

MISSING LINK: INTEGRATED INDIVIDUAL LEADERSHIP DEVELOPMENT, EMPLOYEE ENGAGEMENT, AND CUSTOMER VALUE-ADDED IMPROVEMENT

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Long-term care is a key public issue that affects all of us in some way at some time of our lives. Nowhere is performance improvement and quality management more imperative. Through an 8-month field study and follow-up case study, we discuss how using an integrated approach to individual leadership development, employee engagement, and customer value-added improvement might provide the missing link toward sustaining and growing organizational culture change in a very demanding environment.

LONG-TERM CARE (LTC) continues to be a key public policy issue. Nationally and internationally, the number of older persons increasingly represents a larger proportion of the total population. Consequently, there will be an increasing demand on the long-term (nursing home) care system, in the types, quality, and costs of services. To meet these challenges, Jeon, Glasgow, Merlyn, and Sansoni (2010) state that middle managers in the Australian residential aged-care setting should deploy an integrated approach so that “leadership is reflected in the management roles at all levels” (p. 2). Jeon et al. (2010) say that leadership is the “external focus with future vision” and management is an “internal focus on immediate needs” (p. 2). Although there is agreement that leadership development should include all levels of management geared toward higher performing organizations, there is little consensus among researchers about the best way(s) to develop this culture (Dana & Olson, 2007; Jeon et al., 2010). Direct care workers provide most of the actual nursing home care and yet providers report staggering turnover rates ranging from 45%-100% annually (Harris-Kojetin, Lipson, Fielding, Kiefer, & Stone,

2004). In an industry so dependent upon the actions and reactions of its staff, a key problem is how to engage the staff (both management and frontline) in improving the care and developing innovative approaches for providing long-term care. Scott-Cawiezell et al. (2006) discussed how the nursing home “culture of blame” impacts resident safety and underscored the importance of developing the “capacity to create and sustain improvement.” An integrated approach of leadership development customized for each individual manager or supervisor, combined with employee engagement, and customer value-added improvement has shown promise in case study results and may be a missing link needed to sustain and grow initial change results.

FIELD STUDY

An 8-month field study (September 2006 through April 2007) was designed to understand the factors affecting implementation of a staff participation system designed to engage long-term care employees at all levels in making change on a daily basis. These factors included

motivation and rewards, empowerment, participation in decision making, role and importance of mid-level managers, and organizational trust (Argyris, 1998; Besser, 1995; Harris-Kojetin et al., 2004, p. 1; Huy, 2001). The employee engagement system implemented during the study was based on a documented best practice and took the form of many small, incremental improvement ideas that were approved by management and implemented quickly (Robinson & Schroeder, 2004). Investigation included how such a system, which offered the opportunity for frontline employees to have a “voice” in changes specific to their own work, might be instrumental in fostering a culture of continuous change in the long-term care setting. This combination of the practical application of a staff participation system and change management theories included preassessment and postassessment of frontline nursing employees’ perceptions of their work and work environment, turnover data, and performance data.

A goal of the field study was to offer practitioners in the long-term care industry a staff participation system that could be replicated or adapted as a tool for stimulating systematic, incremental change. The 8-month, four-phased study used a staff perception questionnaire (pre and post), periodic onsite observations, informal interviews, and performance indicator data to assess the implementation of a staff participation system in a long-term care setting and factors affecting this implementation. Two long-term care organizations, similar in size and services, agreed to allow their skilled nursing units to participate in the proposed study. One organization implemented the employee engagement system while the other provided comparative data. Activities within the nonparticipating organization were tracked by the researcher through onsite interviews with the administrator and nursing staff. The selection of these two facilities represented a convenience sampling and required the support of leadership. The goals of the system were to foster a culture of continuous improvement by doing the following:

- recognizing all improvement opportunities focusing on small improvements that visibly affected the employees’ day-to-day work
- engaging the knowledge experts or those employees who performed the daily work processes in any improvement changes
- understanding the process facts through a quick sketching of the steps by which targeted work tasks were completed
- taking immediate action by focusing on small improvements that could easily be implemented by the front-

line staff and their supervisors without a lengthy approval process

Data Collection Instrument and Data Analysis

A 5-point Likert-type questionnaire was developed from questions already tested by other researchers (Cammann, Fichman, Jenkins, & Klesh, 1983; Kiefer et al., 2005). The 48-item questionnaire was used for preassessment and postassessment of staff (CNAs and their managers/supervisors) perceptions of the organization. All employees of both organizations (census sampling) in the targeted units were invited to complete the questionnaire. Reliability analysis was performed after the preassessment administration of the questionnaire. Fourteen subscale levels were analyzed and over 45 employee interviews were documented.

