

**Beyond 'doing': Supporting clinical leadership and nursing practice
in aged care through innovative models of care**

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TITLE: Beyond 'doing': Supporting nursing leadership and practice in aged care through innovative models of care

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ABSTRACT:

Contemporary health care environments are increasingly challenged by issues associated with the recruitment and retention of qualified nursing staff. This challenge is particularly felt by residential aged care providers, with registered nurse (RN) numbers already limited and resident acuity rapidly rising. As a result, aged care service providers are increasingly exploring creative and alternative models of care. This article details exploratory research into one such alternative model of care in a medium sized, regional residential aged care facility. Research findings suggest that the model of care is complex and multi-faceted and is an example of an integrated model of care. As a result of the implementation of this model of care a number of shifts have occurred in the practice experiences and clinical culture within this facility. Results suggest that the main benefits of this model are 1) increased opportunities for RNs to engage in clinical leadership and proactive care management; 2) improved management and communication in relation to work processes and practices; and 3) enhanced recruitment and retention of both RNs and care workers.

KEY WORDS: aged care, nursing, staffing, retention, workforce, model of care

BACKGROUND

Despite evidence linking qualified, professional health care providers to quality patient outcomes (Zhang, Unruh, Liu & Wan, 2006; Mueller, 2002), the reality for contemporary health care environments is shaped by demand issues that far outweigh supply. This is particularly so in aged care, where the shortage of nursing professionals is heavily felt amongst a client population with multiple, complex, co-morbidities and increasing frailty. Nowhere is this more evident than in regional and rural areas of Australia where specialist nursing staff are limited.

While there have been many reasons put forward for aged care's lack of appeal, the fact remains that recruiting and retaining registered nursing staff in aged care is problematic. At the same time, aged care services are facing tightening regulations, funding challenges and an increasing demand for high quality care. Many facilities are compelled to redesign their work out of necessity and the need to ensure the continuation of vital care services to their residents. As a result, aged care service providers are increasingly exploring creative and alternative models of care and staffing in order to best meet the growing demand for high quality health care in light of the dwindling supply of registered nurses. This article reports on research undertaken to explore an innovative, non-traditional model of care developed and implemented at a 70 bed, residential aged care facility in regional far north Queensland.

This innovation was driven by the need to consider alternative staffing configurations in order to optimise available registered nursing staff, provide 24 hour coverage for essential clinical services and to address the growing issue of registered nurses (RNs) working extended hours. This was deemed to be unsustainable in the longer term. In seeking a solution, it was determined that task allocation (particularly medication administration) was either directly or indirectly related to the excessive workload for RNs. While many facilities have delegated the task of medication administration to unregulated care workers or Personal Care Workers (PCWs), the approach undertaken at this

centre was much broader and more comprehensive than merely the re-assignment of a clinical task to a lower level worker.

MODELS OF CARE: Definition

In exploring the literature, it became clear that the terminology and nomenclature applied to various models and frameworks that seek to describe or explain elements of nursing staffing and work organisation within any given health care context was diverse. Terms used include: workplace practice model; workforce staffing model; staffing model; nursing staff mix model; and model of care / care model / nursing care delivery system (Kimball, Joynt, Cherner & O'Neil, 2007; Wolf & Greenhouse, 2007; DoHA, 2005; McGillis-Hall, 2003; McGillis-Hall & Doran, 2003). The terms 'models of care' and 'staffing models' are often used interchangeably and are rarely clearly defined within the literature, while 'workplace practice'; 'staffing models' and 'models of care' are very closely related and enmeshed with each other. Although there are multiple terms used to describe the organisation and roles of nursing staff, the most common of these is 'models of care'. In light of the literature, the term 'model of care' was used in this research and defined as a schematic representation used to organise and explain the delivery of care within a health care setting (Wolf & Greenhouse, 2007). A model of care identifies the members of the nursing and care team, their roles, responsibilities, accountabilities and decision-making authority. While not all of the models of care presented in the literature are represented schematically, which, by definition, is what a model is, they do present a common element in that they outline and organise the roles and practice of nursing and care personnel.

