Carnegie Mellon
Community
ThinkTank
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Healthcare:

The Dilemma of Teamwork, Time, and Turnover

*A report on Rival Hypotheses,
Options, and Outcomes
from the* CARNEGIE MELLON
COMMUNITY THINK TANK

This Think Tank series explores the decisions
in long term healthcare
facing healthcare workers,
administrators, and the community
concerned with

- meeting the need for compassionate caregivers

- working changes in the culture of work and healthcare

- developing a new paraprofessional workforce

- heeding the call for professionalism, recognition, and respect

**The Center for University Outreach
Carnegie Mellon University**

Intercultural Problem Solving for Performance
in WorkPlaces and WorkLives

The Carnegie Mellon Community Think Tank

Creates an intercultural dialogue among problem solvers—from Pittsburgh's urban community, from business, regional development, social services, and education.

And seeks workable solutions to problems of workplace performance, workforce development, and worklife success for urban employees.

The Think Tank's structured, solution-oriented process:

♦ Opens an intercultural dialogue in which employees, line managers, and administrators, human resource developers, educators, and trainers, researchers and community workers meet as collaborators.

♦ Structures this talk into a problem-solving search for diverse perspectives, rival hypotheses, *and* collaborative solutions.

♦ Draws out untapped levels of expertise in the urban community and low-wage workers to build more comprehensive intercultural understandings of problems and to construct community-tested options for action.

♦ Builds a scaffold for Local Action Think Tanks in individual workplaces.

Please visit our web site to see the Findings *of other Think Tanks and to explore a guide to developing your own dialogues as educators, human resource developers, or community groups.* www.cmu.edu/outreach/thinktank/

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THE RECOGNITION AND RESPECT EPISODES

Why We Initiated A Think Tank

The crisis in long term health care—and the acute shortage of qualified caregivers — has been shaped by broad social policies and economic forces in workforce development and healthcare. But it is also a community problem, played out in care centers around this region. And in this context, we know that retention is linked to respect, performance often mirrors the culture of work, and the problems of a minimum wage work life become the problems of the workforce.

We believed that local, workable options for responding to these problems—to the dilemmas of *teamwork, time and turnover*—could be constructed.

But creating more options for action would require the following:
* an intercultural dialogue that draws on the expertise of all stake holders;
* and a problem-solving dialogue focused on a collaborative search for solutions.

The People at the Table

In this series of the Carnegie Mellon Community Think Tank you will hear from the following voices:

♦ Front line caregivers—Certified Nursing Aides, Unit Clerks, Agency staff, and trainees;

♦ LPNs, RNs, Charge Nurses, and Directors of Nursing;

♦ Administrators, human resource developers, business managers, union leaders, and care center directors;

♦ Urban community groups, teachers, researchers and workforce developers;

♦ Reports and conferences organized by regional groups, foundations, academic institutes, and government agencies and offices; and

♦ The published conclusions of national and state organizations including PA Intra-Governmental Council on Long Term Care, the PA Economy League, SWPPA, Iowa Caregivers, and the Direct Care Alliance (see the Resources list on page 41).
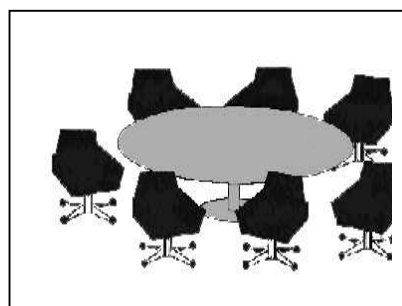
How We Generated these Findings

The Think Tank process begins with intercultural and cross-level problem finding. We use "critical incident" interviews, published work, and "story-behind-the-story" dialogues to 1) identify the key issues, 2) script prototypical problem scenarios around them, and 3) collect strong rival hypotheses about what is *really* happening and why in these familiar situations. We then compile these diverse readings of the problem into a Decision Point Briefing Book organized around key decision points. We are especially indebted to the Lemington Center and Grane Healthcare staff in the development of this Briefing Book.

Think Tank participants use the Briefing Book to focus dialogue on a series of problematic Decision Points—to explore interpretations, consider outcomes, and develop a collaboratively constructed toolkit of workable options.

The insights in these Findings come from both "expert" sessions (drawing on people across the city) and "local action" sessions (working on change within individual organizations).

Decision Point Briefing Book for Healthcare: *The Dilemma of Teamwork, Time & Turnover*	
The Training Episodes	
Decision Point 1.	**Short-Staffed, Again**
Decision Point 2.	**Orientation**
Decision Point 3.	**Training & Mentoring**
The Recognition and Respect Episodes	
Decision Point 4.	**Conflicting Expectations**
Decision Point 5.	**Signs of Respect**
Decision Point 6.	**Forms of Recognition**

We are grateful to the many people who have lent their wisdom and experience, their passion for healthcare, and their respect for frontline workers to this call for community-grounded, action-oriented understanding.

What Can You Do?

♦ We encourage you to use and share the insights of this intercultural dialogue in your own work—in healthcare, education, human resource development, and community action. This document and supporting materials are available on the Outreach web site at www.cmu.edu/outreach/thinktank/.

♦ Consider initiating a Local Action Think Tank in your community or worksite. Build on the findings from this book, helping managers and staff use this collaborative problem-solving process to translate options into site-specific actions. Contact the Community Think Tank team if we could be of help.

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HIGHLIGHTS FROM THE FINDINGS
Some Issues and Options Under Discussion

From The Training Episodes

Short-Staffed, Again

Managers are asking: Where does the solution lie? In hiring, staff support, or retention? *(see page 3)*

Orientation

Experienced staff challenge each other: how do we actually teach "professionalism"? *(see pages 10, 17)*

♦ Option: A "Goal-Setting" meeting at shift changes lets us deal with short-staffed shifts—collaboratively—and models professional problem-solving for new hires. (Developed by a Local Action Think Tank team.) *(see page 11)*

Training & Mentoring

Who is really responsible for training? Managers and staff see it differently. *(see page 13)*

The dialogue makes it clear: it actually takes a *network* of mentors to meet different needs. *(see pages 20, 24)*

♦ Option: Investing in paraprofessional development helps our staff develop "thinking tools" for workplace problem-solving and worklife decision making. *(see page 18)*

♦ Option: Innovative management strategies can build a site-specific training and development plan and can use a "staff-owned" assessment as a tool for change. *(see page 22)*

Conflicting Expectations

Can the Care Center affect how staff and families relate to each other? *(see page 27)*

Signs of Respect

♦ Option: For front line workers, respect can be expressed by the *level* of communication.
(see page30)

Forms of Recognition

Pennsylvania's Frontline Workers report concluded: "Retention problems, while also influenced by wages, are more closely tied to worker attitudes, the treatment workers receive, job and career opportunities, and the nature of the job within the institutional context of the provider organization."

♦ Option: An innovative strategy for awarding recognition, developed by a Think Tank staff team, rewards personal *and* group problem solving (and reversed some managerial assumptions). *(see page 35)*

The "Training Episodes" Problem Scenario

The Decision Makers

Shari	an experienced CNA
Nurse Edna	an RN
Mrs. Williams	the Nursing Home manager
Brittany	a CNA. Today she is a no call, no show.
Renee	a new hire. This is her first job.

Monday Morning Shift (Short-Staffed, Again)

Shari

(Talking out loud)
Mr. Simon needs to be bathed; Miss Eleanor needs to go out for therapy; and Mr. Theodore needs his special tray before he makes a scene.
(Looks at clock)
8 o'clock. Looks like Brittany's going to be a no call, no show. I better call Mrs. Williams—
see if she can get me some help up here. I will get this done.

Shari

(picks up intercom and dials, speaking to Mrs. Williams on the phone)
Mrs. Williams, Brittany's not here again and I've got a full wing. Can you send someone?

Mrs. Williams

Well it's too late now to get an Agency person. I'll see who I can get to fill in. Meanwhile, you've got an RN up there don't you—it's Edna isn't it? I'm sure you can work it out.

Shari

Thanks.
(Looks at the phone, then in the nurse's direction and shakes her head. She looks down the hall toward the nurse's station, where Edna is sitting down, about to make a phone call.)
Edna, could you help get Miss Elenore ready?

Nurse Edna

Well, Shari, I still have my own job to do. I'm doing meds and the charting has to be finished. Did Brittany call off again?

The 8:00 AM Solution (Orientation)

Given Shari's experience, the manager decides to place Renee, a new hire on the floor. Renee completed her CNA training on Friday . This is her first day at work, at her first full time job.

Shari

(Under her breath)
Oh great, as if I don't have enough to do. Now I get to train the new CNA.

(speaking to Renee)
Well first you help me wash Mr. Simon. Then you can get Miss Eleanor ready for therapy.

Renee
OK
(trying to help Shari lift Mr. Simon)
I don't know if this is going to work.

Shari
(aside)
What is she doing? Didn't she learn anything in training?
(speaking)
No, that's not the way you lift someone like Mr. Simon. Here, this way...

Renee
(speaking)
But that's what they showed us in training — OK wait… OK wait… OK, OK.

Shari
Look, I know you're new here and all, but things move pretty fast around here. I can show you the ropes, but you're really going to have to try to keep up.

Renee
(aside)
Dag! What does she expect! I'm just gonna do what I know how. This isn't what I expected.

Two Weeks Later (Training and Mentoring)

Renee is still working on Shari's floor. By 10:00 a.m. it is not uncommon for Shari to have cared for twice as many residents as Renee. Shari rarely asks Renee for any help on 2-person lifts, but finds someone else in the wing.

Shari
(*thinking to herself, but giving only an angry look at Renee*)
Why is she taking a break when her work's unfinished?

(*later*)
Shari
(*sees Renee just standing in the room with Miss Eleanor who won't cooperate with her*)
Go on, I'll do it. *(with a loud angry sigh, she simply takes care of the situation without any explanation)*

End

Decision Point 1. Short Staffed, Again

Monday Morning Shift

Shari

(Talking out loud)
Mr. Simon needs to be bathed; Miss Eleanor needs to go out for therapy; and Mr. Theodore needs his special tray before he makes a scene.
(Looks at clock)
8 o'clock. Looks like Brittany's going to be a no call, no show. I better call Mrs. Williams—see if she can get me some help up here. I will get this done.

