



- Meeting:** NURSES INVOLVEMENT IN CULTURE CHANGE: Opportunity for Improving Residents' Quality of Care and Quality of Life (funded by the Commonwealth Fund)
- Presentation:** October 27 – 28, 2008
- Topic:** Roles and Job Descriptions of Nursing Staff in a Nursing Home Adhering to a Resident-Directed Care Philosophy
- Background Paper:** Kathryn L. Anderson, Director of Clinical Services, Providence Mount St. Vincent, Seattle, WA;
email contact: Kathryn.L.Anderson@providence.org

Providence Mount St. Vincent (PMSV) is a residential care community primarily serving older adults in a number of programs: assisted living, long-term care (nursing home), short-stay subacute care, adult day health, adult family home, and a Wellness Clinic. About 90 children attend an on-site Intergenerational Learning Center (child day care and early childhood educational program) each weekday. The focus of this paper is on the nursing home, which serves 195 long-term care and 20 subacute residents.

All care and services provided at PMSV are guided by a resident-directed philosophy, meaning that residents choose their daily routine and services according to their own values and preferences. The foundation for successful implementation of this philosophy is a close relationship between resident, staff, and family members. A matrixed and nearly flat organizational structure fosters and supports these relationships. (A matrixed organization structure is one in which lines of reporting may be vertical or horizontal, and an individual may report to more than one department or manager.) Resident decision making—although subject to housewide safety, clinical practices, and other policies—is made at the neighborhood level.

Organization of neighborhood nursing services

The organization chart (Fig.1) has a distinctive feature: the absence of a nursing department and a Director of Nursing. Instead, a Director of Clinical Services (DCS) oversees the nursing care provided in any program in which nurses are working (dashed lines). However, the DCS has no direct line authority to anyone providing nursing care. The DCS also works closely with the registered dietitians in Dining Services and with the manager of quality improvement (dashed and dotted lines). Only two departments (a total of two individuals) report directly to the DCS: Clinical Education and Staff Development, and the Wellness Clinic. The DCS is the liaison between PMSV and the Medical Director, and to primary care providers (physicians and nurse practitioners who provide care to residents), clinic providers (dental staff, podiatrist, optometrist, audiologist, complementary health care providers), and pharmacy, laboratory, and radiology services. The DCS fulfills the role of Director of Nursing Services for regulatory purposes, and is also the infection control officer for the entire community (with support from the Clinical

Educator). This organizational structure – one that delegates most clinical decision-making to the neighborhood - permits the DCS to support nursing and clinical services delivery in the assisted living, adult day health, and adult family home programs, as well as manage housewide infection control efforts and the Wellness Clinic.

The neighborhood is the key component in the organizational structure for operationalizing resident-directed care. A neighborhood is a former nursing unit whose physical environment has been transformed into a home through reconfiguration of space and the use of color, furnishings, and live animals and plants. Each neighborhood has a large living space consisting of a kitchen, dining and activity area, and care station (home office area where staff do charting, make phone calls, and hold change of shift report). More important than the physical environment in transforming the living experience for residents is the deeply personal care and the attitudes that staff bring to the job. This personalization and investment of self are, in large part, due to the neighborhood-based organization structure.

A Neighborhood Coordinator (NC) is typically responsible for two neighborhoods, each of which has 20 to 23 residents. NCs are nurses with a minimum of a bachelor's degree; at present, three of six NCs have master's degrees (one is not in nursing). The role and responsibilities of the NC include daily management activities traditionally associated with a director of nursing, such as hiring and supervising staff, supporting staff in resident care planning and implementation, ensuring quality of care, and overseeing the neighborhood budget. NCs interact regularly with family members and respond directly to their concerns.

Each neighborhood has a primary nurse who takes the lead in assessment, planning, and overseeing implementation of the resident care plan. The primary nurse is a registered nurse (preferred) or licensed practical nurse who provides direct nursing care 4 days per week, and works one day per week on Minimum Data Set (MDS) assessments and care plans. MDS accuracy is believed to be linked to knowing the resident by working with him or her every day, in contrast to the typical nursing home model of centralized MDS preparation and coordination by nurses who are not neighborhood-based.

Associate nurses are RNs and LPNs who provide direct nursing care to residents on all shifts. Primary nurses can delegate aspects of assessment and planning, or specific sections of the MDS to other nurses working on their neighborhood.

Position descriptions for all levels of nursing personnel speak to their responsibility for putting resident choice first in care planning and medical intervention, and for maintaining a homelike environment. Orientation for all staff introduces the resident-directed care philosophy. Nurses are provided specific examples that demonstrate their role in promoting resident choice and honoring preferences for medical intervention.