MODELS OF CARE: Literature Review

A number of traditional and non-traditional models of care have been identified within the literature. In brief, there are 5 main traditional models of care: 1. Functional Nursing; 2. Team Nursing; 3. Total Patient Care; 4. Primary Nursing; and 5. Case Management (Crisp & Taylor, 2005; Tiedeman & Lookinland, 2004). These are generally well defined within the literature and are widely understood within the nursing profession. While there are many differences in

the focus, staffing and decision making and accountability structures within each of these models, there are some similarities from a research perspective. Primarily, the research evaluation of all these models in relation to quality of care, patient and staff satisfaction and economic factors is, by and large, inconclusive and contradictory (Tiedeman *et al*, 2004). Importantly, no clear and definitive data supports one approach over the others in all circumstances. This is partly due to variation in the application of these models as a result of the unique nature of the care environments and specific contextual factors. It is also partly due to the fact that registered nurses form an important conduit between policies, models and practice (Venturato, Kellett, & Windsor, 2007), thus the efficacy of any model of care, traditional or non-traditional, depends in large part on the understanding and subsequent application by registered nurses in the practice arena. These contextual factors apply to both traditional models, as well as non-traditional or alternative models of care.

In their review of non-traditional models of care, Lookinland, Tiedeman and Crosson (2005) identified 3 alternative categories:

- 1) clinical (partnered and non-partnered);
- 2) non-clinical; and
- 3) integrated models.

Partnered clinical models are those where an unregulated care worker is partnered with a registered nurse and the two work as a team providing care for their assigned patients. Both work the same shifts, with the RN delegating tasks to the assistant (often referred to as a patient care technician, nursing assistant or nurse extender). The role of the carer in these models is diverse and ranges from the highly technical to assistive, personal care tasks. The registered nurse remains accountable for all care. Non-partnered clinical models are those where the assistive staff provides direct patient care under the supervision and delegation of a number of registered nurses. No partnership exists between the RN and the care worker. In Lookinland *et al*'s (2005) review, non-partnered nurse extenders tended to be based in acute care settings and included nursing and medical students, licensed practical

nurses (equivalent to an EN), patient care technicians, and medication administration personnel. This model is considered similar to a traditional functional model in that tasks are assigned according to role. Non-clinical models involve the use of unregulated care workers in the provision of support rather than direct patient care (Lookinland *et al*, 2005). Roles include dietary aide, personal assistant, unit hostess, concierge, and service and supply staff. Integrated models use a combination of clinical and non-clinical models in that support staff may be involved in both direct care and indirect support activities.

Non-traditional models may also include skill mix models (McGillis-Hall, 2003). These models are generated from studies that seek to measure staffing numbers as an indicator and measure of quality care (Castle & Engberg, 2007; Räikkönen, Perälä & Kahanpää, 2007; Mueller, Arling, *et al*, 2006; Zhang, *et al* 2006; Harrington, 2005a; 2005b; Harrington, 2004; Mueller & Karon, 2004; Schnelle *et al*, 2004; Harrington, O'Meara, Collier, Schnelle, 2003; Harrington, Zimmerman, *et al*, 2000; & Harrington, *et al*, 2000). Skill mix models are based on numbers and proportions of regulated and unregulated staff rather than roles, structure and working relationships. This research tends to be political in nature and has been used in many states in the USA to lobby for, or raise, minimum staffing ratios, through establishing an association between staffing levels and a range of quality indicators.

Lookinland *et al* (2005) note that non-traditional models of care share a common focus on the integration and deployment of unregulated care staff and the reshaping of nursing work to accommodate a broader skill mix and decrease in the availability of registered nurses. The majority of these non-traditional models have been generated from within the acute care sector, however, and thus reflect staffing and skill mix considerations within this context. It is worthwhile noting that these models are often considered non-traditional because they deal with a different skill mix, that is, the addition of unregulated care workers, rather than because they represent an alternative way of conceptualising staffing and care provision.

Very few studies have been conducted to evaluate these models and those that have are often inconclusive as to their effectiveness in relation to cost and quality due to the diversity in the settings and contexts (Lookinland *et al*, 2005). Those studies that have evaluated models of care have focused on specific outcomes, such as staff or patient satisfaction, cost, or specific quality indicators such as infection rates or length of stay. In general though, Wolf and Greenhouse (2007: 384) highlight three observations from Lookinland *et al*'s (2004, 2005) review of the research literature:

(1) RNs have a positive impact on patient outcomes; (2) unlicensed assistive personnel can potentially be used effectively; and (3) outcomes are improved when care is coordinated over time, and accountability is assigned.