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Thanks.
(Looks at the phone, then in the nurse's direction and shakes her head. She looks down the hall toward the nurse's station, where Edna is sitting down, about to make a phone call.)
Edna, could you help get Miss Elenore ready?

Nurse Edna

Well, Shari, I still have my own job to do. I'm doing meds and the charting has to be finished. Did Brittany call off again?

The Story Behind the Story

What is Shari thinking?
*   Why is my floor always the one that is short-staffed? It doesn't seem fair.
*   I can see Edna just sitting down just making phone calls. But if Miss Elenore isn't ready for therapy, I'll be the one they yell at.

What is Mrs. Williams thinking?
*   It's too late now to get someone from the agency. I could hire another person with all Brittany is costing me in agency replacements anyway.
*   Shari's good. She can handle this. I'm glad I can count on her to pick up the slack with these new people.

What is Brittany thinking?
*   I had to work 2 doubles last week and then couldn't even get the afternoon off when I needed it. I deserve this.

What is Edna thinking?

- Just because I am sitting down, doesn't mean I'm not "working." This is MY job and I'll look bad if I get behind.
- Yes, Shari does have to pass up some of Miss Elenore's prep to me, but she wants to pass too many problems to me. I wish she would work harder at solving them herself.

What is going on here? What is the problem?

A teamwork problem

A nurse says:

- RNs are the liaison between the patients and their physicians. Nurse Edna's 'charting' may have been significantly more than paperwork. There may have been an urgency to communicate with physicians during the times that she could reach them in their offices.

A CNA says:

- A lot of people on this staff have diverse backgrounds and experience. When it gets busy, is it unreasonable to expect someone to step in when they have the necessary knowledge to help out? Just pitch in and help no matter what their job title?

A staffing problem

A manager says:

- I simply can't rely on people to come in, even when I give bonuses for no misses and on time. It seems like there is nothing I can do.

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The Decision Point #1: Short Staffed, Again

The Care Center has a chronic staffing problem due in part to turnover and call-offs, which leaves no time to plan.

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Option #1   Shari could handle the problem herself.

CNAs say:

- Shari could work this out with Brittany—if not now, when she comes in. If someone is doing something we don't like, we don't go to the supervisor, we tell *them*.
- Handling it ourselves just makes it our problem. They [the administration] save money; we work more.

Option #2:   Mrs. Williams, Nurse Edna, and Shari could assess the morning's priorities* together *and create a collaborative plan.

SWPPA says:

- Joint problem-solving is different from asking for help. It may be hard for some people if it involves the manager and nurse stepping out of their official roles to help with direct care.

CNAs say:

- They need a back-up plan so everybody shares the load.
- Include at least one "floater" who can step in.

Option # 3:   The Care Center takes a more active role in helping a transition employee deal with the WorkLife problems that affect her Work Place performance.

- Bring back the daycare system. In the past, workers were more inclined to stay because the daycare was such a great convenience.
- If tuition assistance for CNA training were greater, CNAs would have a greater incentive to stay.

Welfare Info Network says:

- Emergency (or regular) childcare could make a significant difference for women in the transition to work.

Direct Care Alliance says:

- Give new workers access to ongoing, one-on-one counseling for dealing with WorkLife problems.

Option #4:   The Care Center solves its turnover problem by taking direct action for retention.

Iowa CareGivers say:

Deal with the top four concerns the CNAs cite:

- – Working short-staffed
- – Wages and benefits
- – Relationship with supervisors
- – Education and training/orientation

Paraprofessional Health Institute and Direct Care Alliance say:

- – Create a "decent job" for direct care givers as paraprofessionals who after a year earn a "living wage" (150% of the minimum wage)
- – Have full time work
- – Receive health care
- – Put the money spent on high-priced temporary replacements into developing long-term health
- – Careers for loyal employees through on-site advancement, adequate pay, and health insurance

Option #5:   The Care Center could revise its hiring strategies.

Screen applicants and verify technical skills in a practical lab, BEFORE hiring. Ask them to demonstrate changing, baths, bed making, and taking vital signs. Do this with a potential mentor and get staff input into the applicant's competency and attitude.

Iowa CareGivers suggests:

- Set high standards for hiring. CNAs would rather work short-staffed than with co-workers who are uncaring.
- Do more pointed screening for skills, willingness to work the actual hours and requirements of the job, and attitudes to work.

Decision Point 2. Orientation

The 8:00 AM Solution

Given Shari's experience, the manager decides to place Renee, a new hire on the floor. Renee completed her CNA training on Friday. This is her first day at work, at her first full time job.

Shari (*under her breath*)

Oh great, as if I don't have enough to do. Now I get to train the new CNA.

(speaking to Renee) Well first you help me wash Mr. Simon. Then you can get Miss Eleanor ready for therapy.

Renee

OK. (*trying to help Shari lift Mr. Simon*)
(aside) I don't know if this is going to work.

Shari (*aside*)

What is she doing? Didn't she learn anything in training?
(speaking)   No, that's not the way you lift someone like Mr. Simon. Here, this way...

Renee

But, that's what they showed us in training — OK wait… OK wait… OK, OK.

Shari

Look, I know you're new here and all, but things move pretty fast around here. I can show you the ropes, but you're really going to have to try to keep up.

Renee (*aside)*

Dag! What does she expect! I'm just gonna do what I know how. This isn't what I expected.

The Story Behind the Story

What is Shari thinking?
- The new ones are only in the way, so you just go on with your day.
- I don't want to scare her away, but why do I have to get hassled by this?

What is Mrs. Williams thinking?
- I can count on Shari; she'll take leadership (and be pleased I recognize that about her).

What is going on here? What is the problem?

New hires don't have accurate expectations about the job.

CNAs say:

- Do people say this is just a job? I'd say maybe 25% say that. There are a lot of them who come in here and say 'I'm here for the paycheck.' But then once they get to know the patients and the coworkers, we don't run into that problem.

- Turnover is mostly a problem with the young kids who get into nursing. They aren't expecting the "second education" on the job, and get resentful. They feel like "I already learned this. I already went to school for this." But there's always more education.
- We are short-staffed a lot. And when the people who are not entirely devoted leave slack, the others must pick it up.
- We work a lot of hours; sometimes I work 2 shifts (16 hours). We often have to. Most of the people do overtime because their heart is in the work, but it requires a special kind person.

It takes a special person, not just somebody who needs a job.

- Only a special person can do this job. You're expected to clean, feed and conduct the activities of daily life for the residents. And when you're short staffed the interaction between the staff and residents suffer. You could not do it just for the money.
- There's still some that'll tell you 'this is just a job…' but it's not. You have to be very, very considerate. There are a lot of things they [residents] say to you that you wouldn't tolerate anyone, anyone saying to you… There are a lot of things you have to consider when you really look at them as a person, not as a patient, as a person.
- People come in here assuming the residents are just patients, but they're not. They're people.
- The residents were Somebody before they got here, and they're still Somebody, and they're due that respect.

If you don't come for the right reasons, you won't stay.

CNAs say:

- Some people are not cut out to do this kind of work. You've got to have a lot of stamina – a lot. You've got to be very committed. You have to understand exactly what these people are going through. Just because they're geriatrics, they're still Somebody.
- The young workers feel they're here because they have to be here, but that's not the reason. We're here because we want to be here
- The people who come here for the money only do the bare minimum and others have to pitch in to pick up, but they usually don't last long because the job does not pay well and is very tough.
- Patients with Alzheimer's disease can be tough, because they ask you the same question over and over, and you just answered it, but you just have to answer it again.
- You have to love nursing, basically.

> *A CNA's Story Behind the Story:*
>
> We need strong men to do this work, too. But I'll tell you the truth. I talked my son out of taking the training. I didn't think he could handle the work, like changing diapers.

> *An RN's Story Behind the Story:*
>
> A lot of our aides really are involved with the residents and their families. They'll bring in little treats like ice cream and french fries from lunch for people or give small gifts on birthdays. And they attend funerals of residents when they die. They aren't just here to collect a paycheck.

An LPN's Story Behind the Story:

I basically got thrown into nursing. I was 18 or 19 looking for a job and was an aide for 5 years. Once I got into the field, I began to like it, and decided I would upgrade my skills. The thing that attracts me is just being around the people. You're basically the only person that takes care of them, so there's a real bond there.

An LPN's Story Behind the Story:

I know how I would feel if I had to leave my grandmother somewhere. That's something you keep before you all times. I try to think, 'If this was my parent. If this was my grandmother." That's basically what keeps me going.

The "old" staff expect new people to "fit in"—or else.

• The ones who come for the paycheck, they don't stay because the other staff, who are dedicated, are not going to let them just be here for that. They had to do the quality work. The Staff will harass them, saying, 'We don't work here like that. You're really in the wrong facility.' They let them know right away. Right away. And then if they can't solve it, they will report it and take it to another level.

> ### Decision Point #2: Orientation
>
> After 120 hours of training, Renee is certified. The current training focuses on "book methods" and regulations. At this point, she has had no hands-on experience with what the job really entails. This is her first job in an institution and the first requiring teamwork. Many new hires make a decision to stay or leave based on their experience before the first paycheck.

Option #1:   *Let people know exactly what they can expect.*

- Give new people time on the floor.
- Give people some experience before you hire them, or even before they start the training.

Option #2:   *Don't scare them. Give new people a sense of support and confidence that they can do this.*

- It is very important for experienced staff to be positive, even upbeat (and not intimidating) during the training. Everyone was, at one time or another, the new kid on the block. Our attitude has a lot to do with the way people feel about their jobs and their willingness to come to work.

Option #3:   *Offer a formal orientation to the big issues.*

Iowa CareGivers say:

- The highest likelihood of departure is in the first three months. Others say the decision is made before the first paycheck. So act early; orient before it's too late.

Big Issues Include:

- The "site culture"—not only history, but also the expectations co-workers have for teamwork, attitude, performance, getting help—things that often go unsaid.
- Policy and procedures: calling off, grievances, etc.
- The practice of Professionalism: Knowledge of one's specialization, Ethics of practicing it, Standards of the field, and Devotion to one's work as a "calling."

Option #4:   *Develop a collaboratively designed, site-specific orientation that creates "buy-in" and uses the expertise of experienced employees.*

The Think Tank says: Some skills need to be taught through "hands-on" experience combined with a formal orientation.