Nurses are supported by NCs and administration when residents make choices that the team feels is not in their best interest. For example, the speech therapist recommends that some residents with swallowing problems follow specific dining recommendations to minimize the risk of aspiration. The nurse's role is to educate the resident and staff about the recommendation, and to document the education and resident response. Nurses share the recommendations with

neighborhood and dining services staff so that everyone has a role and opportunity to offer residents food and drink consistent with the recommendation. Ultimately, residents are permitted to make their own choices about the dining recommendations, and their choices are documented. Nurses who come from more traditional settings, such as nursing homes operating on a medical model and nurses who are new graduates, need reassurance that risk is an inherent part of life, and that individuals living in a nursing home have the same rights to make choices about the conditions of their lives as those living in their own homes.

Neighborhood team members include Resident Assistants (Certified Nursing Assistants [RA, CNA]), a social worker, housekeeper, activity coordinator, and dining host. The dining host serves meals in the neighborhood dining room, participates in or leads food-related activities, and cleans up after meals. A Spiritual Care staff member is assigned to each neighborhood, but is not an employee of the neighborhood.

There are no staff positions with narrow task-focused responsibilities, such as medication and treatment nurses, paid feeding assistants, restorative aides, or bath aides. In contrast to the culture change “ideal”, there are no universal workers. Some staff have more than one job function (e.g., housekeepers assist with meal service, and activity coordinators are CNAs), but most function within traditional roles. Emphasis is placed on all staff being available to assist or respond to a resident’s request for assistance according to their knowledge or training, and never failing to respond to a resident because it’s not in the employee’s job description.

Neighborhood staffing is stable and consistent; most nursing and other staff are permanently assigned to neighborhoods. Absences are covered by an in-house float and on-call pool, and by additional hours or shifts worked by regular staff. RAs rotate resident groups according to a schedule determined by the team, though some neighborhoods do not rotate resident groups at all. The result of consistent neighborhood staffing is that staff get to know residents’ routines and preferences very well, and strong bonds of affection are formed between them.

Resident and employee satisfaction is high. Resident satisfaction is related to their feeling that they are treated with dignity and respect, and are recognized as individuals and people of worth. Staff satisfaction is closely linked to satisfaction with their direct supervisor, and the neighborhood model facilitates close working relationships between staff and the NC. Turnover among RA staff is low, and some voluntary turnover is due to RA staff completing a formal nursing education (RN or LPN) program. Nurse turnover is also low, but is more challenging to address because of the competitive market for nurses across the entire health care continuum.

The nature of nursing in a resident-directed care environment

Until recently, PMSV administration shared the commonly-held view of nurses’ roles in long-term care, that is, that nursing is a set of tasks (medication administration, care planning, assessing residents for change of condition) including documentation. This view and the fact that nurses bring this attitude from other work environments, limits nurses’ imagination about what long-term care nursing can be. Excellent nursing care in nursing homes should be health-promoting, comfort and happiness-producing, and spiritually nourishing.

Many internal and external forces shape the way nursing care is provided at PMSV. Effective long-term care nursing practice is more than low rates of nosocomial pressure ulcers, falls, pain, and complications of residents' chronic health problems. While federal and state regulations define health holistically, in practice, Quality Indicators and state surveyors focus more on whether physical health needs are met than whether residents have a good quality of life or are emotionally and spiritually content. It is difficult to resist the felt demands of the regulatory system to instead pursue alternate, or additional, goals of care.

The healthcare organization of which PMSV is a part, Providence Health & Services (PH&S), uses quality measures for long-term care, for example, pressure ulcers, falls, and influenza immunization rates. Senior and Community Services, the PH&S division in which PMSV is embedded, also measures pain and resident satisfaction. The combined emphasis of regulatory, corporate, and division quality measures on residents' physical health status influences the focus of nursing efforts such that meeting physical health needs can be over-emphasized and addressing residents' holistic health needs is under-valued.

PMSV is working to define nursing practice more expansively so that emotional and spiritual health are elevated to the same level of importance as physical health. A vision statement for professional nursing (Fig 2) makes explicit our goals for nursing practice in relation to each of PH&S's core values: respect, compassion, justice, excellence, stewardship. Linkages have been identified between the resident-directed philosophy and our palliative and end-of-life care practices. Hiring efforts are aimed at selecting nurses for their fit with the mission and philosophy of PMSV, not just hiring nurses for their past experience or potential to succeed in the technical aspects of practice.