It is evident, therefore, that the literature on staffing and workforce issues reflects the diversity of settings and contextual factors. The aim of this research was to explore a non-traditional model of care with an innovative staffing configuration within a residential aged care context. This exploration encompasses key elements of both traditional and non-traditional models of care, including consideration of decision making and accountability, structure (hierarchical or flat), the focus of care (person, relationship or task) and the relationships and roles within each model. In particular, the research was guided by the following research questions:

- 1. What is the model of care in use at this facility?*
- 2. What influence has the implementation of a non-traditional model of care had in the work experiences of nursing and care staff in a residential aged care setting?*

RESEARCH APPROACH

This exploratory study used a range of qualitative methods to address these research questions. Interviews and focus groups were conducted with nursing management, RNs, and a range of care providers in the aged care facility. Staff

interviews included aspects of practice that are a focus of, and were the impetus behind the development of the model of care. This included job satisfaction, perceptions of care quality, workload and stress, teamwork and leadership, as well as other experiential aspects of working within this model. Interviews and focus groups were digitally recorded and transcribed, before being analysed using an interpretive, hermeneutic, analytical approach. This involved reading and re-reading the transcripts and engaging in a dialectical process of questioning the data and searching for answers within the texts.

Setting

The model of care explored in this research was developed and implemented in a 70 bed, not-for-profit, residential aged care facility in regional, far north Queensland. The facility provides a full range of services and includes high care, low care and special care units. The facility is managed by a Nurse Manager and was about to embark on major expansions, which would see it double in size over the next eighteen months. This expansion, coupled with on-going local difficulties in recruiting registered nurses, formed the impetus behind the development of this model of care.

Participants

Participants in this study were full or part-time employees of the aged care facility and had experience working within this model of care. Inclusion criteria for participants included:

- experience working within the staffing model;
- directly or indirectly affected by the addition of the new roles;
- experience of the prior staffing arrangement or the implementation of the new staffing model (preferred);
- able to consent to participate.

In total, thirteen interviews and one focus group were conducted with staff from a range of nursing and care roles. Staff interviewed included the Nurse Manager, Clinical Nurses (CN), Registered Nurses (RNs), Clinical Assists (CAs), Team Leaders (TLs), and other personal care workers (PCWs). Staff had a

range of backgrounds and experiences ranging from 3 weeks (re-employed) through to 26 years. One long-term, low care resident was also interviewed for a client perspective. Specific demographic data is presented in Table 1.

[Insert Table 1 here]

Ethics

Ethical approval for the study was granted by both the aged care service provider and the university Human Research Ethics Committee. All ethical protocols were maintained. Written consent was obtained from all participants prior to interview. Staff were assured of confidentiality and efforts were made prior to each interview to ensure that participants did not feel coerced to participate as a result or condition of their employment. All interviews and focus groups were conducted by an experienced interviewer / clinician, who was considered an organisational 'outsider', in order to minimise the effect of uneven power relationships between clinical staff and organisation management.

FINDINGS

The Model of Care

The model of care is quite complex and multifaceted. The model itself comprises three separate, but integrated new staffing configurations. These are detailed and defined below:

1. Clinical Assists: Clinical Assists function as nurse extenders or clinical assistants to the RNs. They undertake direct clinical care under the supervision (direct and indirect) of the RNs. The Clinical Assist position operates from Monday to Friday from 0700 to 1500 when there is shift coverage by RNs. There are currently three trained Clinical Assists, and all had extended skills and knowledge prior to commencing in this role (1 ex-RN; 1 second year nursing student; 1 ex-EN). Clinical Assists must have completed all the in-house training modules and be assessed as competent in all areas. Daily duties include medications, including eye drops; BSL monitoring; wound dressings;

PEG feeds; and scheduled observations; as well any documentation associated with these activities. Clinical Assists do not undertake any staff supervision and liaise and work closely with the RNs.

2. Team Leaders (clinical): Clinical Team Leaders are PCWs with some supervisory and delegation responsibilities, who assist the RNs in the overall supervision of a work unit / team. Team Leaders have responsibility for a designated work unit – for example, the Special Care Unit, High Dependency Unit; or for a designated shift – for example, the afternoon / evening shift. Team Leaders focus on staff issues and work performance related aspects of their unit and provide a conduit between the care staff in their area and the RNs and nursing management. They play a role in the orientation of new staff, support new and existing staff in their everyday work, perform some advanced clinical tasks (primarily medication delivery), function as Workplace Bullying and Harassment Officers, and represent their teams and work areas at regular Continuous Quality Improvement and Team Leader meetings. They informally monitor staff performance, staffing levels and standards of care, however, they do not discipline staff, engage in clinical decisions or delegate care activities but rather report staff, unit and work issues to the RNs or the Nurse Manager through both informal and formal channels. Team Leaders also undertake extra in-house training and competency assessment using the same modules as the Clinical Assists, however, not all the Team Leaders have done all the modules.

