

*Nursing shortages, funding challenges and increased resident care needs have prompted nursing leaders to re-think residential care delivery. At a B.C. care facility, the non-nurse program management model was replaced with a model of front-line nursing leadership and supervision. RNs/RPNs became **Care Co-ordinators**, a new role covering all shifts on the front-line of care. The impact of these changes are described.*

*By Fiona Sudbury and Nancy Gnaedinger*

# Optimizing LTC nursing resources by redesigning staff mix and leadership model

**T**he Lodge at Broadmead (referred to as "The Lodge") in Victoria, is a 10-year old, 225-bed, non-profit, publicly-funded residential care facility (nursing home) owned and operated by the Broadmead Care Society. 67-per cent of residents have moderate-to-severe levels of dementia, with all requiring 24-7 supervision and care.

## The challenge

Three factors are causing nursing leaders to re-think residential care staffing:

1. a shortage of RNs and Registered Psychiatric Nurses (RPNs);
2. funding stagnation;
3. increasing resident care needs; as new community-based models of care and assisted living are developed, residential care is refocusing on high-needs clients.

These factors can cause the quality of resident care to suffer and reduce the quality of work life for staff members. Recruitment efforts to find RNs and RPNs bear little fruit, and

governments have provided little increased funding. Creative solutions must be sought.

## The goals

The goals of the changes in staff mix and leadership model were:

- to respond to RN/RPN shortages;
- to make optimal use of the existing budget and expertise by developing a role that supports RNs/RPNs to work to full scope of practice;
- to increase clinical leadership in the lodges ("lodge" is the term used for the units or wards at this facility);
- to increase direct care staffing.

The changes unfolded as follows. The organization made the decision to move away from the program management model that had been in place for five years. The Director of Care consulted with peers about staff mix and leadership models to meet current resident care needs and realities. A consultant was hired to do a literature review and design a method for tracking and evaluating changes.

## Care Co-ordinators

Three non-nurse program manager positions were eliminated, and a new role of **Care Co-ordinator (CC)** was defined. This position provides front-line nursing leadership and supervision on all shifts. All RNs/RPNs on staff were invited to apply for the seven CC positions. During a three-month transition period to the CC model, supervisory duties were handled by the Clinical Nurse Specialist, Clinical Resource Nurse and DOC.

The new Care Co-ordinators received initial orientation and training related to operational and supervisory duties. In their former role as Lodge Nurses, they had not had responsibility for the level of problem-solving, quality management, or staff supervision now expected of them.

In the former structure, a Lodge Nurse was responsible for directing the care for 30 to 45 residents in a lodge, and spending a large portion of time administering medications.

In the new role, the CC is expected to be a clinical leader, overseeing care for 110-115 residents and supervising

17 to 20 staff members.

Lodge Nurse positions, formerly held by RNs and RPNs, were converted to Licensed Practical Nurse (LPN) positions and filled, mainly with new graduates. They required intensive orientation and support from the CCs during the initial period.

The savings realized from the reduction in non-nurse program managers and RN/RPN positions allowed for the addition of eight full time equivalents of direct care worker time.

The elapsed time between researching and conceptualizing the new staffing model, and fully implementing it, was approximately six months. The evaluation tracked both the process and impacts of change for 16 months following the initial implementation of the new structure.

### New roles

The new Care Coordinator role at The Lodge includes responsibility for:

- first-line supervision on assigned shifts;
- staff supervision, performance appraisals/attendance management;
- accountability for co-ordination of high quality resident care;
- leadership in assessments and care planning;
- problem-solving with the interdisciplinary team; and
- participation in internal committees and task groups.

The CC role does not include responsibility for medication administration, budget, or hiring.

The revised Lodge Nurse role, filled by LPNs, includes responsibility for:

- nursing functions related to day-to-day resident care;
- providing clinical direction to direct care workers;
- collaboration with The Lodge's interdisciplinary team (including occupational and physical therapists, social workers, activation staff and dietitian) in assessments and care

planning; and

- medication administration and other nursing tasks.

The role of the Lodge Nurse does not include responsibility for staff supervision and performance management.

### The evaluation

During the 16 months following the changes in staff mix and leadership, a formal evaluation was conducted by an external team, using written surveys, a series of group interviews, and tracking of human resource and quality monitoring data. Different perspectives were sought throughout the evaluation, including those of management, care co-ordinators, lodge nurses, interdisciplinary team members, health care workers, residents and family members.

### Managing the challenges

One of the greatest challenges in this reorganization was role clarity. CCs, LPNs and interdisciplinary team members expressed initial confusion and frustration about role clarity; they wanted more specificity of the CC's responsibilities and boundaries. This challenge was met in several ways.

First, the Director of Care established monthly Nursing Leadership meetings.

Second, the CCs and other team members had a chance to express themselves candidly in the evaluation activities. The results of these interviews were used to guide follow-up action by the Director of Care.