Policies relating to nursing and other care delivery at PMSV emphasize the holistic needs of residents and the preeminence of resident choice. Using the example of resident dining choices described earlier, residents are educated about recommendations for diet restrictions or food textures, and are offered food and drink consistent with those choices. Residents may choose whether to follow the recommendations or not, and their choices are documented. Since residents have several options for where to eat (neighborhood dining room, cafeteria, public dining room, gift shop, activities), a PMSV policy about dining choice affirms the resident's right to choose eating location, staff responsibility to be aware of and offer the recommended diet, and the resident's right to make an alternate choice. Documentation of resident choices is emphasized instead of prohibiting the person from making the choice.

Excellence in nursing practice in the context of a social model of care

Society at large views nursing homes primarily as health care institutions, with nurses serving in traditional roles providing illness-focused care to residents. Nursing homes can also mirror society's fears about old age, dying, and death, leading to policies and practices that do not allow residents comfortable, dignified deaths in the place they prefer: home. Most residents do not want aggressive medical treatment at the end of life and many do not want to go to the hospital. In honoring residents' preferences regarding their health care needs, less physical health care might be delivered in comparison to other NH settings. Resident-directed care and palliative care share the same philosophical underpinnings: choice, autonomy, humanity, and dignity.

Excellent long-term care nursing provides the right amount of health care according to the resident's preferences, often in a palliative mode that emphasizes quality of life and symptom management over life extension.

The decentralized organizational structure at PMSV creates the potential for lack of consistency in nursing practices and standards between neighborhoods. Since NCs do not report to a Director of Nursing, nor to the Director of Clinical Services, there is no direct line authority that holds NCs accountable for nurses' performance. For example, problems can arise when individual NCs decide that a new process or practice does not fit the needs of their neighborhood (though this is increasingly rare).

How, then, do care processes become evidence-based, standardized, and meet safety goals? The oversight responsibility of the Director of Clinical Services, along with the matrixed relationships between the DCS and all other nursing staff, creates structures and processes for ensuring that nursing care standards are met. The DCS leads or participates in groups where clinical policies and practices are developed and revised. For example, new ideas often emerge in the weekly Neighborhood Coordinator meeting presided over by the Administrator for Skilled Nursing. Once a direction has been agreed upon, processes are developed or refined in a weekly primary nurse group meeting that is led by the DCS and attended by all primary nurses and NCs (and any other nurses who wish to attend). Policies are written or revised by this same group, or in partnership with an awkwardly-named Documentation Committee, whose responsibilities overlap with, but do not duplicate, those of the primary nurse group.

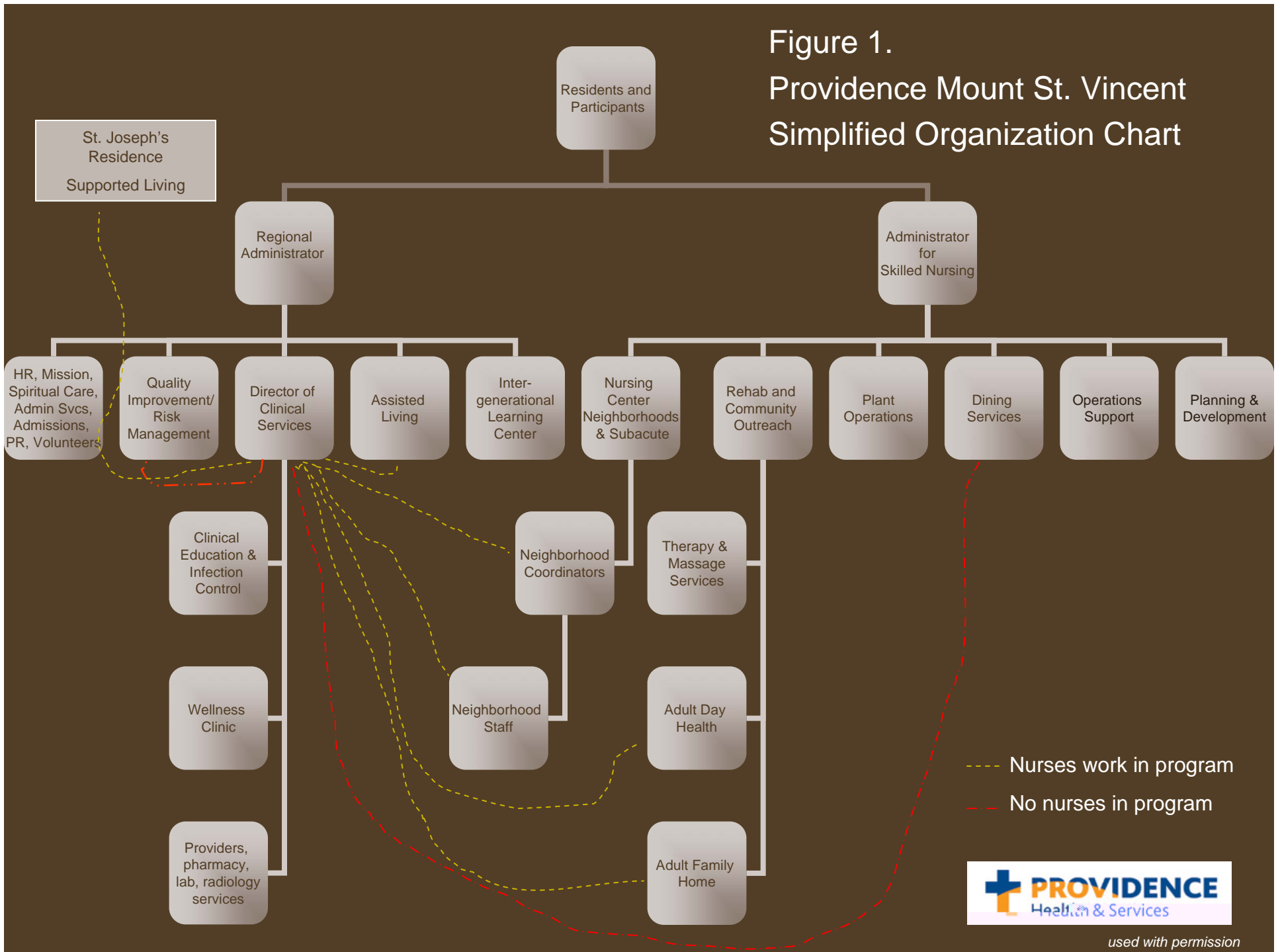
The DCS provides leadership and sets the direction for nursing practice through knowledge, ability to access resources, education of NCs and nurses, and motivation. A variety of resources are used to determine best practice, including the scientific and professional literature, quality improvement resources, clinical practice guidelines, toolkits, standards of practice (e.g., Joint Commission), and professional contacts. The DCS participates in divisional, regional, and company-wide task forces and committees related to quality of care but uses mandates from these larger groups carefully and selectively to stimulate action or change practice behavior.