3. Team Leaders (non-clinical): The non-clinical Team Leaders provide administrative support for both non-direct care related activities (eg. staff education coordination), as well as non-care related activities (eg. kitchen supervision, hotel services, or laundry)¹. This model only deals with non-direct care related non-clinical Team Leaders. This is because they are drawn from the PCW care staff and many combine their responsibilities as a non-clinical Team Leader with direct care shifts as PCWs. Also, as non-direct care, non-

¹ Work activities are considered using a modified version of Morris et al's Nursing Workload Model (2007). This divides nursing activities into direct patient care activities; indirect patient care activities; and non-patient care activities.

clinical Team Leaders, their responsibilities and focus intersect with care staff and care activities.

In light of these new roles, the model of care highlights the complex nature of the staffing configuration at this site. According to Lookinland *et al* (2005), this model constitutes an integrated model of care, as it incorporates both a non-partnered clinical component (the clinical assist role) and non-clinical components (Team Leader (non-clinical)).

The staffing configuration of the model itself is detailed in Figure 1.

[Insert Figure 1 here]

Within the model, the traditional hierarchy of care: PCW – RN – Nurse Manager, is supplemented by three new structures underpinning the Clinical Assist and clinical and non-clinical Team Leader positions. The lines between boxes represent lines of communication, delegation and reporting. While the data suggests that the resident sits firmly at the centre of care activity, the model itself positions RNs in the centre, as they act as a hub for communication, delegation and decision making.

The model, however, comprises more than just staff considerations. It is also supported by organisational and interpersonal components, including an in-house training and competency assessment package. Table 2 identifies the key component parts of the model.

[Insert Table 2 here]

The complexity in this model is centred, not merely on the addition of extra staff roles, but in the differential way in which they are applied. Team Leader roles for example are assigned to individual PCWs, who retain and function as the Team Leader of their unit / section whatever shift or other role they may be working. The Clinical Assist role, however, is shift based – it operates during

the week from 0700 to 1500, when the majority of scheduled clinical care occurs and RNs are available for consultation and supervision. Staff undertaking the Clinical Assist role may also function as general PCWs outside of these hours. Similarly, selected Team Leaders may fulfil the Clinical Assist role during holidays or absences. In this regard, one staff member may perform a variety of roles depending on the time of day / shift and the level of training /competency attained.

Both the Clinical Assist and the non-direct care, non-clinical team leader roles address specific staffing recruitment and retention issues. The role of the Clinical Assist addresses the growing issue of qualified personnel who may be seeking to return to nursing following a break to their career but who, for a variety of reasons, do not seek to re-register or re-enrol. The skill set of the Clinical Assist role offers these staff opportunity and recognition for prior knowledge and skills, while maintaining safe and legal practice. The non-direct care, non-clinical team leader role on the other hand, has the potential to offer an ageing workforce a less physically demanding option that recognises their often considerable work experience and interpersonal skills.

The reason I accepted the job, because at first I said no, because my computer skill and experience was zilch. But then I thought about my age and the physicalness of the job on the floor and I decided to take it.

Team Leader

The introduction of the Clinical Assist role has been a major factor in the perceived success of the model at this site. Their impact is particularly felt by the RNs who identify having extra *eyes and ears on the floor* and enhanced reporting as vital to the quality of care delivered.

If we didn't have those Clinical Assist people that work so closely with us I don't think this model would work, ...They're who we rely on" RN

However, neither the Clinical Assist nor the clinical Team Leaders have extended clinical decision-making authority and responsibility. Clinical decision-

making continues to lie with the RNs, who retain responsibility for assessment and care planning, as well as evaluation and overall quality of care. However, both the clinical Team Leaders and the Clinical Assist role have responsibility for basic assessment, recognition and reporting of clinical and care issues to the RNs in accordance with the expectations of any other PCWs, although there is a higher expectation and requirement for Clinical Assists. This is in keeping with their advanced care role and extra training.

The RN role within this model is also complex and is detailed in the flowchart in Figure 2. This flowchart highlights the RNs' role in clinical care, case management and administration / organisational activities. In relation to their role in clinical care, the flowchart details the delegation and clinical and care hierarchies used in this model.

[Insert Figure 2 here]

Training and competency assessments are an important component of this model, not just from a legal and professional perspective, but because the model relies on a high degree of trust and confidence in the skills, responses and reporting of staff in these extended roles. PCWs undertaking advanced tasks are supported by RNs on an individual basis during the learning phase and undergo a formal competency assessment, followed by a period of observation and informal checking during the initial stages of their new role until confidence is established by both the PCW and the RN.