Third, the passage of time and experience in new roles helped to clarify responsibilities and boundaries. At the conclusion of the evaluation period, however, some staff still felt that roles were not clear enough.

A related concern about role clarity was expressed by members of the interdisciplinary team who stated the new lodge nurses and CCs lacked clarity about the roles of the inter-

disciplinary team members, their responsibilities and areas of expertise. Team-building activities were provided and team rounds and conferences encouraged.

### Perceived lack of skills

A related struggle was that the new CCs were inexperienced in the administrative and supervisory skills required in their new role (e.g., performance management, unusual incident follow-up, processes related to staff injury claims). By the end of the first year, although all CCs had been offered education sessions on these and other topics, some still believed their training was inadequate to meet the requirements of their role.

With regard to the new graduate LPN lodge nurses, some staff were initially critical of their relative lack of nursing knowledge and skills, when compared to those of the experienced RNs/RPNs they were accustomed to working with. There was an unrealistic expectation of the level of function of the new graduate LPNs. Again, orientation, education, supportive mentoring and practice experience addressed most of these concerns.

A major requirement of the change in staff mix and leadership model at The Lodge was that it had to be done within budget, with existing staff and with adherence to collective agreements. To this end, a structured hiring process was followed. The CC positions were filled by RNs and RPNs who were already employed at The Lodge. This provided both advantages and disadvantages.

The advantage was that these RNs and RPNs were clinically experienced and familiar with the facility, the staff, residents, and families.

The disadvantage was that not all CCs were experienced supervisors. During the transition period, a few were considered by other staff members to lack skill in this area. With time and experience, however, the

Care Co-ordinators have grown more competent as supervisors.

### Face-to-face communication

Both CCs and Lodge Nurses expressed the concern that the pace of their work did not allow adequate time to communicate with their supervisors and team about personal or resident care issues. Although every staff member has email access, it was noted that the internet is not an appropriate vehicle for sensitive resident information, nor is it a satisfactory method for team problem-solving.

### Lack of RNs and RPNs

The CC model was intended to provide an RN or RPN presence on all shifts. Unfortunately, it was not feasible to ensure this presence on night shifts due to the nursing shortage. Recruitment efforts were unsuccessful.

### Benefits and impacts

There have been numerous impacts and benefits to these changes in staff mix and leadership model. These impacts and benefits include:

- All levels of staff value having RNs/RPNs rather than non-nurse managers in a leadership and supervisory role. CCs bring "nursing wisdom and knowledge" which, in turn, increases the quality of resident care.
- Most staff are satisfied with the current resident care staffing structure, with the majority rating their quality-of-work life as good or excellent.
- The CC role has gradually become clearer since implementation.
- Despite the CCs' concerns about their lack of training for the new role, most were given very high ratings for their clinical and leadership abilities in a survey of all nursing staff.
- Most of the CCs are mentoring the new Lodge Nurses in a manner that is enriching and satisfying to both parties.
- CCs get satisfaction from knowing

"the director's on-call pager is not going off all the time." They are confident in their ability to problem-solve most clinical or operational issues.

- CCs appreciate being able to work to the full cope of their nursing practice, and value the flexibility of their new role. They claim that their new role allows them more time with residents and families.
- The roles of interdisciplinary team members became clearer to the new Lodge Nurses during the 16-month evaluation period.
- Relationships among CCs, lodge nurses and the interdisciplinary team, strained at first by the changes and the limited experience of some new lodge nurses, gradually improved over the later phases of the evaluation.

### Benefits to "the system"

A review of system indicators revealed the following benefits:

- Existing nursing staff benefited by hiring internally. There were no layoffs. The change provided career-growth opportunities for existing staff.
- Full CC coverage was achieved on the day and evening shifts, and 75 per cent of the time at night for the duration of the evaluation period. When no CC was able to work at night, the senior LPN was designated as "In Charge." Additional training was provided to LPNs in this role and the DOC was available on-call.
- The number of full-time staff providing care increased from 116 to 121, and the average number of hours of resident care per day (HPRD) increased from 2.44 to 2.77 HPRD at the end of the evaluation period.
- Staffing changes during 2004-2006 included an increase in LPNs; decreases in RNs/RPNs due to retirements; and rapid turnover of auxiliary RNs and LPNs - most of whom found full-time employment elsewhere.
- Work-related injuries for CCs and lodge nurses were few and minor in nature: 14 between 2004-2006.

### Benefits to residents/family

Resident care indicators and family members' observations were included as part of the evaluation, with the following results.

- For several months after changes in staff mix were implemented, the number of medication errors increased. This was due to the inexperience of the new lodge nurses, and the introduction of a new pharmacy dispensing system. However, after a few months, medication error rates returned to their low levels.
- Infection rates (e.g. urinary tract and respiratory infections) increased during the year in which the changes took place, then decreased to a lower level than before the changes.
- There was a notable reduction in the number of falls and falls with injury during the 16-month evaluation.
- Family members and residents interviewed a year after the changes in staff mix and leadership model did not report any reduction in service during the transition period; they knew which staff members to call on for specific needs, and they all praised nursing staff highly.

