Staffing and Administrative Issues in
Special Care Units

By Leslie A. Grant, PhD, Sandra J. Potthoff, PhD, and Douglas M. Olson, PhD

Staffing and administrative issues are among the most serious problems facing nursing homes and assisted living facilities in the United States. Staffing and administrative practices are critically important to organizational performance in terms of finance, human resources, level of quality, and satisfaction. In this article, we highlight the importance of five organizational systems as they relate to organizational performance: (1) environmental design, (2) programs, (3) information systems, (4) human resource management, and (5) leadership. A fundamental challenge facing researchers and practitioners today is translating research into practice. We describe a collaborative research strategy to better inform researchers, practitioners, and policy makers about how to simultaneously improve special care unit performance and expand our knowledge base.

Key words: *administration, Alzheimer's disease, organizational performance, special care units (SCUs), staffing*

Staffing and administrative practices in dementia special care units (SCUs) in nursing homes and assisted living facilities are critical to organizational performance in terms of finance, human resources, level of quality, and satisfaction of staff members, residents, and family caregivers. Staffing and administrative issues have taken on added urgency in recent years. As the U.S. economy expanded during the 1990s, the labor market tightened. New challenges emerged for a long-term care industry already burdened with the negative stigma of working in a nursing home. In many parts of the United States, severe labor shortages have exacerbated problems of recruitment, retention, and turnover among nursing home administrators, registered nurses (RNs), licensed vocational nurses (LVNs), and certified nursing assistants (CNAs).[1-3] Staff recruitment and retention are among the most serious problems facing the long-term care industry today.[4]

Over the past decade, research has advanced our knowledge about how staffing and administrative practices affect quality of care in SCUs,[5] but the translation of research into practice has been slow. To bridge the gap between research and practice, we propose a collaborative research strategy whereby researchers and practitioners form partnerships. To bring researchers and practitioners closer together requires more active involvement of practitioners in the research process. Using this research strategy, researchers and practitioners each provide their specific expertise to develop research that furthers both

theoretical and applied knowledge. To make research findings more useful to practitioners, SCUs can be studied from the framework of organizational systems encompassing leadership, environmental design, programs, information systems, and human resource management. Both an organizational systems framework and a collaborative research strategy should yield research findings that are more easily applied by the practice community.

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satisfaction among staff members, and satisfaction with services among residents and their family caregivers. Five key organizational systems influence SCU performance. Ideally, all five systems are aligned because deficiencies in one system impede performance of other systems.

Leadership. Effective organizational leadership is critical because it tends to drive all other systems. Top management's vision and strategy affect programs, facility design, information systems, and human resource management practices. Leadership sets the agenda, supports change, and develops effective communication. Without effective leadership, improvement in other systems becomes difficult.

Environmental design. This includes architectural, interior, and landscape design features. Size of the unit, safety or security devices, centralized versus decentralized dining, or easy outdoor access affect the daily lives of residents and staff members.

Programs. Daily activities have a direct impact on the quality of life. Some SCUs have operational models adopted from hospitals (medical model). Other SCUs have borrowed from hotels and restaurants (hospitality model). Still others are reminiscent of home with emphasis placed on familiar social roles and activities that offer continuity with a resident's past (community model).