The importance of trust within this model extends to the selection of PCWs for additional training and an extended role. Traits such as diligence, honesty and communication skills are all important.

There were experienced staff that I didn't consider suitable... there's certain personality traits that I look for and one is that I need to feel that they'll come and report any concerns. They won't try and just mask it.

RN

While staff selection for the new roles was a vital component in this model, its introduction, was done slowly and incrementally, with evaluation and modification occurring during the process, in order to enhance staff acceptance and support.

While the model itself is fairly complex, its influence over the care practices and work experiences of all levels of nursing and care staff was clear and dramatic. The following section highlights the major influences of this model on staff's work and practice experiences.

Experiential Shifts

Both nursing and care staff report important shifts in their work experiences as a result of the implementation of this model of care. There have been four major shifts in practice and thinking associated with the implementation of the new model of care. These shifts are identified in Table 3.

[Insert Table 3 here]

Each of these shifts represents a major change in the type of practice or ways of thinking about work that have been associated with the changing model of care. While each of these shifts is identified individually in this table, they are inextricably linked to each other. For the purpose of this article, however, the four shifts have been grouped into two clusters: Shifts 1 and 2 will be explored together as a change to ways of thinking about and orienting practice, while shifts 3 and 4 are discussed as a change to ways of working.

Shifting practice orientation

The shift in practice orientation is an important one in that it is at the heart of the model of care. This shift is two-fold in that it occurs at an individual level (individual practice orientation) and at the broader cultural level (clinical culture orientation).

The shift from *doing* to *leading* has been a significant practice change for many key personnel, particularly the professional nursing staff, who have moved towards a clinical leadership approach to practice. This is closely aligned with the change in their work functions that facilitates a focus beyond the timely completion of clinical tasks. Prior to the implementation of the new model of care, the RNs were engaged primarily in clinical tasks with medications, BSLs and wound care taking the majority of work time, while documentation and assessments were fitted in around clinical tasks.

Before we had the Clinical Assist model, the RNs were doing all the pills and dressings and things, and that was fine. But the pill round, because you were the RN, you had so many interruptions... we actually went to the extent of getting orange jackets and on the back we wrote 'Administering medications, Do not disturb' or something like that. RN

The interruptions experienced by RNs often resulted in increased chance of error or limited or hurried interaction with residents.

You were running... when you hurry I think more mistakes get made when you're rushing and I think mistakes were gotten made that we didn't even know about possibly... RN

The clinical support offered by the Clinical Assist has enabled RNs to move from a task driven role to one of oversight and clinical leadership. For residents this has meant that staff are more approachable and can provide greater interaction without feeling rushed or hurried.

Well, its freed up the nurses...they [the CA] can do it [medications] quickly and efficiently. I mean you can go up and there's always someone there [nurses' office]. ... She [the RN] seems to know exactly what to do. She never ever makes you feel flustered or anything... They don't just rush by anymore. Resident

For many PCWs, the training and support received in preparing them for their new roles, as well as the on-going support from the RNs and other Team Leaders at regular meetings, has been a vital component in their ability and desire to undertake the role.

If it wasn't for the education we get, I would probably never do this... I was quite worried about it [the role] because I feel I'm... I'm a high school drop out but I think I was chosen because of my years here and the respect from residents.... And I got help from the other team leaders. You're not on your own.

Team Leader

Indeed the issue of support, particularly from the RN staff, was an important aspect of the workability of this model for all participants. This support was both generic in its focus:

... the RNs are right behind you, If anything goes wrong the RNs are right there...

Team Leader

and specific to certain times such as starting a new role or associated with certain clinical tasks that PCWs found difficult or stressful.

XXX trained me with medication and she stayed with me until she saw that I was confident enough to do it myself... she would never let anybody go unless she thought they could...

Team Leader

This notion of support, however, was not limited to the RNs, but rather flowed down through the clinical culture, with Team Leaders and Clinical Assists alike also identifying their role in supporting newer and less experienced staff. Thus, while the Clinical Assists, Team Leaders and PCW staff still strongly identified with the *doing* nature of their roles, there was also an element of *leadership* amongst their peers. This was evident in the way that staff in these roles identified themselves as role models and mentors to other staff.

We do act as examples... because people do look to ask us like mentors or role models.

Clinical Team Leader

For some, this mentoring included imparting skills and knowledge, as well as work and time management.

I also like to teach them too and show them... its not just coming to work to do your job....it's good for the brain. I like a bit of a brain challenge. That's why I keep them stimulated as well and let them learn.