- Assign a Mentor
    - Make a careful choice as to who is assigned. Are they equipped to teach and advise?
    - Clarify the motivation for being a mentor. Is it extra work that will end up slowing the mentor down? Or is it a form of recognition that carries value? (See ideas under the Recognition, Decision Point #6).

- Allow new hires to shadow experienced staff members.
- Initiate "Shift Goal-Setting" meetings to deal with problems (like being short-staffed), and invite ALL the staff affected to attend.
  - Use this to create a team approach to problems and decisions, and to model good decision making.
  - Use it as an Orientation strategy to teach how teamwork is done.
  - Give new hires a sense of the care center's "site-culture"—attitudes, expectations, ways of dealing with stress, and standard practices. Often, these are things that are difficult to get across in a lecture.
  - Tape the meeting so people who miss it can listen to the tape and not feel excluded. However, since listening to the tape may take time that could be spent on patients, it might help to have a few Walkmans that could be loaned out.

To teach Professionalism, you must model it, as in the Shift Goal-Setting meeting. But you also need a direct approach—discussion and definition that serves as a "point of reference" when it is needed.

- Lectures don't do it. So make the teaching experiential. Use skits or problem cases that teach what professional means in context.
- There are lots of professional practices you could choose to focus on (like phone answering), but which ones matter most, when training time is limited? Hold a group dialogue to set priorities. Establish a common point of reference.

The process developed by PAL (Professionalism at Lemington) and the Carnegie Mellon Community Think Tank:

- Mixes formal presentation with a structured discussion process that involves new and experienced employees.
- Clarifies the different "roles" everyone on the staff plays (see Option #6 under Decision Point 3, Training).
- Involves staff at all levels in identifying problems, proposing and testing options as a problem solving team.

Option #5: ***Contract for an outside EAP program to support career development.***

A Maryland study says:

- Employee Advancement Programs support the health of the region and industry as a whole, letting workers shift among jobs and sites to where the need is greatest.

Option #6: ***Prepare for the shock of transition and for the WorkLife problems that will arise.***

The Direct Care Alliance says:

- A counselor on staff helps people in transition problem solve and reduce the inevitable friction.

- Combining high standards for performance with support to meet them can make work a stabilizing experience, even amid other chaotic contexts.
- Create a systematic response to this higher level of life crises, rather than an ad hoc or individual response.

Option #7:   Create a three-month transitional "process."

- Replace the "handbook" no one reads with a "workbook" new employees work through (with a mentor/staff developer) as a series of learning and problem solving tasks, including small milestone achievements that are recognized.

Iowa CareGivers say:

- Make sure veteran and new CNAs have the same training and understanding of techniques and skills to reduce tensions and risk.

Decision Point 3. Training and Mentoring

Two Weeks Later

Renee is still working on Shari's floor. By 10:00 a.m. it is not uncommon for Shari to have cared for twice as many residents as Renee. Shari rarely asks Renee for any help on 2-person lifts, but finds someone else in the wing.

Shari (*thinking to herself but only giving an angry look at Renee*)	**Shari** (*Sees Renee just standing in the room with Miss Eleanor who won't cooperate with her*)
Why is she taking a break when her work's unfinished?	Go on, I'll do it. *(With a loud angry sigh, she simply takes care of the situation without any explanation.)*

The Story Behind the Story

What is the working knowledge people really need? Some Rivals:

It's teamwork that makes the biggest difference.
- You have to rely on your co-workers. Mostly, this means the other CNAs.
- Helping experienced and inexperienced staff to work together and see themselves as a part of a team.
- Sometimes agency staff have been coming to a facility for quite a while, so they usually "blend in with the staff." They know what their boundaries are and aren't afraid to solve a problem within their limits. Agency nurses tend to be repeaters. Even so, the irregular and unpredictable work force creates scheduling problems and makes widespread sense of teamwork impossible.
- A lot of CNAs, like the older ones that have been here, work together. If they need help, they work like as a team. And the new employees, and some of the older ones, just would rather do it on their own instead of asking for help. The ones that do work together, it's easier for them because they just go with one, and they complement each other.
- Workers who come to a Care Center at the same time tend to bond as unofficial work teams.
- Accept that there are conflicts between personalities. But not all employees will get along the same way. However, if they are willing to work as a team, then they should get along fine.

Professionalism and respect are the keys to succeeding with patients.

CNAs say:
- Time management is important, but it has to done on your own, because patients don't like to be rushed. You might come in and say 'My name is whatever and I'm here to help you. We're going to get you out of bed right now. Is that all right with you?' Most of them say 'Yes, honey, come on.' But if you come in to a patient's room and you say 'I'm in a hurry, I ain't got time for nothin', I got to do it real quick.' That woman's going to tell you 'You can leave *now.*'"

- Yes, I have seen people who weren't committed and I have to say something. You have to approach patients as a professional because there is a certain amount that you have to be dedicated to. The most common problems are with respect. [For example] getting loud when they're talking to the patients, yelling, uh, 'What your light on for?' Something like that instead of being, 'What can I do for you?' you know, not knocking on the door, their privacy, you're supposed to knock, stuff like that. And I have to say something to them.

- We have a nurse resident's trust although they do not know her very well. She is friendly and although there is a language barrier, she understands some of the questions and comments that the residents ask, similar to a mother and her child who is first learning to talk. It was difficult for me to understand what some of the residents were asking her or telling her, but she responded as if there was nothing to it.

- She also seemed perceptive in interpreting body language and with her own seemed to put the residents at ease. She walked in and semi-introduced herself, distributed the medications while explaining what she was doing and why.

The Working Knowledge new people need is about decision making and figuring out strategies.

CNAs say:

- There can be patients that you really, really like, and you want to spend more time with them, but the other residents need to be taken care of, too. Sometimes you can switch with somebody. Like, if one CNA gets along with another CNA's patient and that CNA gets along with a patient of the other's, they may switch. But the priority is to make sure everyone gets taken care of.

- When you're working short, you have to decide who gets done first. Basically, you start with the ones that need to be up to be fed. They need to get up and washed and in to the dining room. Then you go from there. Next would be the ones who go to therapy.

- When the floor is short, once we get here, if there are employees who haven't shown up, you usually have more on your assignment, so you just go from there and start zooming at it. The supervisor tells us that our assignment has changed.

- As a CNA, problem-solving is not a big part of the job. Just use common sense.

- You hope that you'll come and everybody will be in agreement with whatever it is that they're supposed to do that day. But of course, being human, it never goes that way. Sometimes you have to really, I don't want to say trick them, but you know what I mean, sort of present the situation so they'll be more willing to do what they need to do. It takes a little bit of skill to convince them that this is for your best interest.

- Residents tend to be pretty familiar with you. So things usually fall into place. Then there are times when you just can't force anything on anyone, cause they have rights just as we do. You just have to continually be on it, understanding them. By knowing your residents, knowing what their needs are, knowing what they're being cared for, it helps a lot in tracking problems if they come up.

- There are two ways of getting things done. There is the book way, which is taught in training, and there is the real way, which is how to get everything done under demanding situations. It is good to know both techniques because they can be interchangeable, and it is usually necessary to teach the new CNAs the real way that things get done.

- All issues of care are "important" so you have to find the most important "important" things. You make sure pain is managed, diabetics have their sugar/insulin controlled, and everyone gets fed. Things like vitamins come last.
- Make sure everyone is clean and presentable, and turned every couple hours to avoid bedsores. If you're short-staffed, they might not get dressed that day. You do the most important things first.

> *A CNA's Story Behind the Story:*
> There was a resident—I reminded him of someone else, someone he didn't like. He would curse at me and refuse to let me help him. So I would have my coworkers go in first, which threw him off of his expectations. He still remembered that I reminded him of someone, but then I would sort of disarm him, saying, "Well, with this beautiful face, how could I not remind you of someone?"

Professionalism is more than daily care.

- On Documentation: Say, for instance, if a resident is not in agreement with certain medications or certain care regimens, your documentation is very important. Once your primary care physician comes in and evaluates the situation, and he finds that a resident hasn't done this for ten days and she hasn't taken her medication for three or four, it has to be noted somewhere. Then they can have some other plan of attack that they can use to get the resident to be more cooperative.

Nurses say:

- CNAs really look out. With certain residents it's kind of hard to pay extreme attention to every and anything that's going on with them and that's where my CNAs come into play. They serve as my eyes and ears for me. If there's problems that maybe I have missed. And they're probably more prepared for that because they are hands-on, all the time, everyday, with their care. Bathing them, changing them, dressing them. They are more attuned to see more problem areas, than I will because I'm out on the floor, I have 30 of them, and I'm giving medications. Bed sores or whatever issues come into play. They are really my first line of defense, because they will alert me to whatever existing or new problems or anything that occurs.
- A lot of people, they feel a lot of times that CNAs are not really respected. I think it's basically the job itself. Sometimes they feel that way, but I don't. Because a lot of times without them, I wouldn't know half of it, and I see my residents every day. What I mean to say is digging, and seeing below the surface, they're a real help.

Who trains new people—and how?
- Some employees don't like to accommodate new staff, but others will take the new ones under their wings. It's a matter of personality. Sometimes, though, employees are assigned the job of orienting a new person who follows them around. The experienced employees are expected to explain their jobs to the new person. Some employees feel that this slows them down and they resent it.
- Training new CNAs: Officially, I take them around, show them how I do things, show them how each resident is done, give them little hints. I'm a particular person. I tell them if they follow this way, you'll do OK.
- The supervisor points out the new people to certain aides to follow along with them. Orientation slows me down a little bit, but I just tell them if you'll watch and follow after me, you'll be OK. You might as well train them and train them right.

- [The people that try to cause conflict will say] 'Well, we don't do it like this there,' and 'How are you all so friendly' and 'Why don't you get angry?' There's no need to get angry. I always tell the staff that in the time you stand there and complain about something that you can just complete it. And they'll say, 'Well how come?' but I'll say, 'But you know, while you're standing there, you could have it done.' All in all, I work a lot of agencies, I work at another hospital, and I always tell the staff that no matter where you go really it's the same. There's different faces, different names, but it's the same.