Information systems. Better information systems are needed to provide the critical feedback loop to the leadership to drive organizational improvement in each of the
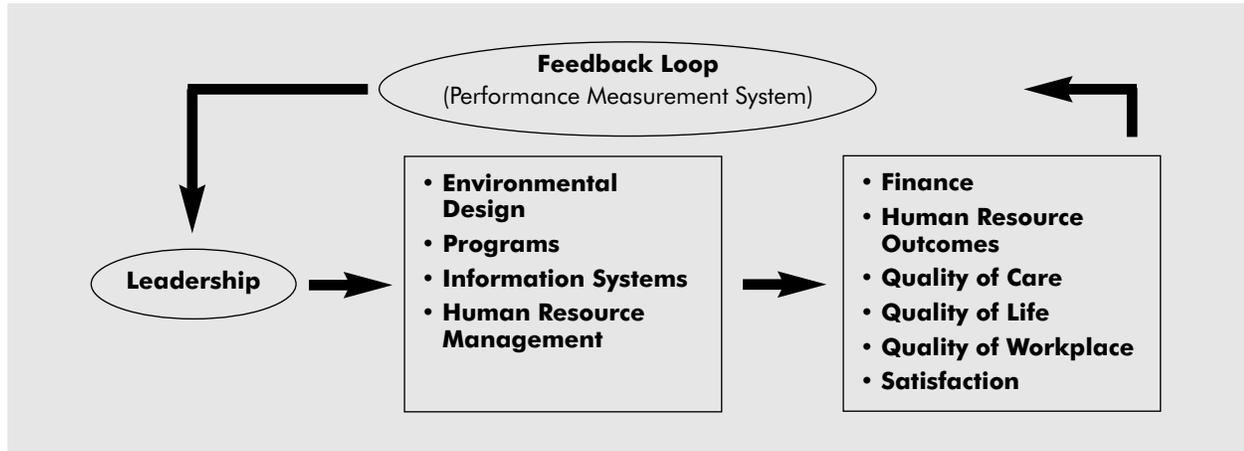
ORGANIZATIONAL SYSTEMS

Figure 1 depicts an *organizational systems* framework that can be applied to facilities serving persons with Alzheimer's disease. It identifies five key organizational systems affecting SCU performance. A range of outcomes can be used as SCU performance indicators. Financial outcomes are typically things such as lease up rates, occupancy rates, or operating margins. Human resource outcomes are things such as staff recruitment, retention, and turnover. Quality of care outcomes are measures of clinical performance in areas such as behavior management, medication errors, nutritional status, or hospitalization rates. Quality of life outcomes encompass things such as resident autonomy, dignity, and resident involvement in meaningful activities or meaningful social relationships. Quality of the workplace refers to job design, work routines, and staffing patterns as they relate to job stress, burnout, and workplace injuries. Satisfaction refers to job

Figure 1. Organizational systems framework.

indicators of SCU performance. Typically, organizations have information systems to track basic financial data (e.g., payroll, billing, and accounting). Most information systems fall short when it comes to tracking nonfinancial outcomes such as quality of life, quality of the workplace, or satisfaction.

Human resource management. This encompasses such things as hiring practices, staff training and development, supervision, job design, and performance evaluation.

Other articles in this issue focus specifically on environmental design (see Calkins) and programs (see Van Haitsma and Ruckdeschel). Our focus is on systems related to staffing and administrative issues. Some practical applications of research findings related to staffing and administrative issues are highlighted. Research underscores the importance of staff assignment, staff training programs, and SCU presence within a facility.

Staff assignment. The importance of permanent staff-member assignment for persons with Alzheimer's disease is critical to SCU care.[6] More consistent staff-member assignment leads to better staff member and resident outcomes.[7–9] In nursing homes, staff assignments are more consistent in SCUs than non-SCUs.[5,10,11] One way to improve quality of care and quality of the workplace is to rotate staff-member assignments less frequently by minimizing reassignment of staff members from one unit to another. Permanent staff members have greater opportunities to establish meaningful interpersonal relationships with residents and their families. For dementia residents, persistent staff turnover and shortages are bound to aggravate disorientation and disrupt the continuity of care.[3]

Staff training. The adequacy of dementia-related training for staff members is vitally important.[6,10,12,13] However, levels of training between SCUs and non-SCUs are inconsistent.[11] Training in some SCUs is minimal.[7] Where dementia-related training programs are available to all staff members, the presence of an SCU within a facility may lead to more dementia-related training facility wide.[10] Such training is associated with lower turnover among nursing assistants. Research suggests that *how* you train the staff members is vitally important. Facilities with better training programs tend to use a variety of staff training methods to develop skills and knowledge related to dementia care. Training may involve such things as sending staff members to workshops, using films or

videos, bringing in outside consultants, providing reading materials (newsletters or articles), developing a training manual, hiring an in-house expert who serves as a resource to other staff members, providing in-services, using role-playing techniques, and having an orientation program for new staff members.