Clinical Assist

Closely associated with the notion of leadership is the movement from *individuals* to *teams*. Participants spoke of *my area, my resies, and my team* and see the role as both recognition and reward for their work performance and experience. Despite the seemingly hierarchical nature of the model, staff in the Clinical Assist and Team Leader roles saw their role as supportive rather than directive. This was associated with a team approach to care and their specific role in the care team.

I still see myself on the same level as everybody else so to me I am just part of the team.... I just feel I can be the one that they can come and talk to about things and then I will go and get something done about them...
Team Leader / CA

Despite seeing themselves as part of the team, staff in these new roles showed a degree of pride and satisfaction at having their experience, motivation and skills recognised in this way and expressed a sense of ownership and engagement with their new responsibilities, their work unit and the people in it.

They were assessing me for a long time ... and they don't pick just anyone... People can really step up here...
Clinical Team Leader

This engagement and team identity was also recognised by the RN staff, who saw benefits for residents from this increased staff engagement.

...the more we seem to empower the carers, the more they were understanding what was happening, saw the whole holistic approach of the residents and were getting more involved in everything to do with the residents.
RN

The combination of heightened engagement and reporting requirements has also led to a staff perception of the value of communication and data gathering in their daily work. Staff reported being more aware of their role in monitoring and reporting and all Clinical Assists and clinical Team Leaders saw this as an important part of their role. For the RNs, being *kept in the*

loop was a vital part of their practice and all went to great lengths to ensure that information flowed freely up and down the care hierarchy.

This care hierarchy is an important feature of this model and, as mentioned earlier, the complexity of the model is in part due to the multiple roles undertaken within the model. This is explored further under the second major shift that occurred as a result of the implementation of the model of care – the shift in the organisation of work.

Shifting work organisation

The shift in work organisation comprises two key shifts – the move from *single roles with broad foci* to *multiple roles with tighter foci*; and the move from *reactive* to *proactive* practices and processes. In part, the movement from single roles with wide ranging responsibilities and tasks to multiple roles with narrower foci, is related to the size of the facility with its lower RN numbers and the need for PCWs to extend their role to non-clinical tasks, such as education and systems coordination activities.

Because we're a small site we've incorporated multi roles. But I think the main component of this model is your Clinical Assist, not so much the Team Leaders.
RN

As the above quote suggests, from a clinical perspective, the Clinical Assist role has been particularly influential in driving many of the shifts and outcomes associated with this model of care. This role provides a good example of the tightening foci of roles in this model

that's what their job is and that's what they focus on. And their main issue is to do it right and do it correctly and report any problems and they seem satisfied with it.
RN

The Clinical Assist role is also a good example of the multiple roles now being undertaken by staff. All the staff that undertake this role have multiple other roles, including PCW and Clinical Team Leader. Indeed, some staff may have three roles – incorporating clinical and non-clinical team leadership, as well as

PCW shifts and other roles such as Dementia Champion or Continence Coordinator. Despite these multiple roles, staff report being clear on the tasks and responsibilities of their roles and state that they have no problem in separating and managing their work in this way.

I guess I am a bit more focused than I was... Team Leader / CA

For RNs, the ability to compartmentalise and focus aspects of their practice has contributed to more manageable workloads and greater job satisfaction. In line with the move toward a leadership approach, the clarification and tightening of foci for various roles and the support from the Clinical Assist has supported the RNs to shift from reactive to proactive care. This has allowed the RNs to step back from everyday tasks and *focus on the big picture*.

We're trying to get more involved in clinical indicators and documenting that and trying to get an overall picture instead of just focusing on clinical review and what's needed for that, trying to focus on weight management and everything else. RN

Thus the introduction of the model, while complex and hierarchical, has actually focused and clarified roles and expectations for all staff and enabled RNs to assume a proactive, leadership approach to care and case management. Although hierarchical in nature, the strengthening of team affiliations based on notions of support rather than control has ensured that a collegial atmosphere is maintained.

Limitations

It is important to note the following limitations to this study. Qualitative and observational data was recorded in 2008 and represents the views and experiences of those interviewed. Such findings are not, nor do they claim to be, generalisable beyond this site at this particularly time. The model is also undergoing evaluation to explore its impact on more quantitative measures of staff satisfaction and quality care. Indicators in this evaluation will include staff turnover and clinical indicators, such as falls, medication errors, infection rates

and skin tears. Changes to resident acuity and documentation, as well as economic indicators, will also be considered.

