creates. The term “written-up” denotes wrongful behavior and punishment, and creates a negative, fearful feeling. If staff perceive that this is how problems are addressed, this may continue to fuel fear and a lack of trust. These are not the feelings that the current administration wants to foster.

Decision making was viewed as hierarchical. When staff were asked about how decisions were made they referred to their director such as social service director or activities director, the unit manager, DON, or NHA as making the decisions. CNAs reported that the MDS nurse or charge nurse might ask them about residents but they were not part of the decision making process regarding resident care. For some people, having their supervisor make all the decisions was not viewed as a problem, but for others it was. Within units, perceptions varied. Some staff viewed they were part of a decision making process for unit specific issues or resident care and others did not. The lack of consistency in perceptions of working relations within units is noteworthy.

Perceptions of one’s ability to influence decision making varied among staff. Some licensed staff perceived they had authority to make decisions regarding resident care on their unit. Other licensed staff and CNAs did not. Some believed their charge nurse or unit manager listened when concerns were raised, others did not. Many perceived that decisions were handed down without input from staff on the unit. Examples include changes in a MAR process, a resident weighing process, and even feedback from a risk management group. Some staff perceived that issues such as falls were discussed in a risk management group and interventions were “handed down” by this group who did not know the resident.

### **Teamwork**

The amount of teamwork displayed varied considerably between departments, units, and even hallways within units. However, it is important to note that a high percentage of people interviewed felt as though teamwork existed to some degree whether it be between two people or within one shift on a unit. Staff on “the better unit” perceived greater teamwork and this was supported by our observations of staff assisting each other with tasks, answering each other’s call lights, and asking if another staff member needed help. In general though, teamwork was isolated to people or shifts and did not consistently include multiple disciplines, levels of staff, or shifts. For example, the 7-3 shift worked well together, but the other shifts did not, or two disciplines worked well together on a unit but had negative things to say about another.

The facility has many long term and dedicated employees. Dedication and commitment was evident from the number of employees who had considerable longevity. The majority of staff embraced the value of “resident comes first” and this was demonstrated by positive interactions with residents. Laughter, concern, touching, and positive verbal interactions were openly displayed. Generally, staff responded quickly to resident needs. The strong value of resident care was not enough however to bridge conflict between shifts or disciplines as there was considerable finger pointing.

In our interviews, we encountered many negative comments about nursing that probably foster silos and an “us versus them” working environment. Nursing is undoubtedly the largest group of employees when counting licensed and unlicensed staff, so intuitively this group of people will experience more problems when introducing change or fostering growth. However, these verbal expressions perpetuate an “attitude of blaming” and

finger pointing. These attitudes likely impede the development of positive relationships and collaborative teamwork necessary for resident centered care. Examples of expressions include: “nursing takes anything you say as a personal criticism, you pay a price if you say something to nursing;” they [nursing] get back at you one way or another; “they are right and everyone else is wrong;” “big disconnect with nursing;” “we are supposed to write ‘em [CNAs] up;” and “nursing is a challenge, lots of times we have to go above the person to get things done.”

One of the major impediments to teamwork, as voiced by staff, was pulling to cover other units. Comments such as “staff are floated, they get fed up and quit;” staff don’t know who they are going to work with or where; people will call in sick if they know they are not working on their own unit; and people don’t feel valued when they are floated. One aide was observed discussing being pulled the day before. She described feeling overwhelmed and near tears the entire evening because no one helped her. Conversely when two staff members described not being pulled their comments were positive: “residents love having the same staff member everyday;” and “I am always in the same spot. It is like my family over here.”

Staffs’, including social service, activities, and some nurses, perceptions of CNAs are very demeaning. It is likely that these perceptions are being communicated in subtle and not so subtle behaviors. Certainly CNAs who repeatedly call in sick, take too many breaks, and do not fulfill their responsibilities are problematic, but what is noteworthy was the use of language to describe CNAs across numerous interviews, units, and disciplines. These comments include: *numerous* references to CNAs as “kids”, nightmares, needing to be “watched closely”, not on the same program, difficult, sloughing off, not in it for the resident, just kids who think they know it all, having attitudes, and as being the biggest challenge. This is a major impediment to teamwork and CNA empowerment.

As the facility moves toward the concept of neighborhoods, it is important to note that not everyone understands what that means at their own individual unit level. Not understanding what this means for one’s unit and job will probably continue to foster feelings of uncertainty and fear about jobs. One person shared, “front line staff need to have buy in with culture change – they are still wondering if their input will be included and what this is all about.” Not everyone has bought into the concept of “neighborhoods” in fact there are some in leadership positions that oppose the concept. One staff member shared that she didn’t like this “neighborhood thing.” She believed that staff needed to be flexible and work on other units. She tells staff they work for [name of nursing home], not a neighborhood and she tries to move them around as much as possible.