In summary, differences in the demographic makeup of long-term care workers who participated may have contributed to different perceptions of work, work environment, and/or a willingness to participate voluntarily in organizational improvement. The uncertainty of generalizing results to a larger population is acknowledged as a limitation of the study.

Implementation

While the focus of the field study was nursing employees, the participating organization chose to involve all managers and employees of the skilled nursing facility in the implementation of the staff participation system. This choice permitted cross-functional teamwork when a proposed improvement required the buy-in from other departments. After the initial introduction of the system to all employees, the facilitator/consultant trained and coached managers to lead the implementation of the system. Because of the demands of long-term care work and limited time available for time away from the job, management training occurred each week in 30-45-minute increments during regularly scheduled manager meetings. Implementation was slower because managers were learning by doing. Managers had two roles: (a) encourage and mentor employees in suggesting and implementing individual ideas for improvement and (b) serve as leader for a process improvement team. From October 2006 through April 2007, managers led six cross-functional process improvement teams (two teams were led by nursing managers). Concurrently, employees were individually submitting improvement ideas to supervisors and managers. Managers and supervisors could approve improvement ideas for immediate implementation, work with the employee to adapt it into one that could be implemented, or explain the reason it could not be approved.

During the first meetings, managers expressed confusion on how the system would be different from what they already do. They questioned how employees could continually come up with small improvements. Some felt that they already asked employees for suggestions and had a good working relationship with them. However, aside from anecdotal descriptions of a few improvements, the managers had no specific system to document the types and numbers of implemented improvements made over the last year or the participation rates. Managers expressed frustration that some employees took advantage of the organization through unplanned absenteeism. Also, they expressed frustration over the challenge of reducing turnover. Although this confusion and skepticism gradually lessened, it contributed to lulls in implementation. When this happened, the reporting of documented improvements by department became a catalyst for management corrective action and learning.

Early in the process, frontline employees expressed doubt as to whether management would really listen and implement their improvement ideas. Examples were cited of past experiences at other organizations where proposing improvements resulted in negative consequences for the employee. The administrator played a key role in promoting the system.

Performance and Qualitative Data Results

The participating organization implemented and documented a total of 100 improvements as a result of the staff participation system from September 2006 to April 2007. Figure 1 shows the number of improvements documented and implemented during each month of the study for the nursing units compared with the entire organization.

Of key importance, Figure 1 illustrates the management learning curve and the adjustments that were made because of documentation reports. In the beginning, there was an initial surge in ideas, which tapered off. Because of the documentation, management was aware of the decline in ideas and took corrective action by adding biweekly updates by department.

Of the 100 implemented improvements during the 8-month period, the nursing department was responsible for 60% of those improvements. Overall, 36.6% of all employees chose to participate (excluding managers) by proposing or implementing improvements. In addition to knowing the overall participation rate as implementation progressed, the managers were updated on the names and numbers of new participants. This enabled them to provide informal recognition as they met and talked with employees. Furthermore, it emphasized the need to encourage all employees to look for improvement ideas and led to discussions of why some employees offered ideas and some did not.

By design, improvements varied in type and potential organizational impact. Some represented small improvements specific to individual employees but many more involved improvements that affected resident satisfaction and safety.