SCU presence. Research indicates that opening an SCU can have a number of benefits for staff members working with persons with Alzheimer's disease. SCU presence in a facility is associated with lower turnover among professional nurses,[10,12] perhaps because SCUs offer greater opportunities for professional nurses to develop their skills.[13] SCUs may increase job satisfaction through enhanced administrative supervision, better organizational structures, more teamwork, improved relationships with residents, more pleasant physical environments, and more staff-member support groups compared to non-SCUs.[14,15] In general, these studies suggest that job satisfaction, burnout, and demoralization are not related to SCU versus non-SCU designation, per se, but to other organizational factors common to both SCUs and non-SCUs.[5,14,15] It may simply be that facilities with good staffing and administrative practices are more likely to open an SCU than those without such practices.

Advocates call for better care through more dementia-specific staff training, higher staff-to-resident ratios, and more consistent staff assignment.[16–20]

Perhaps the most controversial staffing issue facing SCUs has to do with staffing ratios in facilities serving persons with Alzheimer's disease. There is little consensus about optimal staff-to-resident ratios in SCUs. Staffing ratios vary widely both in nursing facilities and in assisted living facilities. A recent study completed by the Health Care Financing Administration (HCFA) found strong associations between low nursing staff ratios and the likelihood of quality of care problems in nursing homes. Facilities with staffing ratios falling below critical thresholds were more likely to experience negative outcomes in terms of avoidable hospitalizations, declines in activities of daily living (ADLs), pressure sores, weight loss, and poorer resident cleanliness and grooming.[21] Minimum thresholds that undermined quality of care were 0.45 hours per resident day for registered nurses (RNs), 1.0 hours per resident day for licensed practical nurses (LPNs), and 2.0 hours per resident day for certified nursing assistants (CNAs). An independent panel of

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experts recommended even higher ratios (a combined total of 4.55 nursing hours per resident day).[22] In 1998, only about 11 percent of nursing facilities met a 4.55 hour standard. To meet it, more than 50 percent of facilities nationally would have to increase staffing ratios by more than 50 percent. Fifteen percent of facilities would have to more than double their current staffing ratios.[21] Existing federal regulations for Medicare/Medicaid certification do not specify minimum staffing ratios in nursing facilities or SCUs.

Although it is impossible to predict what minimum staffing ratios (if any) might be adopted in the future, a federal mandate to increase staffing ratios in nursing homes would invariably exacerbate labor shortages. On the other hand, with more adequate staffing ratios, the quality of the work environment and quality of care might ultimately improve. Several strategies might be used to address labor shortages in coming years. First, the professional and paraprofessional workforce might be increased by recruiting more immigrant workers (a trend that is already occurring in many parts of the United States). Alternatively, greater efficiencies might be achieved in the organization and delivery of care through the development and use of new technologies. Because labor accounts for the majority of operating expenditures in nursing homes and assisted living facilities, pressures to increase staffing ratios will raise the cost of service delivery.

LEADERSHIP PRACTICES

Recent research looked at the relationships between leadership practices, organizational practices, and employee satisfaction in nursing facilities.[23] The following four leadership practices were studied.

Focused visionary looked at leadership's setting direction for the future of the facility and having a vision that is focused (as opposed to trying to move in too many directions or having too many things championed at the same time).

Supporting change looked at leadership's encouragement of staff members taking on new initiatives.

Communicating the message looked at leadership's priority placed on communication with employees.

Visibility in the organization looked at leadership's physical presence within the facility (as opposed to just spending time in administrative offices).