### **Scheduling and orientation**

Scheduling and orientation were two issues that were frequently mentioned by staff as contributing to low staff morale, conflict, and frustration. Staff expressed that two schedules were made, a long version covering two weeks and a daily. However, the daily schedule could be quite different from the longer schedule. Staff expressed anger and frustration over not knowing when and where they would work. Staff also expressed a lack of communication and feedback regarding vacation requests.

Many staff noted that orientation of new staff and continuing staff education were significant problem areas. Comments included: new staff don’t get trained; CNAs are

thrust into their job with little training; orientation is one of the weakest areas; we hire a lot of CNAs right out of school; new staff need more education – they are very green; we all need training here, but all they care about is sending down a bunch of paperwork on how to do things. That's not how you learn the correct way to do things; and “new staff orientation is a joke;” “staff need to understand why they have to do things. Why is considered a bad word here;” and “we need better orientation that is directed to the level the person is when they are hired and not just education, but experience too.”

In summary, this nursing home has been through turbulent times. Staff feel positive about the new administration and staff believe in the mission – the resident comes first. However, this period of chaos has resulted in fragmented communication, a lack of trust, the development of silos that hinder problem solving, and low staff morale, primarily with CNAs. Problems with communication, teamwork, and problem solving thwart staff efforts to fulfill the mission – resident centered care – in a manner that is personally rewarding for staff.

## Summary of case studies

### Resident centered mission and values

The better performing homes had clearly articulated resident-centered values that were both explicitly stated by staff and implicitly stated through day-to-day activities. Simply, the care and quality of life of residents was the reason for being. In order to accomplish a resident centered mission, a second, equally important value was demonstrated, i.e., care of staff. In NH1 and NH3, administrative staff role modeled care and respect for staff in a variety of ways: pitching in when necessary; being seen out on the floor; acknowledging the presence of individual staff; having the resources (staff and equipment) to get the job done; and recognizing staff in a variety of ways such as birthdays, tokens of appreciation, or support during difficult personal issues.

Although the prominently displayed plaque described a resident-centered mission, staff meetings and conversations in NH2 were focused on financial concerns, filling beds, and passing an impending survey. The conflict that arose between caring for residents, financial efficiency, and passing a state survey contributed to an erosion of trust between the administration, middle managers, and staff. In NH4, the new administrators were creating and promoting a resident centered mission; however, they had not been in place long enough for this vision to permeate the working conditions of this home. The home continued in a state of conflict and mistrust.

### Leadership

In NH1 and NH3, the leadership (including administrators, middle managers, and charge nurses) role modeled trust, open communication, teamwork, and horizontal decision-making. Leaders set clear expectations, yet trusted staff to be flexible and creative when solving problems. Leaders were open to new ideas and valued staff participation in decision making. In fact, few problems were “brought up the chain of command.” Staff were encouraged to solve the problem at the level it occurred. Openness, trust, and flexibility promoted the identification of problems and allowed problems to be solved at the lowest level possibly, frequently at the bedside.

In the poorer performing homes, leadership was diffuse and without clear expectations. Problem solving was clearly lacking. When problems were identified, there was a lack of creativity in problem solving and a lack of empowerment for a variety of individuals, including front-line staff, to engage in problem solving. Solutions came from the top – down and were not embraced by the staff affected by the problem. There was a lack of accountability and follow through. Further, leaders did not demonstrate trust, creativity, and a willingness to “pitch in.” For NH2, being part of a large chain or corporation created an additional hierarchy of rules and regulations that thwarted creativity toward addressing problems within their own specific context. For NH4, chaotic changes in administration had led to a breakdown in trust. In fact, leaders at the manager levels fostered more conflict between disciplines.

### Teamwork

In NH1 and NH3, individuals pulled together to accomplish the mission, resident-centered care. Formal leaders role modeled mutual respect and helping each other out; this in turn was role modeled by other staff within and across disciplines. Staff demonstrated numerous mechanisms of appreciation such as verbal praise, tokens, and thank-you notes that enhanced teamwork. Staff knew enough details about each others’

personal lives to demonstrate emotional support and concern. Staff described feeling like a family.

In the poorer performing homes, administrative personnel and unit managers were not as visible nor seen "helping out." The lack of problem solving and positive interaction with administration fueled a lack of trust and the formation of cliques. Very little appreciation was demonstrated. People worked more in silos; cross discipline teamwork even within units was not evident. In both of the poorer performing homes, CNAs expressed feelings of disempowerment and being unvalued.

#### Communication

In NH1 and NH3, trust, appreciation, and resident-centered-core values embraced by staff, promoted numerous informal and formal communication channels. Formal communication patterns such as notices attached to bulletin boards or paychecks were used; however, what was noteworthy were the numerous methods of informal communication regarding resident care that were used spontaneously and routinely. Informal communication flowed seamlessly within and across disciplines and between staff on units.

In NH2 and NH4, current and past conflict around the core mission eroded trust, thereby promoting the breakdown of communication. Formal communication mechanisms, such as reading and signing off on new policies, were not routinely used. Informal communication patterns were rarely used, except within cliques. This decreased the amount of information that was shared regarding resident care.