- [Does she take problems with less-than-perfect care to management?] No, I do it myself, and normally I don't have a problem after that. That's your job, and the thing of it is with management here is that if someone is doing something, you're just as guilty. Peer monitoring has been effective in making us feel like a family. It's the work ethic. I try to tell people, 'All the patients are yours,' and most nurses that have a problem, it's because they don't go by that rule.

A manager says:

- I stand next to one of my employees and work along side him or her. You see that I have on work clothes. This is how I come to work every day. I want the people in my department to understand that it is about everybody doing the wok, getting it done.

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Decision Point #3: Training and Mentoring

New hires have "book" knowledge but not the " working" knowledge it takes to cope with the workload and contribute to the team. Should management (and other staff) invest the effort it takes to cultivate a paraprofessional, in an entry-level (possibly temporary) worker? If so, who mentors; who trains? In what ways?

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Option #1: Develop—and motivate—professional performance with small steps and achievement-oriented on-the-job training.

Direct Care Alliance says:

- Design the job as a series of competencies each employee can attain and demonstrate.

- Construct training around small steps and explicit achievements in entry-level jobs.

- Recognize progress. Advance the new employee through a set of new responsibilities based on demonstrated competencies.

- Offer formal recognition of these steps at increasing levels of public significance, from a "check off" by the Mentor, acknowledgement in meeting with a Supervisor, and recognition in staff meetings or in a memo, to "certification" by Staff Development program, and recognition by the company, including bonuses or a pay raise.

- Facilitate access to other educational opportunities.

Iowa CareGivers suggest:

- Implement inexpensive, short-term incentives to maintain motivation and momentum with a new program, such as: poster contests, team competitions, dinners, awards/certificates (with other incentives for those who can't take part in advancement programs).

Unit Clerk and CNA Trainees name their motivation:

- My satisfaction at my job is tied to my sense of accomplishment. It's important to me that I helped secure VA benefits and services for residents. I was offered the opportunity for training (for myself and my daughter) because I had distinguished myself as a Unit Clerk. And now I'm participating in the goal setting meetings for the floor.

- What motivates retention? The possibilities for advancing, for receiving extra training, for realizing a dream are all more important in satisfaction than sign-on bonuses and similar things.

Policy Analyst rivals:

- Achievement depends on knowing what it takes to succeed. But employees often receive mixed messages on the job about what the priorities really are. Or multiple supervisors (who don't work it out with each other) give different messages. So the employees get in trouble, or fail to make progress. Goals need to be communicated more clearly—in written form, in descending order of importance. But the truth is, supervisors may need help here.

Human Resource Directors say:

• One incentive is to offer scholarships that pay for schooling, but ask for two years after they have finished. *Rival*: more facilities are doing this so the incentive is less, and nurses still leave because the salaries are so much better outside of long term care.

• The best way to motivate is to first locate, then harness their passion for the work. Effective workers are interested and stimulated. Find out as soon as possible what they are comfortable with "before they already have their foot out the door."

• The best way to find that passion is through personal contact, especially through mentors. A new hire might not feel comfortable telling her supervisor the tasks she likes and dislikes, but a mentor could help place workers in roles where they will excel and succeed.

PA Intra-Governmental Council on Long Term care says:

• One 'culture change' indicator [which] showed a very dramatic and consistent effect [was] the degree of frontline worker involvement in the care planning process . . . [This was] repeatedly associated with lower levels of recruitment and retention problems, lower reported rates of staff shortages, and fewer job vacancies.

RN rivals:

• When you sit down and ask employees to come up with goals to make the unit function, it can be difficult to get them to even fill in three lines on a form. They knew what they wanted, but it seemed they couldn't find the words. So the problem is making this process of goal setting work.

The Think Tank says on training younger workers:

• Generational differences affect learning. If a task needs to be done, Baby Boomers assume they should do it; Gen Xers need to be specifically asked—they also expect more immediate rewards, positive reinforcement, and the visible possibility of upward mobility or progress from their effort.

• One option for motivating the young generation of workers is taking them aside to recognize "you are doing a good job" but also ask them to figure out how to make certain things work better (that is, to both appreciate and give a sense of control over the work situation).

• Give people input into the kind of recognition they get: If veterans like a pin, baby boomers might want an option, and Gen Xers might say: "Whatever it is, give it to me now, because I might not be here next year."

Option # 2:   Help paraprofessionals develop "thinking tools" for professional problem solving and personal decision making.

Direct Care Alliance says:

• A missing, "essential element" in the development of direct care paraprofessionals is training in the transferable "critical thinking" skills—problem-solving and communication.

Carnegie Mellon Outreach says:

• Professional orientation and mentoring tools (such as the *Decision Maker's Asset Assessment and Journey Book)* are "thinking tools"—they ask employees to take responsibility for their *own* growth. New employees need to:
  – See themselves as decision makers,

  – Be able to use explicit strategies for exploring alternatives and evaluating options,

–   Develop plans for increasing their own worklife assets and making changes.

PA Intra-Governmental Council on Long Term care says:

•   More training has a positive effect on retention. . . The strongest relationship was found between providers that spent the largest amounts for training and the objective measure of staff retention.

The Think Tank poses rivals about how to do such training:

•   *Rival*: So how do you learn goal setting and decision making? One answer is "experience": You learn at home. You either have it or you don't. Just pay attention, pick up on the flow. Some people gravitate to care work; however, you can care *too* much and that hurts your ability to work.

•   *Rival*: But if you leave this kind of learning to "experience," will inexperienced employees be able to do the more explicit communication and goal setting everyone said was so needed? For instance, the Unit Clerk noted that the skills she was taught in medical records helped her to function in other roles on the floor.

•   *Rival:* People learn better in structured situations that support a certain kind of thinking. Holding shift meetings, in which people work collaboratively to decide on goals, is one way to empower. Experienced workers can acclimate you. And mentors—if they actually want to help—can make a difference.

Option #3:   Link WorkPlace learning with WorkLife growth.

Direct Care Alliance and Iowa CareGivers say:

•   Training needs to focus on job-specific skill and knowledge that give people confidence they can "do" this. But it must also deal directly with socialization to the world of work.

•   Initiate or mentor the development of a CNA peer networking or support group within the site.

PA Intra-Governmental Council on Long Term care says:

•   It takes a special person to do the work of a direct care worker—a job that demands compassion, dedication, a patient positive attitude, and professional, reliable teamwork. But they are not treated or looked at as special, respected, or valued. An attendant puts it: "I want to feel like a person."

•   At the same time some workers are there because they need a job—any job—to meet welfare requirements and have little initial motivation and less preparation for its demands.We must recognize these two "camps" and that the effort to train the unprepared, pick up the slack as they learn, and be short-staffed if they leave regularly increases the burden on the "professional" direct care worker.

But what is the starting point for training? A Director of Nursing Says:

•   Before you put a lot of effort in training and mentoring, you have to find out first if they want to do this. They need to have a good idea that they want to be in health care. They need to know what to expect—people will be short with you. Anyone can learn the tasks, but you have to have the motivation within your heart that you want to do this job. Some high schools are giving this experience. Let them try to do the role playing we just saw in the Think Tank.

- *Rival*: I had children. It wasn't about coming back to my wife to say, "Hey, it wasn't what I expected." She ain't going for that. I had to handle it whether the job was bad, good, or whatever. That's how you got to think before going into a job.

A Health Care Business Owner says:

- Even if someone's coming off welfare, you can't force a person into this work. If you don't have it in here, you aren't going to do it. And we don't have time or opportunity to teach them. It may cost us more money in the short time they are there than it's worth, even if government agencies offer job tax cut. If you need a job, go to McDonalds. We need to pull our profession up.

- In short, the starting point for retention is selection, not training. Workers need to come with a caring attitude, basic skills, and a desire to work.

So how do you build professional attitudes? The Think Tank says:

- "Professionalism" in healthcare starts with the quality of compassion. It's like the values and manners that are part of your upbringing, or the desire to work. This can't be "taught" but it can at times be "caught" (through relationships like mentoring).
  - *Rival:* Once someone is decided, there is still a lot of frustration you have to support them through.
  - *Rival:* But we don't have time to teach those basic attitudes. It has to be what you bring from home.
  - *Rival:* What if someone hasn't had that experience at home? Is it hopeless?

PA Intra-governmental Council on Long Term Care says:

- Direct care takes a "special" person. We recognize that unprepared workers need socialization to work that addresses their struggles with a worklife. But it is equally important to help the committed, "special" workers connect their personal journey with their work (through markers of respect and advancement and opportunities for professional development).

Option #4 : Create a " network of mentors"—who meet different needs.

The Think Tank points out different roles:

- A good mentoring plan recognizes the diverse kinds of support people need to succeed:
  - A traditional Buddy who is in your corner and can show you the ropes, the lunch room and the supplies;
  - An on-the-job Mentor who helps translate book knowledge into "working knowledge" on the floor ;
  - A Guide to professional growth who motivates an on-going assessment of your assets, plans for reaching goals, and decision making;
  - A personal Role Model selected by the new employee;
  - An Expert resource for gerontological questions and dilemmas: a person, a handy text on symptoms, a regular discussion group;
  - A social service Resource (or a trained confidential counselor) for dealing with worklife problems; and
  - A Support Group set up to share both problems and solutions.

- Mentors should be volunteers (rather than assigned); they should receive training which is treated as professional development; and they should be publicly recognized for both service and their skill advancement.

Iowa CareGivers suggest:

- Prepare CNAs to mentor and orient new CNAs, which means they:
    - participate in planning such a program—a factor essential to its success, and
    - do this as an advancement option, for a bonus or pay increase.
- Train Mentors in their task and provide quarterly follow-up to new Mentors to problem-solve, gain peer support, and prevent burnout.
- Begin a system of training new hires at night because, in most cases the night shift is when problems arise. Day training can be misleading, because if you expect things to run smoothly, when you do end up short-staffed on a night shift you are not prepared.
- Develop an extended training process—including review and recognition.