### Benefits to nurses

The transition period at The Lodge was an intensely busy and difficult period for all involved, as workload and work responsibilities shifted and the new CCs and LPN lodge nurses adjusted to their new roles. Although other simultaneous organizational changes added to the pressures, there were many significant benefits of this change to The Lodge.

The organization benefited by the presence of front-line nursing expertise and leadership, and by the increase in direct-care staffing for residents. The CCs were empowered to take a leadership role and to work at their full scope of practice. Similarly, LPNs were given a chance to work at their full scope of practice.

Further, the role of the Clinical Re-

source Nurse required less time providing day-to-day clinical support on the lodges, now that the CCs were in place. This increased the amount of time the CRN was able to dedicate to practice support at a broader level, for example, developing practice guidelines, providing education, managing infection control, monitoring clinical quality indicators, and introducing a new electronic health record system in preparation for implementation of the Minimum Data Set.

The Clinical Nurse Specialist notes that the CC role allows for more in-depth nursing assessment, which in turn creates opportunities for better care planning and richer teamwork and consultation with team members. Thus, the new CC role supports the promotion of excellence in practice.

The role of the DOC is much clearer than in the previous program management model. Now, accountability for quality of care follows a direct line of reporting. The DOC also notes a significant benefit in freeing experienced nurses from time-consuming medication administration so they can provide clinical leadership to the many new graduate LPNs who have joined the staff.

### Lessons learned

Many lessons were learned from the changes that took place at The Lodge. For example, the amount of time and energy it takes for leaders to undertake a redesign of leadership and staff mix is substantial and not to be underestimated. Comprehensive planning before implementing major change is crucial. For example, a support and training plan for people about to take on new roles should be well thought out in advance.

Also, in a unionized facility, it is not possible to lay off existing staff when changes of this kind are made. Collective agreements often provide a significant degree of employment security. The advantage is that staff

members moving into new roles are familiar with the facility and its rhythms, as well as with the residents and their families. The disadvantage is that previous peer relationships among staff members may make it difficult for new supervisors to be accepted as leaders.

Staff, whose roles are to be significantly changed, should be consulted about these changes beforehand. They must clearly understand the reasons for the change. This helps them provide meaningful and helpful input and be less resistant to change.

It is essential to ensure that staff members who are given new roles are clear about the substance and boundaries of those new roles, and have the skills required to fill them - or the support, mentoring and education to acquire the skills within a reasonable period of time.

It is important to ensure that all members of the care team are aware of the substance and boundaries of each other's roles and scope of practice. When changes in staff mix and leadership model are made, the composition of the "team" changes considerably. It is critical, therefore, to provide team building activities to allow for relationship-building and understanding of team roles and functions.

It takes considerable time for people in new positions to grow into their role. Staff in new positions (especially those who are also new graduates, and/or new to the facility) need to be supported and given time to learn the job. It is important to maintain realistic expectations.

There needs to be a strong mentorship program for new LPNs. It may be too much to expect mentorship to come easily from nurses who are also in new roles, such as the CC role - especially when they themselves are adjusting to new responsibilities.

During times of change, continuous information, in multiple forms, should be provided to staff, families, volunteers and capable residents.

Conducting an evaluation is very valuable. It keeps everyone "on track," helps identify issues to focus upon, and empowers staff members when they are asked about their experiences and advice.

If too many major changes occur in one organization at the same time, they can negatively impact staff members and leaders' morale and ability to function effectively.

Nursing leaders who are expected to implement major changes need significant time and resources. . .

- to do careful, consultative planning;
- to assess how proposed changes will affect operations;
- to decide on a time frame that makes sense within the larger context of the facility;
- to prepare a logical and realistic implementation plan;
- to create comprehensive orientation plans for new positions and staff;
- to be sure that new staff members and people in new staff positions are adequately prepared for their jobs, have the support and mentoring that they require, and receive the recognition they deserve;
- to deal with expected and unexpected impacts on staff morale and daily operations; and
- to spend time on evaluation.

During times of change, it is more important than ever to give all staff members, including administrative leaders, support and validation. They need recognition that it is difficult to implement major changes while carrying on with the daily work of facility operations. Finally, all nursing staff members should be included in celebrations of success! ■

### About the Authors

Fiona Sudbury R.N., B.Sc.N., M.H.Sc., G.N.C.(C.), is Director of Care, The Lodge at Broadmead. <Fiona.Sudbury@tvcs.ca>

Nancy Gnaedinger, B.A., M.A., is a Consultant in Gerontology, Victoria, B.C.

Author contact: (gnaedinger@shaw.ca).