## Quantitative Analyses

### Research Questions:

Are there differences between better and poorer performing homes on staff perceptions of communication, leadership, and teamwork?

What is the relationship between staff perceptions of communication, leadership, and teamwork and nursing home staff turnover, deficiencies, and quality indicators?

Table 1: Comparison of NH1 and NH3 with NH2 and NH4

Case Study	Leadership	Communication	Teamwork
Better performing NH1 and NH3	3.33	3.38	3.59
Poorer performing NH2 and NH4	3.24	3.11	3.36
t statistic	.9154	2.878	2.326
P value	.180	.002	.010

NOTE: Homes participated in the survey data collection reported in Year 2 regarding leadership, communication, and teamwork.

The “better performing homes” demonstrated significantly higher mean scores for communication and teamwork when compared to the “poorer performing homes.” The mean leadership scores for “better performing homes” were higher, but were not significantly different from “poorer performing homes”.

Table 2: Comparison of Teamwork, Communication, Leadership with Total Turnover

N = 86	Teamwork	Communication	Leadership
Turnover <sup>^</sup> Pearson correlation	-.325**	-.367**	-.138
P value	.002	.002	.203

<sup>^</sup> Turnover data from 2004

Homes with lower staff perceptions of teamwork and communication had statistically significantly higher levels of total staff turnover.

Table 3: Teamwork, Communication, and Leadership with Total Deficiencies

N = 96	Teamwork	Communication	Leadership
Total Deficiencies <sup>^</sup> Pearson correlation	-.282**	-.258**	-.147
P value	.003	.006	.077

<sup>^</sup>Note: total number of deficiencies for 2004

Nursing homes where staff held lower perceptions of teamwork and communication had statistically significantly higher numbers of total deficiencies. Negative perceptions of leadership were associated with higher levels of deficiencies, but the correlation was weaker and not statistically significant.

Table 4: Teamwork, Communication, and Leadership with Quality Indicators

	Teamwork	Communication	Leadership
Total QIs <sup>^</sup>	-2.17*	-2.57**	-2.36*
	0.030	.010	.018

<sup>^</sup>Through convening a panel of experts and using a Delphi technique, Rantz et al. (2000), set thresholds for quality indicators. Thresholds were set by this panel in an attempt to describe better or worse resident outcomes when comparing facilities to themselves and others (for more information see Rantz et al.) Using a threshold, each nursing home can be examined for the number of times it is above or below the set threshold on a specific quality indicator. Furthermore, looking at the number of times one is above or below a threshold on a specific quality indicator over time gives a better indicator of performance in a particular area. Looking at one quarter only, provides a simple snap shot of care and may or may not be indicative of care provided on a more routine basis. Looking at trends provides a more sensitive analysis of homes performance over time. Thus we used the thresholds established by Rantz et al., and examined homes performance in each of 14 indicators (listed below) over 4 quarters in one year (2004). A nursing home that was above the threshold on an indicator in one quarter received a “1” and if the home was below the threshold they received a “0”. A nursing home below the threshold on all 14 indicators across all 4 quarters received a total score of 0; and home above the threshold on all indicators across all 4 quarters would receive a score of 56.

- Q9: Occasional/frequent B/B no plan,
- Q8: Bladder or Bowel Incontinence,
- Q7: Incidence of cognitive impairment,
- Q6: 9+ meds,
- Q5: Sx of depression w/o antidepress therapy,
- Q4: Symptoms of depression,
- Q24: Stage 1-4 pressure ulcers,
- Q22: Daily physical restraints,
- Q2: Falls,
- Q17: Incidence of decline in late loss ADLs,
- Q16: Bedfast residents,
- Q15: Dehydration,
- Q13: Weight loss,
- Q12: Urinary tract infections

In summary, staff perceptions of communication and teamwork are significantly related to turnover, total deficiencies, and quality indicators. Furthermore, the homes we selected for case study analysis were significantly different from each other on these measures as well. Staff perceptions of leadership were different in the case study homes and were related to quality indicators as well.

## Implications

- Communication, leadership, and teamwork are important organizational characteristics related to nursing home performance as measured by turnover, deficiencies, and quality indicators. Our qualitative work suggests that the organizational mission (resident-centered values) combined with more effective leadership/management skills, are important to improving resident care. Findings from this study suggest that leadership/management development would be a highly important area worthy of future effort.
- Provider organizations must bear some of the responsibility in promoting organizational development in the areas of communication, leadership, and teamwork in their respective nursing homes.
- The measure of leadership may need to be revised. Insights, gained from the case studies, suggest that items on this measure may require revision to be more sensitive to the nursing home context.
- Nursing homes may wish to invest in training that teaches all levels of leadership in the home basic communication, problem-solving, and conflict resolution skills. The leaders, in turn, would become role models for other staff members.

## REFERENCE

Rantz, M.J., Petroski, G.F., Madsen, R.W., Mehr, D.R., Popejoy, L. et al. Setting thresholds for quality indicators derived from MDS data for nursing home quality improvement reports. *Journal of Quality Improvement*, 2000; 26: 101-110.