DISCUSSION and CONCLUSION

The innovative model of care explored in this research has highlighted the complex, multifaceted and comprehensive nature of staffing issues and models of care for residential aged care services. In part this is due to the staffing levels, particularly the limited number of registered and enrolled nursing staff, and the skill mix within this clinical environment. The model itself is comprised of a number of components, including staffing and other human components, organisational components, and personal and interpersonal components. The model considers education, clinical leadership and delegation and accountability pathways within its remit.

This model of care adds three new positions into the care staff configuration: Clinical Assist, clinical Team Leaders and non-clinical team leaders. Of these, the Clinical Assist is identified as most associated with positive clinical shifts, including the shift from 'doing' to 'leading', from 'individuals' to 'teams'; from 'single roles with broad foci' to 'multiple roles with tighter foci', and from 'reactive' to 'proactive' care and processes. However, all positions have contributed to the shift in focus and enhanced care.

What is important to the implementation and successful uptake of any model though, is appropriate support and education for registered nurses. Non-traditional models incorporating unregulated care workers require registered nurses with skills, knowledge and a commitment to the delegation of tasks and supervision of staff. Such models are dependent upon communication, team work, clinical leadership and the clear articulation and role modelling of values and focus (Venturato *et al*, 2007; Lookinland *et al*, 2005). From an organisational perspective, any given model of care should "be strategic in alignment with the organisation, sustainable over time, and replicable... (and be) based on scientific evidence" (Wolf & Greenhouse, 2007, p. 384, 385).

Given current shortages in registered nurse numbers, increasing resident acuity and consumer demand for high quality aged care, it is essential that the aged care sector considers not only broad recruitment and retention issues, but also begins to explore alternative models of care. In this way, residential aged care facilities may maximise the impact of their registered nurses on quality of care for older people in residential care in Australia.