The Think Tank suggests:

- Focus first on developing the essential *relationships* that let new hires enjoy their work and work effectively. These relations are what keep you going.
- Help the mentee build relationships with peers and management and with patients and their families.
- Give the mentee room to be imaginative (like relating through music).
- Use question and answer periods to create open communication and connections.
- Give structure to the ways of connecting by treating informal mentoring as a "best practice" method.
- When you don't have enough time to orient people before they have to be put on the floor, they get into bad habits and don't want to be told other ways. You need to make a situation in which people want to seek out a mentoring relationship.
- As a nurse or supervisor you also have to manage the fine line between being a boss and a friend. I know what's going on and have to say something to my boss; but I don't want to be an outcast and still have to keep the communication going on with these people who I count on to do their job and help me with mine. Be firm but fair—"get with the program."
- Use these relationships as the place to understand and deal more effectively with diversity.

On Combining Mentoring and "Teaching"

- Formal mentoring can use role-playing and scenarios to model professional behavior and ways to handle typical problem situations.
- Orientation is the key to employee's success: make sure welfare-to-work hires come prepared: there's no time to teach on the job.
- Use the last two weeks of a three-month training as a period of mentor-influenced training that extends book knowledge to hands-on-experience.
- Start with programs in the schools. Let students get hands-on experience helping out at the facility.
- There's a saying that "nurses eat their own," and when a new hire can't complete her daily assignment (after six weeks training and mentoring) other staff get frustrated. Here you need a mentor who can speak as a partner or co-worker and ask, "What's the problem here? How can I help you?" Maybe she can find out what the problem really is (e.g., lacks confidence, is going by the "book," doesn't grasp the system?) in the way a supervisor couldn't.

On Weighing the Costs and Benefits of Mentor Programs:

- Mentoring can take time away from everybody's job. And staff do not have the time to teach basics (including compassion).

- During the training/mentoring period, new hires are not counted as workers, but as a second set of eyes.

- You can't teach and forget. People need consistency and routine monitoring and follow-up mentoring.

- Effective programs such as Grow Your Own Nurse allowed aides to move up the educational ladder to nurse (but they have disappeared with government funding).

- Becoming a mentor can give aides one of the critically needed opportunities for "small-steps" achievement and recognition (e.g., CNA-level 1; CNA-level 2).

- Informal mentoring is common. But to create a climate of professional performance, mentors must be intentionally selected, prepared, and recompensed.

- Formalize the mentoring role in writing: who can mentor, what do they do, what benefits do they get? And let the mentor and mentee read and agree to this agreement for themselves.

- Treat mentoring programs like any pilot program and test how they work.

Option #5: ***Use innovative management strategies: start a cross-level, intercultural problem-solving process to build a site-specific training and development plan.***

Start with values. A Hospital Administrator says:

- A traditional management approach would start with the supervisor's code—and we would be doing more of the same, creating the same stresses that are leading to turnover. The concept of a collaboratively developed code is the break-through thinking. Moreover if you want to have good role models and mentors, you need to start with everyone telling the same story.

A Policy Analyst says:

- Connecting values to action is the key. I've seen it work in different settings; it creates respect. (*Rival:* If it's just an "exercise," it flops.)

PAL (Professionalism at Lemington) and the Carnegie Mellon Community Think Tank suggest a set of steps:

- Initiate a Think Tank with all staff: teach strategies that develop an in-house capacity for collaborative problem-solving and begin a site-specific analysis of problems and options.

- Commission the staff, working in pairs, to develop a portrait of individual roles & their relationship to others' roles. In the Think Tank develop new Options for training based on this analysis.

- Integrate this process into the on-going training of new (and old) staff—make sure everyone is working from the same understanding.

Assessment is essential. A Business Advisor says:

- If you do any of these changes or initiate collaborative problem-solving, what's the point if you don't measure the impact on retention or recruitment?

- Some possible measures: Percent turnover (*Rival:* that figure can be too gross a measure, affected by too many variables to capture effect). Exit interviews. Or try intermediate indicators: Number of grievances, sick time, tardiness, employee satisfaction surveys over time, changes in management practices.

A Policy Analyst says:

- Taking a broader workforce view, another measure of change has to recognize employee development. Leaving may be a positive outcome for an aide with no career ladder. Notice for instance how the CMU Asset Assessment measures growth in decision making and networks of support.

Managing change. A Healthcare Administrator says:

- One of the big problems of creating a major change is you have to change everyone together, but many are not willing or capable of that. Idea: create a laboratory or prototype from scratch, staffed by people who want to be there. When it becomes the place everyone wants to work, change spreads across the unit (versus being defeated by the inevitable sources of resistance at the start).
- *Rival*: It's normally hard to pull staff off the floor for new training or to find resources for it; however the current climate may be a good one for experimentation.
- *Rival*: Some folks are always ready to try new things, and other powerful negative leaders will always make it difficult to promote change. But the folks in the middle are the crucial swing vote. You need to study employee satisfaction to find what they want.
- *Rival*: Cycling people, including skeptics, through a positive experience like the Think Tank can create a new attitude on the floor among others, who then want a chance to participate.

Option #6:   Distribute the Responsibility—and Recognition—for Doing Professional Development (Orientation, OJT) across All Levels of Staff (It Takes a Whole Building).

- Collect "What Would You Do?" stories of typical problems, to use as problem cases in Orientation and staff development sessions on decision-making. Use first hand stories to illustrate and teach the features of professionalism.
- Work out a collaboratively developed Code of Conduct that makes values, expectations staff can have of each other, and patterns of behavior more explicit, more open for discussion.
- Make sure everyone is telling the same story: Take old staff through the same training/orientation.
- Choose good role models/teachers to become Journey Book Mentors and leaders of decision-making sessions for new (& old) staff.

Who trains? The DCA and Iowa CareGivers raise rival answers:

- The front-line supervisors are the most important coaches. A good relationship with a nursing supervisor is the top factor in job satisfaction.
- Direct care workers say this is the responsibility of the Staff Development person—who needs to spend a large percent of time on the floor, mentoring and monitoring new staff. They note they do not have time (and are not given released time, recognition, or recompense for taking a training role).

- Managers say direct care workers can make the biggest difference by taking a mentoring and teaching role.

Using Assessment as a Tool for Change. A Business Advisor says:

- Get people involved. Ask them to tell you what are the important things in their job to measure. Then make management relate to what people say is important. When you create a measure of performance, you build a feedback system. You make data collection part of a system of learning—a practical tool for learning if what you are doing is right. This works in manufacturing, in high performance companies.
- *Rival*: But TQM has resulted in superficial participation for low wage workers when the governing criteria are how to increase productivity.
- *Rival*: To most staff, management assessment projects mean "Here you come, looking for me to make mistakes."

A Care Center Administrator says:

- I try to treat everybody fairly and equally; do a pizza party for everyone. But what they really indicated to me in our Think Tank was a need for individual recognition. So I've got to figure some way so I can say they did this, this and this; so they get that recognition and I'm not accused of favoritism.

Carnegie Mellon Outreach says:

- Let the unit operate as a Think Tank and take more responsibility for designing and doing the assessment itself: for deciding, what are the indicators of high performance? What is changing?
  - A local action Think Tank group surprised their Administrator when they identified one of their top options as changing how recognition was given. And they were able to propose a workable, equitable strategy for managing the change as well, so that judgment came from both the staff and the supervisor.

The "Recognition and Respect Episodes" Problem Scenario

Shari   an experienced CNA
Jan   an RN charge nurse
Mrs. Williams   the Nursing Home manager
Renee   a new CNA; this is her first job
Miss McCarthy   a resident's daughter

Renee is now in her first month of work, assigned to work the day shift with Shari.

In the Hallway (Conflicting Expectations)

Miss McCarthy

(with a raised voice)
Are you the one supposed to be taking care of my mother? Why is my mother still in bed at 11 AM on Sunday?

Renee

(frowns, turns her back and walks away abruptly, not looking at Miss McCarthy as she speaks)
I'm doing my best to get to her. We're short-staffed this morning.

Miss McCarthy

Never mind. You obviously can't help me. I want to talk to someone in charge.
(walks to nurse's station)

I am Mrs. McCarthy's daughter. I just found my mother still in bed. Do your people realize it's 11 AM? I know my mother, and she would never have been in bed this late voluntarily. Your people can't get around to their jobs whenever they feel like it. That's my mother in there!

Jan

I'm really very sorry, Miss McCarthy. I know our CNAs try their best. We have a lot of residents here.

Miss McCarthy

I'm not interested in your management problems. I'm interested in my mother's care. I feel terrible when I think no one is taking care of her. That young woman… I don't understand what's so difficult.

Jan

I can promise you I will look into the situation. We have a new aide and I'll talk to her.
(As Miss McCarthy walks away, Jan says to herself)
I know where she's headed.
(Miss McCarthy walks briskly out, heading for the manager's office)

At the Nurse's Station (Signs of Respect)

Jan

Renee, I know you're pulling double-duty today, but we shouldn't still be doing basic care at almost lunchtime. And you just can't get an attitude even if the family does. I am going to have to talk to Mrs. Williams about this. She needs to know this woman is very upset.

Renee

Look, I told her I was on my way to her mom next! What am I supposed to do? I have 14 residents for AM care this morning. None of them wanted to get up before 8 AM. And all of them might or might not have company coming after church.
(Turns away talking to herself, but so Jan can hear)
We take care of these people's parents every single day, and they want to show up once or twice a month and criticize me? The only time anyone notices what you do is when you have a problem or mess up. Forget this!

In the Office (Forms of Recognition)

Mrs. Williams

So what's the problem on your floor?

Jan

Miss McCarthy got to you too? I had a talk with Renee already. She's acting like she's going to quit.

Mrs. Williams

(*shrugs shoulders with a helpless look*)

End

Decision Point 4. Conflicting Expectations

In the Hallway

Miss McCarthy

(with a raised voice)
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(As Miss McCarthy walks away, Jan says to herself)
I know where she's headed.

(Miss McCarthy walks briskly out, heading for the manager's office)

The Story Behind the Story

What is Miss McCarthy thinking?

- It really upsets me to see my mother like this. And I am paying the Center to take care of her—I have the "right" to tell them what I expect (and to tell them off when I don't see what I expect).

What is Renee thinking?

- This feels like a no-win situation. I can't defend myself to Miss McCarthy because policy says our staffing issues shouldn't be aired in front of the family. But I know that my supervisor won't defend me, either, because her priority is to pacify Miss McCarthy. So I just have to swallow it, which makes me feel pretty abandoned. I know I'll look "guilty" and there's nothing I can do about it.