With the exception of leadership visibility in the organization (on which all facilities tended to score high), leadership attributes were found to affect organizational practices and employee satisfaction. The organizational systems framework just described highlights the linkages between leadership and other organizational systems. To the extent that these systems are aligned, organizational performance improves. Conversely, misalignment impedes performance. Improvement in organizational performance is especially difficult to achieve without effective leadership in the areas of strategic vision, change management, and effective communication.

COLLABORATIVE RESEARCH STRATEGY

Five key organizational systems (environmental design, programs, information systems, human resource management, and leadership) need to be studied simultaneously to determine how they affect SCU performance. To implement this research agenda, we propose a research strategy to engage researchers and practitioners in a collaborative partnership. This strategy enables practitioners to provide input into the research questions and measures within an overall theoretical research framework, providing researchers with insights into the operational constraints that inhibit diffusion of research findings into practice. This strategy synthesizes researcher and practitioner expertise into studies that produce findings that concurrently further both theoretical and applied knowledge. Active practitioner participation motivates researchers to engage with them in active feedback and dialogue as findings are generated.

An example of this collaborative research strategy applied to nursing facilities was conducted by the second and third authors.[23–25] Using the Malcolm Baldrige National Quality Award as a conceptual framework,[26] the research study investigated the relationships between leadership, quality management practices, and staff member and resident outcomes in nursing facilities. This research involved staff members from 75 nursing facilities in three major long-term care provider organizations. Data collected for the study were used to provide immediate feedback on organizational performance at the facility and corporate levels. The practitioner participants played an active role in developing the measures for the feedback loop describing organizational performance. The study found that staff member absenteeism, job satisfaction, and job stress are related to human resource management practices.[24,25] Leadership practices within a facility were found to predict quality management practices and employee job satisfaction.[23] This study shows the benefits of using a col-

laborative research strategy to improve organizational performance.

Systemic methods of performance improvement in healthcare organizations have emerged.[27-29] These methods have been described by names such as continuous quality improvement (CQI), total quality management (TQM), hospital-wide quality improvement (HQI), and quality improvement (QI).[30] These methods reflect a growing emphasis within healthcare organizations on assessing and monitoring on a continuous basis organizational processes that affect organizational performance. New research strategies for studying SCUs are needed to improve organizational performance in SCUs. An organizational systems model has enormous potential for improving the knowledge base about SCUs. Collaborative research strategies should facilitate the translation of research into practice and better inform researchers, practitioners, and policy makers about the possible benefits of such collaboration.

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REFERENCES

1. Singh DA, Schwab RC. Retention of administrators in nursing homes: What can management do? *Gerontologist* 1998;38:362–369.
2. Singh DA, Schwab RC. Predicting turnover and retention in nursing home administrators: Management and policy implications. *Gerontologist* 2000; 40:310–319.
3. Cohen-Mansfield J. Turnover among nursing home staff: A review. *Nursing Management* 1997;28:59–64.
4. Accorinti KL, Gilster SD, Dalessandro JL. Staff programs focus on reducing turnover. *Balance* 2000; 4:12–14,28.
5. Grant LA, Ory M. Alzheimer special care units in the United States. *Res Practice Alzheimer Dis* 2000; 4:19–43.
6. Holmes D, Splaine M, Teresi J, et al. What makes special care special: Concept mapping as a definitional tool. *Alzheimer Dis Assoc Disord Int J* 1994; 8(suppl 1):S41–S53.
7. Teresi J, Grant LA, Holmes D, Ory M. Staffing in traditional and special dementia care units: Preliminary findings from the National Institute on Aging Collaborative Studies. *J Gerontol Nurs* 1998;24:49–53.
8. Teresi J, Holmes D, Benenson E, et al. A primary care nursing model in long-term care facilities: Evaluation of impact on affect, behavior, and socialization. *Gerontologist* 1993;33:667–674.
9. Teresi J, Holmes D, Benenson E, et al. A primary care nursing model in urban and rural long-term care facilities: Attitudes, morale, and satisfaction of residents and staff. *Res Aging* 1993;15:414–432.
10. Grant LA, Potthoff SJ, Ryden M, et al. Staff ratios, training, and assignment in Alzheimer's special care units. *J Gerontol Nurs.* 1998; 24: 9–16.
11. Teresi JA, Holmes D, Ramirez M, et al. Staffing patterns, staff support, and training in special care and nonspecial care units. *J Mental Health Aging* 1998; 4:443–458.
12. Grant LA, Kane RA, Potthoff SJ, et al. Staff training and turnover in Alzheimer special care units: Comparisons with non-special care units. *Geriatr Nurs* 1996;17:278–282.