RESEARCH QUESTION RESULTS

Although the performance data and qualitative data supported the positive effect of staff participation, questionnaire subscale scores show some change but were less conclusive. First of all, the short time frame of 8 months from preassessment to postassessment did not allow

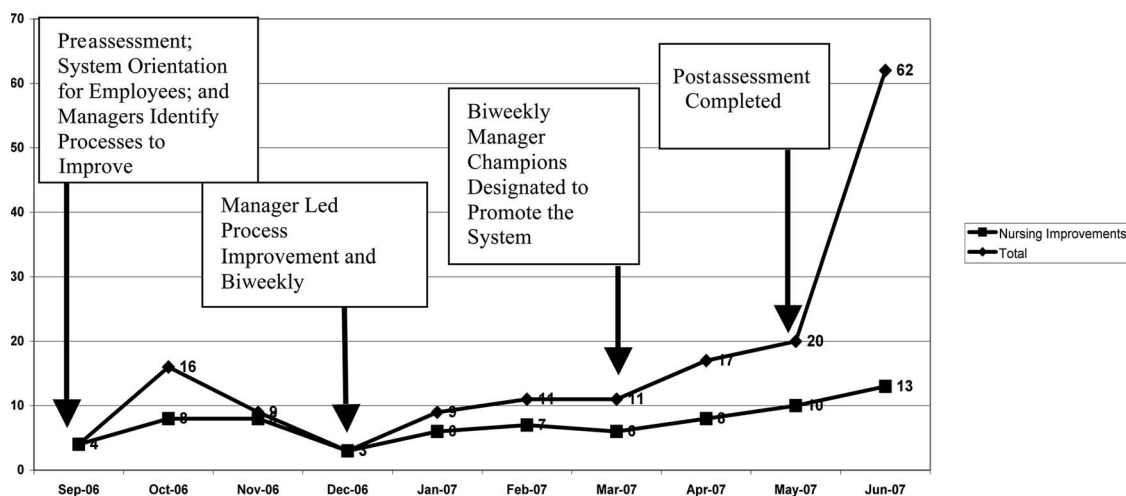


FIGURE 1. NUMBER OF NURSING EMPLOYEE-IMPLEMENTED IMPROVEMENTS COMPARED WITH OVERALL TOTAL EMPLOYEE-IMPLEMENTED IMPROVEMENTS AS A RESULT OF IMPLEMENTATION OF STAFF PARTICIPATION SYSTEM

for the staff participation system at the participating organization to be fully developed and deployed to all employees. Managers were obligated to participate at least minimally because of the organization's commitment to participate in the research. Although frontline employees were encouraged by management to offer ideas and asked to serve on teams, their individual participation was largely voluntary. In addition, the nonparticipating organization was engaged in continuous quality improvement initiatives and employee satisfaction efforts that were independent of the study.

Research Question 1

Question 1: Is there a difference in the staff perception of their work environment after implementation of a system that encourages staff to have more input into making changes that affect their capability to produce results (staff participation system)?

The participating organization's mean scores on the questionnaire increased in self-report of effort and global empowerment while the nonparticipating decreased. However, both organizations increased mean scores on organizational involvement, internal work motivation, intention to stay, ability to make workplace decisions, ability to modify the work, and management listens to CNAs. Mean scores on job satisfaction and job involvement decreased slightly for the participating while increasing for the nonparticipating. No significant results were found for the multivariate analysis of covariance (MANCOVA) analysis for Section I of the questionnaire. Analyses of Section II subscales indicated significant change results for two of the subscales: Ability to Make Workplace Decisions and Management Consults CNAs.

Observation and interview data indicated that it is challenging to find the right balance of empowerment authority for the job of direct care worker. In a highly regulated industry, many processes and procedures are mandatory. Some participants seemed to have difficulty in answering questions about the extent to which they were allowed or encouraged to make decisions on their own. Direct care workers were most confident when talking about their own personal commitment to taking good care of the residents.

Research Question 2

Question 2: Is there a difference in the rate of change in staff perception of their work environment between a facility implementing a staff participation system and one not implementing a staff participation system?

If the questionnaire data are considered alone, statistically significant change according to MANCOVA analysis was limited to two subscales (Ability to Make Workplace Decisions and Management Consults CNAs). Because the nonparticipating organization was also making changes as evidenced by change between the questionnaire subscale scores and interviews with staff, the limited comparative change between the two organizations would imply that the rate of change between the two organizations is slight. In addition, observations and interviews with managers and frontline staff indicated some change in the perception of the potential benefits of engaging staff, including employees' taking more initiative for handling problems without calling a manager during the evening or on weekends.