What is Jan thinking?

- It is inappropriate for Renee to be doing AM care at 11:00, especially on a Sunday when she knows that families visit. She should have asked for help if she was unable to finish her tasks in a timely manner.

- I want to do what I can for Renee without getting too involved. I refuse to get dragged into this; conflict management is not in my job. Plus she does have to own up to her mistake. This is not my battle; it's better not to take sides.

What is going on here? What is the problem?

Nursing staff say:

- The family members just can't accept the situation. The daughter is "coming in with guilt" that her mother is in a nursing home in the first place. But if she raises a fuss she feels like she is doing something. The staff shouldn't have to deal with this.

A charge nurse says:

- The people that succeed in this job have to have some real ability to handle stress and frustration. Maybe it's God-given, but it's definitely something innate in the worker at some level. Frustrating things happen; you have to learn to cool down.

A Human resource staff member says:

- The staff is clearly not trained to deal with conflict management. And that means they can just make the situation worse.

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Decision Point #4: Conflicting Expectations

A family member discovers that the Aide has not provided the level of direct care that she expected to see. She confronts the harassed Aide who is working the floor by herself, then takes the issue to Supervisors.

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Option #1:   ***Renee could handle the problem herself and tell Miss McCarthy about being short-staffed.***

CNAs say:

- That would take the heat off Renee—she wouldn't have to let it keep looking like it is her fault they are understaffed.
- You aren't supposed to tell families if there are any problems. Just tell them to talk to the supervisor.
- Family members don't care about staffing problems anyway. They just want things done like *they* think it should be.

Option #2:   ***The CNA could encourage the family members to help out. Show them what they can do.***

A Human Resources Manager says:

- Family members don't always understand that they are welcome to participate in their parent's care—dressing, changing sheets, feeding. Or they feel frustrated because they don't know how to give special care. You have to show them.

Option #3:   ***The Center could encourage family to pitch in.***

- This needs to be communicated by the Center, not just the staff. And it would be a way to encourage appreciation for what the CNAs do.

Option #4:   ***Prepare the staff to deal with conflict.***

- Offer conflict resolution training to all the staff, not just supervisors.
- Hold a staff Think Tank on these kinds of problems and let the staff share their options of managing conflicts.

Decision Point 5. Signs of Respect

At the Nurse's Station (Signs of Respect)

Jan

Renee, I know you're pulling double-duty today, but we shouldn't still be doing basic care at almost lunchtime. And you just can't get an attitude even if the family does. I am going to have to talk to Mrs. Williams about this. She needs to know this woman is very upset.

Renee

Look, I told her I was on my way to her mom next! What am I supposed to do? I have 14 residents for AM care this morning. None of them wanted to get up before 8 AM. And all of them might or might not have company coming after church.
(Turns away talking to herself, but so Jan can hear.)
We take care of these people's parents every single day, and they want to show up once or twice a month and criticize me? The only time anyone notices what you do is when you have a problem or mess up.   Forget this!

The Story Behind the Story

What is Jan thinking?

- I know the CNAs work hard. But Renee just needed to deal with it.

What is Renee thinking?

- The tension of every day is just building up. (She doesn't have any sense it is going to change.)
- I give respect when I get it. But not when I am treated like that.

What is going on here? What is the problem?

Being professional means you have to give respect—even in difficult situations.

- (Comment on workers who don't work with as much as commitment as they should) Yes [I have seen examples of this] and I have to say something. Well, you have to approach them, you have to approach them as a professional because there is a certain amount that you have to be dedicated to. And the most common problems are with respect. [For example,] getting loud when they're talking to the patients, yelling, 'What your light on for?' Something like that instead of being, 'What can I do for you?' you know, not knocking on the door, their privacy, you're supposed to knock, stuff like that. And I have to say something to them.
- My job, my responsibility is to make sure the residents are safe and in a clean and comfortable environment. I have an additional responsibility, a commitment, to be sure that when family and visitors come to the Care Center, they will also feel at ease. It will not only look clean, it will smell clean, not like a "nursing home." This is HOME to our residents. Today I was outside putting up the Christmas lights.

Getting respect—receiving explicit signs from supervisors, managers, and the institution—carries a message that in turn motivates professional attitudes.

- A lot of people, they feel a lot of times that CNAs are not really respected. I think it's basically the job itself. Sometimes they feel that way, but I don't. Because a lot of times without them, I wouldn't know half of it, and I see my residents every day. What I mean to say is digging, and seeing below the surface; they're a real help.

- I look at this building as my second home, partly because I'm here so much, but mostly because I love what it represents. I just get it done– if I have to do it myself. They appreciate it though. This Care Center is sending me to school to get certification in what I do. That shows that they care about how I do my job.

It can be hard to see the basis for many staffing decisions. People then assume different explanations. For instance, they may assume "managers are trying to…"

- Balance the ratio of staff to resident, whatever the difficulty of the floor or the particular needs of the day.

- Balance the number of competent people to give each floor an equally able team.

- Rely on the "can do" people and give them the newer or slower people in a pinch.

- Keep teams together to let them build a workable unit.

- Keep the sections with paying or "transition" residents filled first.

- Put the "squeaky wheel" staff who complain, wherever they will work.

> ### Decision Point #5: Signs of Respect
>
> The Charge Nurse must deal with the signs of an angry, disrespectful attitude and unprofessional behavior on the floor. Meanwhile, the Aide, who is looking at the larger situation, sees a parallel lack of respect for her situation–and does not feel motivated to behave as a valued professional member of the staff.

Option #1:   ***Increase communication over decisions in both directions.***

- Let all staff know about changes of plans that affect them.
- Share with staff the logic and process of how staffing decisions are made, open up a discussion about equity, and invite suggestions for creating it.

Iowa CareGivers say:

- Seek the council of direct care workers regarding equipment and supply purchases, over current needs and storage and convenience of supplies.

Option #2   ***Integrate direct care workers as full members of the health and social services care team through their direct participation in care planning conferences, staff meetings, and quality improvement efforts. (SWPPA).***

Iowa CareGivers say:

- Listen and respond to direct care workers regarding residents' condition and care. Get back to CNAs about what was done and how observations were helpful.

Option #3   ***Explore forms of recognition that identify and celebrate a respect for direct care staff as paraprofessionals.***

- Go beyond a focus on rules and behaviors that seem "school-like" (i.e., attendance, tardiness).
- Be sensitive to people who grieve the loss of residents. Allow selected staff to attend memorial services; hold a memorial service in the facility.

Iowa CareGivers say:

- Because the relationship with residents is a key factor in job satisfaction, include residents in recognition events that honor CNAs.

Options #4:   ***Include training in professional behavior, conflict resolution, etc. in OJT—recognizing the diverse cultural practices and expectations people may bring to a new workplace.***

- CNAs need to give administrative staff credit for supporting programs that place value on direct care work in the organization.

Decision Point 6. Forms of Recognition

In the Office (Forms of Recognition)

Mrs. Williams

So what's the problem on your floor?

Mrs. Williams

(shrugs shoulders with a helpless look)

Jan

Miss McCarthy got to you too? I had a talk with Renee already. She's acting like she's going to quit.

The Story Behind the Story

What is Jan thinking?

- Why do I always get stuck in the middle?

What is Renee thinking?

- Why do I bother with this? I *am* trying, but nobody appreciates it. You can care a lot about these old folks, but it's just not enough sometimes. I feel like I don't even want to come back tomorrow.

What is Mrs. Williams thinking?

- *(slumped wearily at her desk)* What am I supposed to do? We pay as well as we can—better than lots of places. I give a little bonus for no call-offs and even throw CNA parties. What else can you do?

What is going on here? What is the problem?

It's a WorkPlace problem: What matters is recognition for workload, for work well done, and the value of what people do.

- Working with other staff, especially making fair resident/staff assignments and scheduling lunch and break times.
- Residents' care is distributed among CNAs as if each resident has an equivalent amount of work, but the amount of work required does vary from resident to resident. Administrators say, "We don't look at that really, which we probably should." For example, our aides each had fourteen residents, but one aide had seven residents that could "do themselves" (meaning they could tend to most of their personal care needs). The other aides considered them as "not even there," feeling the workload was unevenly distributed.
- Some facilities don't look at what people can and can't do. Instead they just look at numbers. To keep peace, sometimes the workload has to be redistributed.
- Many CNAs think that their job would be better if they received more recognition than they currently get, which seems to be none. In one facility, the state did the yearly inspection and the nurses got a little present, but the aides didn't get anything at all, and that's not right.

- A "thank you" every now and then would be nice. It may be "my job," but it would be nice to know someone appreciates us.

- Always do your best. "Everyone is overwhelmed."

It's a WorkLife issue: What matters is recognition of the problems we have to face—on the job and just getting to work.

- Is management understanding in these situations? I think at first they didn't understand, but after you explain to them what it is, they're OK. There's not as much back and forth communication between management and the workers as there is between the workers themselves, but it's not as if they're isolated.

- You have a support system, and sometimes they move people from one unit to another. But if you know the job, you help out when you can.

- If an aide is organized, knows her assignment, and has a routine, there is time during the shift to complete the assignment. However, the high turnover and the presence of agency staff can interfere with the efficiency of the aides' work. High turnover is everywhere. It was shocking at first, but you have to expect and adapt to it.

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Decision Point #6: Forms of Recognition

The workplace seems to lack a "climate of recognition." But no one seems sure just what form it should take.

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Option #1:   Simple appreciation.

- We would just like to hear a "thank you, have a good day." Or a "thank you" over the intercom at the end of a shift.
- Some times it's nice to be thanked personally, but "we're all good" so thank us all.
- We don't work for pizza.

Option #2:   Recognition of problem solving—given on the floor/ on time.

- When a problem comes up and the supervisor asks for special effort, she needs to stop by on the floor to see how the situation is going (rather than simply make sure "the work is done").
- Make the recognition of Professional Performance and Special Merit a systematic process. This option uses a 3-step process:

Step 1. The shift supervisor does walking rounds on a regular basis during the shift with three goals in mind:
  - To *show* more directly that she cares about difficulties staff face ("Is there anything I can do?") to actively look for positives, and to express appreciation for work well done.
  - To recognize daily performance (noting where are residents up, dressed, positioned—and where they are not—seeing the appearance of the room etc).
  - To inquire about problems and notice "weak links" in the team who may need additional training, reassignment to a more experienced staff member, or a review of expectations and skills.
  In short, the shift supervisor uses these regular rounds, early and mid-way in the shift, to see how the team is doing, hold a team meeting, and help solve problems. But she makes a point of speaking to individuals with performance problems in a more private one-on-one setting.

