LPNs as Change Agents:

Building LPN leadership capacity to enable practice change in residential care homes

By Dr. Sienna Caspar, PhD, CTRS, Assistant Professor, University of Lethbridge - Faculty of Health Sciences

Person-centred care is described as a care philosophy in which a positive relationship is established between a resident and staff member that respects the care recipient's preferences and life history, honours identity, and enables engagement in meaningful activity (Fazio, Pace, Flinner, & Kallmyer, 2018). The purpose of our project was to improve the provision of person-centred care in residential care homes (RCH) by building the leadership capacity of licensed practical nurses (LPNs) such that collaborative decision-making and supportive teamwork is enabled and encouraged.

Person-centred care encompasses all aspects of care; however, we purposefully selected mealtimes as a focus for this project because mealtimes are concrete, regular, frequent, and discrete events that, when designed in a person-centred way, can have positive outcomes for both care staff members and residents. Research demonstrates that training is needed to support mealtimes with a person-centred, social focus (Murphy, Holmes, & Brooks, 2017; Reimer & Keller, 2009). The CHOICE educational program helps to address these training needs and is based on research evidence to support relationship centred-dining in long-term care (Wu et al., 2018). The principles of CHOICE include Connecting, Honouring Dignity, Offering Support, Identity, Creating Opportunities and Enjoyment (Wu et al., 2018).

For this project, we used the FASCCI (Feasible and Sustainable Culture Change Initiatives) model for change developed by Dr. Sienna Caspar, to support the successful implementation of the CHOICE principles into everyday mealtime care practices. The FASCCI model draws significantly from the Model for Improvement developed by Langley et al., (2009). The FASCCI model adds two key features that are not included in the Model for Improvement. The first is the provision of leadership training (Caspar, Le, & McGilton, 2017) to team leaders—who, in this project, were LPNs working at the selected residential care home. The second feature is the active exploration and application of three key intervention factors that are necessary in ensuring the feasibility and sustainability of the change initiative. These include: predisposing factors (e.g., effective communication and dissemination of information), enabling factors (e.g., conditions and resources required to enable staff members to implement new skills or practices) and reinforcing factors (e.g., mechanisms that reinforce the implementation of new skills) (Caspar, Ratner, Phinney, & MacKinnon, 2016).

After receiving training in both responsive leadership (Caspar et al., 2017) and the CHOICE principles, LPNs learned how to lead a Process Improvement Team (PIT) in the implementation of co-developed, clearly defined aims and practice changes associated with person-centred mealtimes. The PIT, which was led by the LPNs, included key stakeholders (e.g., health care aides [HCA], family members, managers, interdisciplinary team members) and utilized plan-do-study-act (PDSA) cycles to implement the selected practice changes in mealtimes. Each PDSA cycle cultivated collaboration, mutual understanding, and knowledge sharing among the PIT members. By integrating CHOICE education program and the FASCCI model, this project aimed to improve mealtime experiences of residents while simultaneously building leadership skills and collaborative decision-making amongst LPNs and other care staff members. Ethics approval was received through University of Lethbridge Research Services and the University of Alberta. Institutional approval was also obtained from the site in which the project was conducted.

The Mealtime Scan (MTS) (Keller, Chaudhury, Pfisterer, & Slaughter, 2017) was used to measure outcomes and determine whether or not the project was achieving its goals. Forty mealtime observations using the MTS were completed over the course of six months in two dining rooms, with ten observations at baseline, ten at two months, ten at four months, and ten at six months. Observations were equally divided between the dining rooms in the RCH with ten lunch and ten supper observations completed in each. Mealtime environment scores started increasing immediately following the intervention, with statistically significant improvements noted in all mealtime environment scales by six months, including the: physical environment (z=-3.43, p=0.004); social environment (z=-4.17, p<0.001); relationship and person-centred scale (z= -4.121, p<0.001); and overall environment scale (z= -4.08, p<0.001).

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Physical environment. MTS+ assessment of the physical environment includes such mealtime elements as noise levels, seating arrangements, sufficiency of lighting, aroma of food, decorations and ambience, and availability of condiments for residents to choose from. Almost all elements of the environment that scored low at baseline showed significant improvement as a result of the intervention. For example, baseline observations demonstrated that, prior to the intervention, the television was turned on during 100% of the observed meals, food aroma was present during only 10% of the observed meals, and the dining room doors were locked in between every meal. Whereas, at the conclusion of the intervention, the television was off during 100% of the meals and food aroma was present for 60% of the meals. In addition, one of the first changes that the PIT members implemented was to open the doors to the dining room throughout the day so that residents were enabled to come and go as they chose. Implementing this strategy had a significant impact on the overall dining experience as it enabled staff and residents to focus on the social aspects of the dining experience rather than ensuring that the tasks associated with dining were completed and residents removed from the dining area within a set amount of time.

Social environment. The social environment is assessed based on the quality/type of five social interactions (e.g., between residents; between residents and staff; staff to staff; etc.) and their frequency. Ratings (0 = never, 4= frequent) are based on the frequency of the interaction as observed and scoring for the social environment scale is

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based on the predominance of social interactions that involve residents in contrast with task-focused interactions that exclude residents. Resident-to-resident interactions improved over the course of the intervention, as did other positive interactions, such as staff interacting with affection to residents. Task-focused interactions were reduced, resulting in an overall increase in the social environment score over time.

Person-centred care. Person-centred care practices are primarily evaluated by assessing the degree of choice given to residents regarding mealtime activities (e.g., Did they have the opportunity to assist with mealtime tasks? Were they given a choice of where to sit? Were they offered a choice regarding use of clothing protectors?) and whether or not the residents' needs were prioritized over the mealtime care tasks (e.g., Was the meal interrupted by the distribution of medications? Were residents' needs met when they became evident to staff?). Significant improvements were made in all aspects of person-centred care following the intervention.

Process assessments were conducted to understand how the project was being implemented (e.g., What kinds of problems were encountered in implementing the changes to mealtimes? To what extent were the person-centred mealtime strategies implemented as planned?) and to determine whether or not it is sustainable (e.g., Are the mealtime strategies continuing to be delivered? If not, why not?). Process assessments were conducted using data from detailed notes taken during each of the PIT meetings and from one to one interviews during which PIT members were asked to evaluate both the process and the outcomes of the project. Here is a sampling of some of the things they told our project team:

"I see a calmer environment, residents enjoy being able to eat earlier and leave at will, as well as a more social environment; there are so many more meaningful conversations."
– Dietary Aide

"Residents are a lot more happy with more choice, extra portions and second helpings along with the time to enjoy it."- HCA

"I really enjoyed having the doors open all day and I see the clients visit with each other while they have their coffees. I enjoy being more resident-focused. It's always a good thing and just reminding us not to forget those little things. They do make a difference to residents." – LPN

"This team is very engaged. They have been willing to try, implement, and try again. They have taken the initiative to challenge the way we have 'always done' things which takes great courage and leadership. It has been an absolute privilege to witness the passion and energy of this group wanting to improve the quality of care. They are an amazing group who have truly taken and ownership for making change and sustaining the change." – Manager

In summary, our study offers evidence that practice change initiatives that focus on stakeholder engagement can provide a promising method for improving the provision of person-centred mealtime practices in RCHs. Our findings indicate that person-centred change initiatives in RCHs should incorporate individuals at all levels of care and need to take into consideration the socio-structural components of the care environment. Our study also elucidates the importance of cultivating an empowered workforce by implementing practices that enable and encourage collaborative decision-making and increase the autonomy and self-determination of care staff. We found this to be essential to the outcomes that occurred as a result of the change initiative. ■

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