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Figure 1: Model of Care

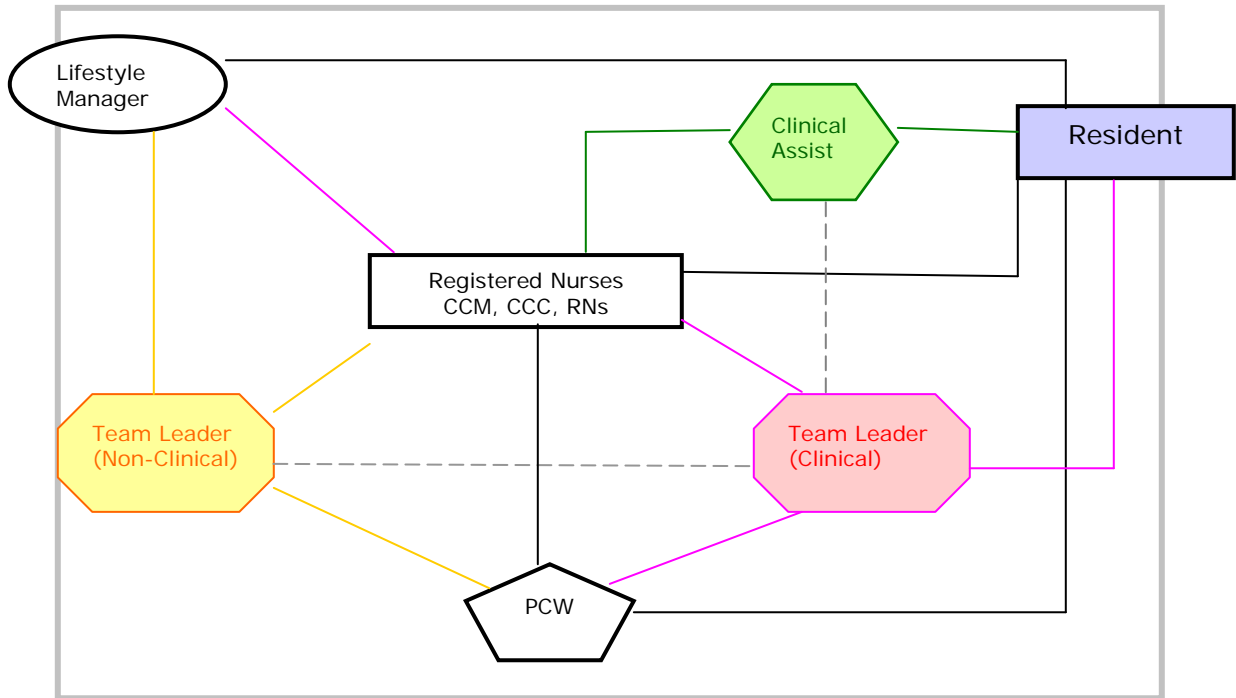


Figure 2: RN Role and Responsibilities

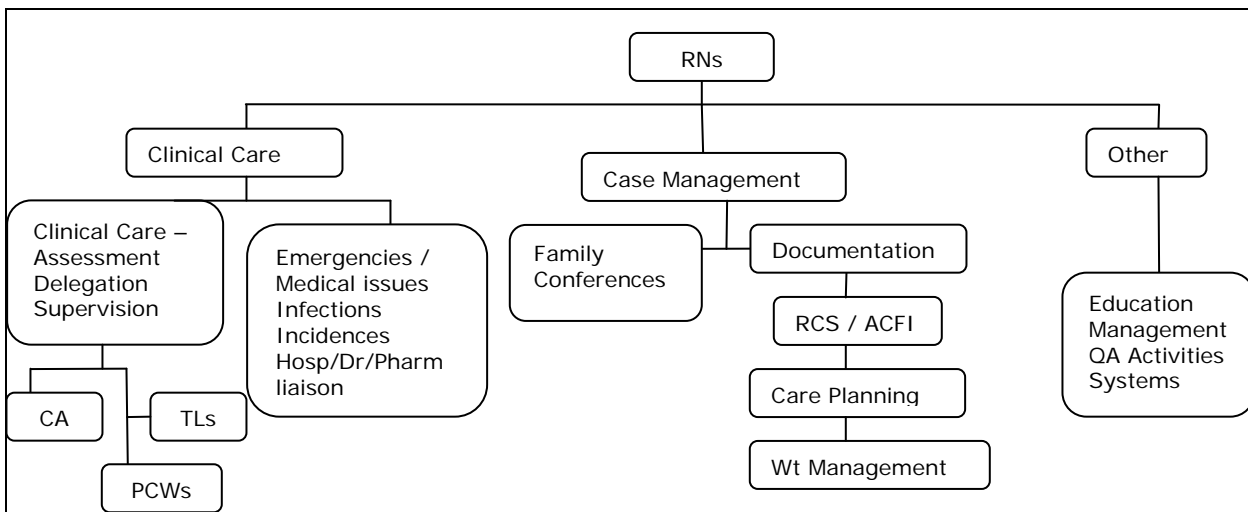


Table 1: Participant Demographic Profile

Participant	Position / Level	Years exper.	Background
1	RN	10+	Acute care unspecified
2	RN	3 weeks (prev. employment exp)	Acute care unspecified / Education
3	RN	8 years	Acute care unspecified / Re-entry RN
4	PCW / DT / non-clinical team leader	6 years	Prev. 4 yrs P/T of an RN degree
5	CA	18 months	Previous EN.
6	APCW	26 years 2 yrs as an APCW	Prev cleaner / kitchen (13 years) on site; Cert 3
7	CA	3 – 4 years	2 nd year nursing student
8	PCW / APCW / non-clinical team leader	10 years	
9	APCW / CA	18 years	Work interruptions – 2nd time employed at site.
10	PCW	Not stated	
11	PCW	1 year	
12	Administration	Not stated	Responsible for recruitment and rostering
13	Resident	2 years	N/A

Table 2: Components of the Model

Components	Sub-components
1. Staffing Components	<ul style="list-style-type: none"> *Lifestyle Manager *Care Coordinator *Registered Nurses *Clinical Assists *Team Leaders *PCWs
2. Other Human Components	<ul style="list-style-type: none"> *Residents & Families *Pharmacist *GPs
3. Organisational Components	<ul style="list-style-type: none"> *Staff Selection *Staff Training & Competency Packages: <ol style="list-style-type: none"> 1. Medications 2. PEG Feeds 3. BSLs 4. BPs 5. IDC 6. Oxygen 7. Wound Care *Team Leader Meetings *Resident & family communication / education * Policies and Procedures (eg. RN medication check) * Physical environment
4. Core Personal and Interpersonal Components	<ul style="list-style-type: none"> *Communication <ul style="list-style-type: none"> Listening / Observation / Reporting Technology–Walkie Talkies *Clinical Leadership <ul style="list-style-type: none"> Role Model / Mentor *Diligence / Honesty / Trust

Context

- Legislation
- Regulatory requirements
- Poisons & Drug Act
- Professional standards & position papers
- Staffing – recruitment & retention issues

Table 3: Thematic Shifts

Shifts	From:	To:
1	Doing	Leading
2	Individuals	Teams
3	Single role broad focus	Multiple roles tighter focus
4	Reactive	Proactive