REFERENCES *continued*

13. Maas M, Buckwalter KC, Swanson E, et al. Training key to job satisfaction. *J Long-Term Care Admin* 1994; 22:23–26.

14. Ramirez M, Teresi J, Holmes D, et al. Ethnic and racial conflict in relation to staff burnout, demoralization, and job satisfaction in SCUs and non-SCUs. *J Mental Health Aging* 1998;4:459–479.

15. Karner TX, Montgomery RJV, Dobbs D, et al. Increasing staff satisfaction: the impact of SCUs and family involvement. *J Gerontol Nurs* 1998;24:39–44.

16. Coons DH. Training staff to work in special Alzheimer's units. *J Alzheimer Care Related Disord Res.* 1987;2:6–12.

17. Coons DH. Training direct service staff members to work in dementia care units. In: Coons DA, ed. *Specialized Dementia Care Units.* Baltimore, MD: Johns Hopkins University Press; 1991:126–143.

18. Orr-Rainey NK. Establishing a dementia unit. In: Sloane PD, Mathew LJ, eds. *Dementia Units in Long-Term Care.* Baltimore, MD: Johns Hopkins University Press; 1991:128–155.

19. Alzheimer's Association. *Guidelines for Dignity: Goals of Specialized Alzheimer/Dementia Care in Residential Settings.* Chicago, IL: Alzheimer's Association; 1992.

20. Aronson MK. Dementia care program and staff variables. In: Aronson MK, ed. *Reshaping Dementia Care: Practice and Policy in Long-Term Care.* Thousand Oaks, CA: SAGE Publications; 1994: 31–42.

21. *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Report to Congress.* Washington, DC: Health Care Financing Administration; 2000.

22. Harrington C, Kovner C, Mezey M, et al. Experts recommend minimum nurse staffing standards for nursing facilities in the United States. *Gerontologist* 2000;40:5–16.

23. Olson DA. *How Do Leadership Practices Influence Nursing Facility Employee Satisfaction?: A Multi-Level Structural Equation Model Analysis of Long Term Care Quality Leadership Practices.* Minneapolis, MN: University of Minnesota; 2000. Doctoral Dissertation.

24. Todd-Malmlov A. *Predictors of Stress and Satisfaction among Nursing Assistants in Long-Term Care Organizations.* Minneapolis, MN: University of Minnesota; 1999. Masters Thesis.

25. No author. *Do Call-Ins Indicate Problems in a Facility's Human Resource Practices?* National Science Foundation Research Brief. University of Minnesota, Department of Healthcare Management; 2000. Unpublished report.

26. Malcolm Baldrige National Quality Award Program. United States Department of Commerce, Technology Administration, National Institute of Standards and Technology. http://www.quality.nist.gov.

27. Batalden PB. Organization-wide quality improvement in health care. *Topics in Health Record Management* 1991;11:1–12.

28. Berwick DM, Godfrey AB, Roessner J. *Curing Health Care.* San Francisco, CA: Jossey-Bass Inc., Publishers; 1990.

29. James BC. TQM and clinical medicine. *Frontiers of Health Services Management* 1991;7:42–46.

30. Joint Commission on Accreditation of Healthcare Organizations (JCAHO). *Quality Improvement in Long Term Care: How Quality Improvement Can Help Fulfill OBRA '87 Requirements.* Oakbrook Terrace, IL: JCAHO; 1992.