Step 2. The shift supervisor then uses the merit recognition made on systematic walking rounds to recognize *consistent* professional performance (not just a good day or bad day) and give weekly Merit Points to individuals. These points can accumulate and may be used for various individual perks (choice of days off, gift certificate, raffle tickets).

Step 3. To create a balanced review, the team does a similar evaluation, picking MVPs or awarding points for special merit.

Option #3:   *Find a way to recognize—and hear—the expertise of paraprofessionals.*

- Include direct care staff in care plan discussions.

- Staff development needs to listen to staff evaluation of new hires.

- Managers only hear what aides tell them, but their needs and concerns do not always make it beyond supervisors to Directors Of Nursing. Create a clear channel.

- Transform regular staff meetings from "complaint" sessions to productive "problem-solving" sessions.

  – Direct care and nursing staff meet in 2 separate groups. A portion of the meeting is devoted to naming the most pressing problems and getting a sense of priorities.
  – But the second half—which produces what the group will "report out"—is devoted to suggesting workable solutions to these problems.

- Staff members could, with a little training, take the role of moderating this problem-solving dialogue and challenging the group to imagine "rivals" and take responsibility for *solving* problems.

- Between meetings, representatives collect suggestions from the floor for dealing with the issues raised in the problem-solving sessions.

Option #4:   *Collaborate with staff to identify priorities and build a plan for perks and recognition using available resources and opportunities.*

- Possible priorities for perks include:

  – Team, floor, group recognition for a period of safety, good reports.
  – Personal recognition for no call-offs or for on time over 2 month period.
  – Prizes, lotteries in which all who are eligible participate.
  – Parties, picnics, pizza events.
  – Staff Appreciations Days; Employee of the Month contest.
  – Develop community awareness for direct care givers (see Iowa CareGivers).
  – Put party money into practical needs: new uniforms, team requests, or individual bonuses for performance.
  – Let staff set their own performance criteria for individual or group recognition within a budget for "professional performance bonuses."

- Recognize the importance and quality of direct care work.

  – Supervisor spends enough time on floor (other than in midst of problems) to see performance.
  – Professional staff steps out of job classification to help out (e.g., Housekeeping director sees a need and collects laundry or waste baskets; nurse or supervisor helps in direct care; staff development director is on floor mentoring new hires as they work).
  – Staff has regular or informal office meeting with supervisor, or a personal memo to name and recognize particular actions.

- Recognize Individual Needs

  – Uniform flexibility (e.g., recognize individual body types).
  – Transportation problems.
  – Special scheduling needs.

- Lotteries, group parties etc. *alone* are not satisfying, because everyone knows there are "slackers", and it is not fair that they get the same credit and rewards as the hard workers.

Option #5:   *Offer ongoing" small-steps" incremental recognition based on quality and/or length of service.*

- Give "credit" for successful completion of training, even if it is required training, structuring is a part of a path to advancement.

- Recognize many forms of accomplishment:
  – Mentoring and increased responsibility.
  – Meritorious performance.
  – Levels of experience.
- Offer multiple forms of small step recognition:
  – Bonuses.
  – Certificates.
  – Public indicators of status: special badges, pins.

Option #6   *Exert decisive leadership in ways that create a visible climate of equity.*

- Turn the professional expectation—that each member of a team act like a "team player"—into a requirement.
  – Revise job descriptions to institutionalize some degree of helpfulness and flexibility.
  – Set explicit performance expectations so simply finishing one's individual duties (e.g., completing one's charts) is not the sole standard for evaluating performance in a team.
- From time to time senior staff members meet to renegotiate, clarify, or reaffirm their expectations of each other and the staff they supervise.
- Part of this discussion focuses on how "tough decisions" are being made. The staff uses these cases in point:
  – To clarify how the "chain of command" and decision making process is working and should be working,
  – To know when they can expect support for taking local leadership, and
  – To figure out how they can better work as a team.

CARNEGIE MELLON COMMUNITY THINK TANK
"EXPERT" SESSION

Options For Action In Healthcare: Creating/Retaining Paraprofessionals
April 3, 2001 - 4:30-7:00
Carnegie Mellon - Roberts Hall - Singleton Room

Roster of Healthcare Professionals

Rose Alvin
Program Director
Faith & Community
The Mentoring Partnership of SW PA

Silvio Baretta
Senior Partner
World-Class Industrial Network, LLC

Katie Cody, LPN
Assisted Living
Independence Court

Eric T. Conley
President/Owner
Sweet Home Care

Marlene Derewicz
Director of Resident Care
Independence Court

Earl Ash Evens
President & CEO
Faith-Based Network

Nancy Gillette
Senior Consultant
VHA Pennsylvania

Jerry Halpern
Health Academy Director
Langley High School

Hannah Holm
Policy Analyst
Three Rivers Workforce
Investment Board (TRWIB)

Vanessa Lund
Policy Analyst
Workforce Connections
PA Economy League

Tracy McKoy
CNA
Lemington Care Center

Joe Mertz, Ph.D.
Associate Director
CMU Center for University Outreach

Maureen Pedzwater
Job Developer
Reemployment Transition Center (RTC)

Ian Rawson, Ph.D.
President
Hospital Council of Western PA

Garnetta Simmons
Administrator
Harmar Village Care Center
Grane Healthcare

Joe W. Trotter, Ph.D.
Mellon Professor and Director
CMU Center for Africanamerican
Urban Studies and the Economy

Ursula Uhl
Director of Human Resources
Baptist Homes of Western PA

Lisa Thorpe-Vaughn
Director
Pittsburgh Leadership Foundation
Training Institute

Diane Jackson
Unit Clerk
Lemington Care Center

Ruthie King
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UPMC Health System

Paulette Washington
Faith & Community
The Mentoring Partnership of SW PA

Nancy Zionts Senior Program Officer
Jewish Healthcare Foundation

Carnegie Mellon Think Tank Supporters and Students from
The Rhetoric of Making a Difference Class

Monica R. Costlow
Bethany L. Elder
Kathleen A. Fischer
Tim Flower
Susan Gilpin
Christina Koshzow
Grace Raso
Leslie Setlock
Joanna F. Smiley
Lisa Thorpe-Vaughn

Dr. Linda Flower	**Wayne Bradley Cobb**	**Susan Swan**
Director	Director Community Education	Research Associate
	Carnegie Mellon Community Think Tank	

PARTICIPANTS' RANKING OF PRIORITIES AND EVALUATION OF THE 4/3/01 EXPERT THINK TANK

5 HIGH / 1 LOW

														Avg. Each Question
Is the Briefing Book ACCURATE?	4	3	5	5	5	4	5	4	4	5	5	4	5	4.5
What options are IMPORTANT ?														
Link retention to professionalism	5	4	4	5	4	4	5	4	5	5	5	3	5	4.38
New approach to paraprofessional development	5	5	5	4	5	5	5	4	4	5	5	4	5	4.69
Focus on workplace & worklife	4	5	5	4	5	5	5	4	5	5	5	5	5	4.69
Focus on decision making problem solving	5	5	5	4	5	5	5	4	5	5	5	4	5	4.77
Wider mentoring network	3	4	5	4	4	4	5	4	5	5	5	5	5	4.46
Management strategies for collaborative problem solving	4	5	5	5	5	4	5	4	4	5	5	4	5	4.62
What would be USEFUL ?														
Local Action Think Tank	3	5	4	5	5	2	5	4	4	5	5	5	5	4.31
PP training for decision making	4	5	5	5	5	3	5	4	4	5	5	4	5	4.54
Follow up expert ThinkTank	5	4	5	5	5	4	5	4	4	5	5	3	5	4.54
GENERAL EVALUATION AVG.	4.2	4.5	4.8	4.2	4.8	4.4	5	4	4.1	5	4.9	4.2	5	4.54

WHAT WAS THE MOST SIGNIFICANT ASPECT?
Discussion. Exposure to Journey Book. Looking for solutions or options. Excellent opportunity to learn and share concepts
Not alone. Many or all with same problems. Very open, safe, insightful dialogue.
Networking with others and comparing ideas. Dialoguing with such a mixture of people. Learning from other experiences
Sharing ideas in a semi-structured process.

HOW WOULD YOU ADAPT/ IMPROVE THE THINK TANK?
Promote it. Results need to be communicated (in simple terms) to a much broader audience.
More focus on dialogue, less intro, overview.
Expert "think tank" is good but action and implementation need to be expedient.

HEALTHCARE RESOURCES

Allegheny County Area Agency on Aging (ACAAA) http://www.county.allegheny.pa.us/aging

Catholic Health Association http://www.chause.org

Carnegie Mellon Center for University Outreach http://www.cmu.edu/outreach/thinktank/

Contemporary Long Term Care www.cltcmag.com/

Direct Care Alliance www.directcarealliance.org

Iowa Caregivers Association http://members.aol.com.iowacga/report.html

The Keystone Research Center http://commondreams.org

The National Network of Career Nursing Assistants http://www.cna-network.org

Occupational Safety and Health Administration http://search.osha-sic.gov

Paraprofessional Healthcare Institute (PHI) www.paraprofessional.org

Service Employees International Union (SEIU) www.seiu.org

Southwestern Pennsylvania Partnership for Aging (SWPAA)

Pennsylvania Intra-Governmental Council on Long Term Care www.aging.state.pa.us/aging/cwp

Pennsylvania Economy League, Workforce Connections- www.accdpel.org

The Urban Institute- www.urban.org

Welfare Information Network http://welfareinfo.org

RELEVANT REPORTS, RESEARCH and TOOLS
CARNEGIE MELLON OUTREACH

Reports Available on the Carnegie Mellon Outreach Website www.cmu.edu/outreach

Community Think Tank Brief #1. Urban employees in the new workplace. (Fall 2000). Carnegie Mellon University, Pittsburgh, PA. http://outreach.mac.cc.cmu.edu/thinktank/docs.html

Findings: Negotiating the Culture of Work and Technology. A Report on Rival Hypotheses, Options and Outcomes from the Carnegie Mellon Community Think Tank. Eds. L. Flower and S. Swan. Spring 2001. 38 pages.. http://outreach.mac.cc.cmu.edu/thinktank/docs.html

Drawing on the Local : Carnegie Mellon and Community Expertise. A Report from the Community Problem-Solving Dialogue. November 1, 1999. http://english.cmu.edu/inquiry/drawing.html

Working Partners: An Urban Youth Report on Risk, Stress and Respect. The Community Literacy Center and Carnegie Mellon University. 16 pages. . http://english.cmu.edu/clc/partner.html

Related Research

Flower, L. (1997). Partners in inquiry: A logic for community outreach. In L. Adler-Kassner, R. Crooks, & A. Watters (Eds.), *Writing the community: Concepts and models for service-learning in composition* (pp. 95-117). Washington, DC: American Association of Higher Education.