As shown in the organization chart, the Clinical Educator is one of the few staff who report directly to the DCS. Working together, they identify topics to increase nurses' knowledge base and skill level, develop curriculum or find an expert to speak on a particular subject. Continuing education on topics of clear relevance to daily practice helps maintain high standards of care.

The DCS promotes excellence through personal relationships with staff, acting as a nursing advocate, and communicating enthusiasm for the work the nurses are doing. Making rounds on all shifts, the nurses see the DCS as more than a title but a person who recognizes excellence publicly, writes personal notes of appreciation to individual nurses, and works to inspire each nurse to perform at their highest level possible.

The pursuit of excellence is also visible in efforts to hire nurses with the level of education associated with or required for a given position. Nurses are knowledge workers, not simply technicians. A more advanced educational foundation is key to achieving the goal of producing a high level of holistic nursing care. All management positions require a BSN, with a master's degree preferred. One goal is that all primary and associate nurses will be registered nurses in the future, though this goal is not attainable at present. Future linkages with a nearby nursing baccalaureate (BSN) program, participation by PMSV nurses in a BSN completion program, and a nursing scholarship program should all help to attain the goal of a well-prepared nurse workforce in the future.

Figure 1.
 Providence Mount St. Vincent
 Simplified Organization Chart



--- Nurses work in program
 --- No nurses in program



Professional Nursing Practice at Providence Mount St. Vincent

Nurses at Providence Mount St. Vincent fulfill the Mission of Providence Health & Services through compassionate service to residents, program participants, rehabilitation patients, fellow employees, visitors, and volunteers.



Respect. PMSV nurses respect residents' preferences and choices about how they live their daily lives, and the health care they wish to receive. We advocate for our residents in healthcare encounters so their needs and wishes are met. We work alongside our team members in ways that foster confidence and growth.



Compassion. PMSV nurses promote the spiritual, physical, emotional, and social well-being of residents. We share their joy in the pleasures of companionship, daily routines, and faith. We are present for residents, their loved ones, and each other during times of pain, uncertainty, sorrow, and loss.



Justice. PMSV nurses offer their knowledge and skills in service to all residents, regardless of their personal characteristics or background. We treat team members with kindness and fairness. We embrace diversity as an opportunity to know each person and broaden our personal perspective.



Excellence. PMSV nurses strive to give the best possible nursing care to residents every day. We continually look for ways to improve our practice so residents are as healthy and happy as they can be. We share our successes and work together to solve our problems.



Stewardship. PMSV nurses try new ideas and question old practices so that all of our care is necessary and helpful. Our nursing care is elegant in its simplicity and ability to achieve good outcomes through highly personalized interventions.



As people of Providence, we reveal God's love for all, especially the poor and vulnerable, through our compassionate service.