Flower, L. (1998) *Problem-solving strategies for writing in college and community*. Ft. Worth, TX: Harcourt Brace College Publishers.

Flower, L., & Deems, J. (2002). Conflict in community collaboration. In J. M. Atwill & J. Lauer (Eds.), *New perspectives on rhetorical invention*. Knoxville, TN: University of Tennessee Press.

Flower, L., Long, E., & Higgins, L. (2000). *Learning to rival: A literate practice for intercultural inquiry*. Mahwah, NJ: Lawrence Erlbaum.

Swan, S. (2002). Rhetoric, Service, and Social Justice. *Written Communication* 1(19), 76-108.

Swan, S. (in prep). *Rhetorical Praxis for Social Justice*. Doctoral Dissertation for Carnegie Mellon University.

Young, A., & Flower, L. (2001). Patients as partners: Patients as problem solvers. *Health Communication* 14(1), 69-97.

Educational Tools

The Decision Maker's Asset Assessment and Journey Book. A Computer-Supported Assessment of Supporting Networks, Assets, Personal Plans and Progress.   Software, CD and Guide for youth and staff development programs.

What's Your Plan?: Sexuality and Relationships. Young, A., and L. Flower. A Multi-Media Dialogue & Tutorial for Personal Decision Making.

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Carnegie Mellon Outreach
www.cmu.edu/outreach
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Carnegie Mellon University, Pittsburgh PA 15213
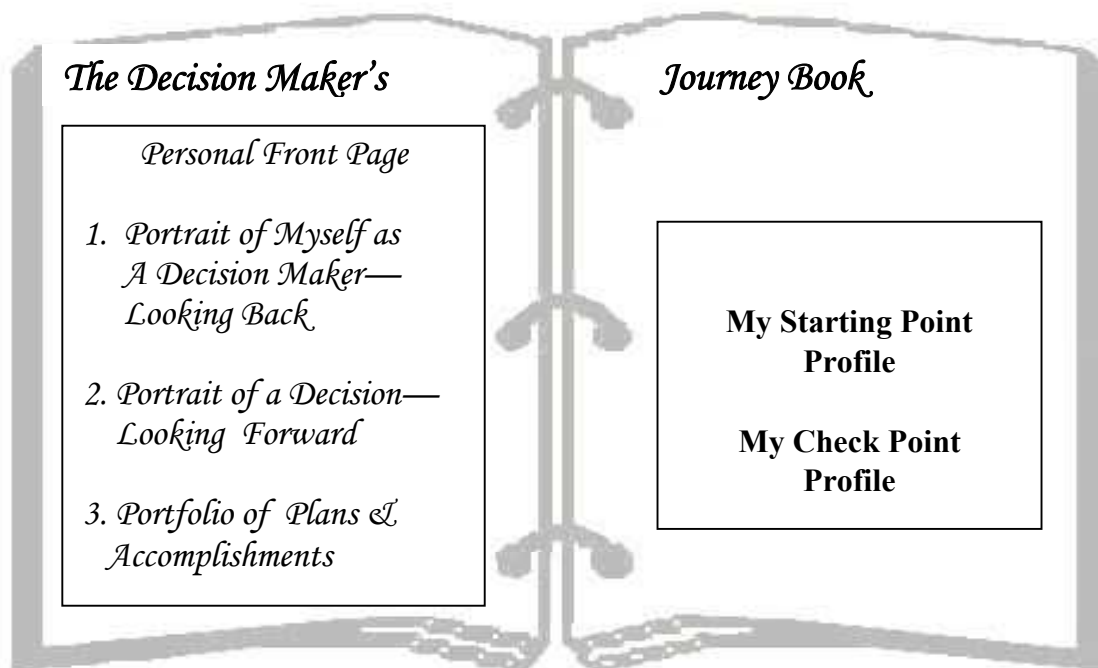
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Why Should Adults Engage in Self-Assessment?

New employees are continually being assessed by trainers, managers, and peers, but they are rarely asked to engage in a reflective, goal-directed self-assessment of their own actions or assets. To build an *identity as a decision maker*, a person needs not only the opportunity to make meaningful decisions, but also the awareness that his or her own (sometimes unexamined) actions have reasons and consequences. To be a *reflective decision maker*, one needs, in addition, strategies for assessing one's assets and goals, for making plans, and for evaluating options and outcomes.
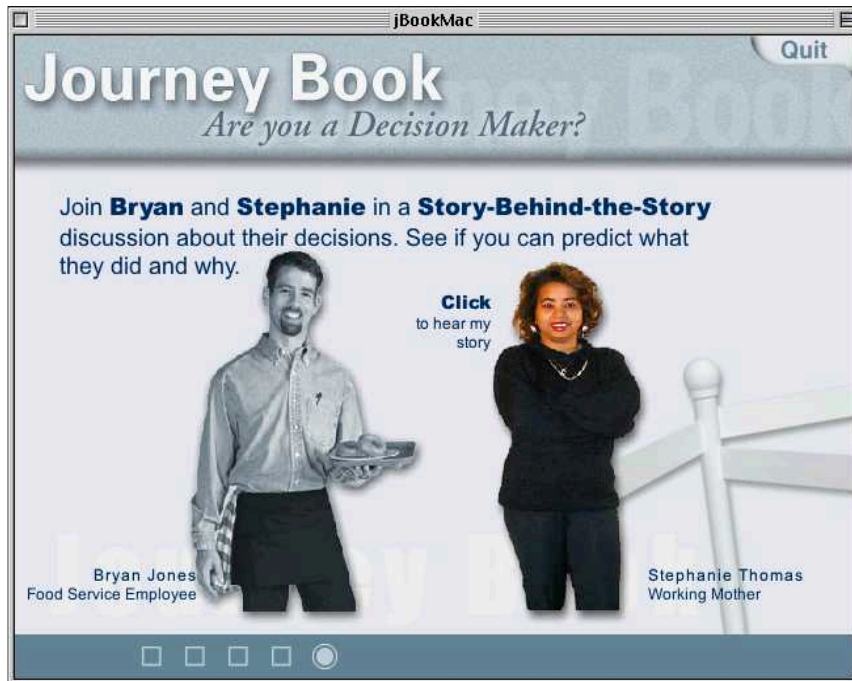
How Can You Support Decision Making?

Decision Makers provides a scaffold for building this problem-solving identity and strategies for reflective self-assessment. The Carnegie Mellon team supports the process with a seminar and support for teachers and mentors, computer tools, and a final formal analysis of growth and change. Together the Assessment and Journey Book function
  As a personal planning portfolio for youth
  As a placeholder for personal and problem-solving conversations with mentors
  As a tool for program assessment

The Decision Maker's   *Journey Book*

Personal Front Page

1. *Portrait of Myself as
   A Decision Maker—
   Looking Back*

2. *Portrait of a Decision—
   Looking Forward*

3. *Portfolio of Plans &
   Accomplishments*

**My Starting Point
Profile**

**My Check Point
Profile**

The Journey Book CD
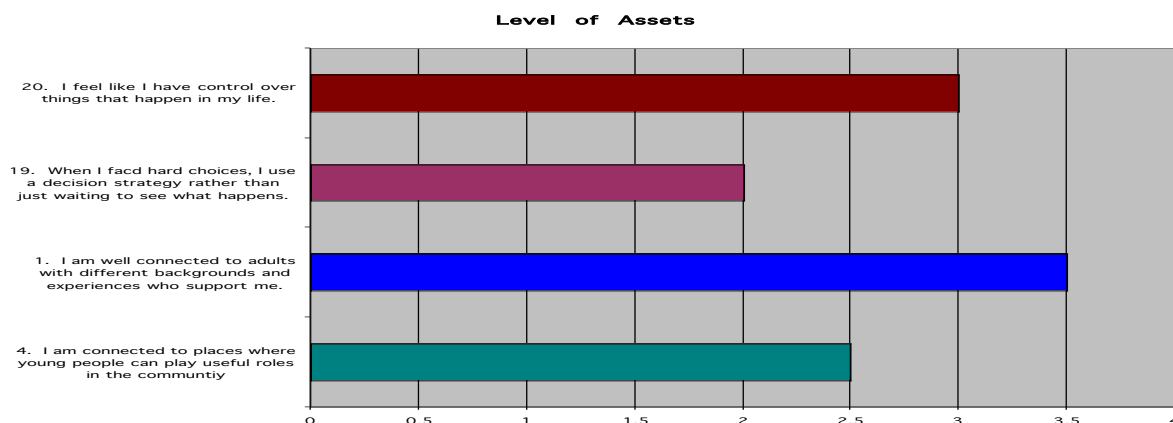

The CD lets users practice decision making by:
- Hearing about real problems
- Learning decision making strategies
- Comparing rival predictions of how they handled the problem.

Decision Makers use this same process to build their own Journey Book

The Asset Assessment

The Carnegie Mellon Assessment gives a quantitative picture of the Decision Maker's
- Asset base (in terms of agency, motivation, decision making, support networks, and dealing/with others)
- Networks of support and
- Level of reflective decision making

Level of Assets

- 20. I feel like I have control over things that happen in my life.
- 19. When I facd hard choices, I use a decision strategy rather than just waiting to see what happens.
- 1. I am well connected to adults with different backgrounds and experiences who support me.
- 4. I am connected to places where young people can play useful roles in the communtiy

Carnegie Mellon Decision Makers
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