Initially, managers questioned the need for a formal system when they already talk to employees and encourage them to offer suggestions and ideas. Some employees indicated that things like this had been tried before. Others felt that managers were not so visible on the floor working and listening to people as they would like them to be. Other employees felt that "some managers don't take CNA input about residents seriously and think that CNAs don't know when they are with the residents all of the time." Staff perception subscale results indicated that there was more work to do in this area because even though there were significant results on the Management Consults CNAs, there were changes for both the participating and the nonparticipating organization. It is likely that the challenges with involving all shifts equally during implementation affected this result, too. The fact that management was learning by doing slowed implementation and the ability to reach all of the employees.

The collective analysis of questionnaire scores, observation and interview data, and performance data indicated that implementation of the staff participation system generated positive results for the participating organization. However, the sample size of employees who completed both the preassessment and postassessment was small, the measurement time period was relatively short, and significant changes in subscale scores were evident for 2 of 12 subscales.

The survey results data show that no single initiative or process is a panacea for promoting change. Key evidence from the research, including this study, is the potential of such employee involvement systems to increase management effectiveness by moving the managers toward the role of "real change leaders" (Katzenbach, 1996, p. 33). Robinson and Schroeder (2004) suggest that effectively utilizing employees' ideas will become a critical management competency for the future.

Implementation of the staff participation system in this study was designed to foster a culture of continuous improvement. There are two key factors that worked together to set the foundation for building a culture of continuous improvement. The first was a system, which defined how improvement would occur, and the second was the involvement and support of middle management and frontline supervisors. Both these elements contributed to changes in the climate of the organization, which sets the tone for future culture change. Sopow (2006) differentiates between climate and culture. Climate encompasses “rules and regulations, communication models, employee incentives, and other key factors that speak to the emotional and knowledge needs of employees” (Sopow, 2006, p. 14). Culture can be described as “deeply rooted traditions, values, beliefs, and sense-of-self” (Sopow, 2006, p. 14).

In the study, the staff participation system that defined how improvement was to occur began with the managers. Managers identified processes that they personally wanted to improve and led small improvement teams in quickly mapping the current process and recommending improvements. Concurrently, employees were asked to identify small improvements that related to their own jobs, discuss the proposed improvements with their supervisor, and then implement the improvement as quickly as possible. The goal was to engage employees in recognizing small improvements that could be made every day as a part of doing their regular job and implement the improvements quickly without a lengthy approval process. Letting employees choose what to improve as it relates to their job may actually improve “internal commitment” over time (Argyris, 1998). Others argue on a larger scale that reward and recognition systems need to address the knowledge within the organization to solve current problems as well as the development of the knowledge needed to operate in the future (Lawler & Worley, 2006). The system studied was focused on utilizing the knowledge within the organization.

FINDINGS FROM CASE STUDY FOLLOW-UP

The field study concluded in April 2007 but the participating long-term care organization continued the staff participation system. Shortly after the completion of the study, early successes began to fade so additional training materials were developed to support the organization. This additional external support comprised leadership training directly related to the 8-month field study. During 2008, the long-term care (LTC) management team received 10 hours of leadership training in the fol-

lowing areas: common goals, communication, systematic employment involvement, leading process improvement teams, and fact-based improvement. One-hour certified continuing education modules were created for each of the 10 training areas. Even though some value was created in the leadership training sessions, it became clear that the long-term care facility’s management team was struggling with just managing their everyday responsibilities. Individual manager buy-in and participation in the training sessions varied greatly. The final assessment of the 8-month field study and the additional leadership training demonstrated that the interventions had not instilled the leadership mindset and teamwork required to fully sustain and grow employee engagement and continuous improvement efforts. No further external support was provided and no additional progress updates occurred from June 2008 through January 2010.

In February 2010, one of the researchers from the original field study engaged the LTC management team with the intention of re-energizing the staff participation system and identifying additional constraints related to leadership mindset and teamwork. The first 2 months of this secondary engagement applied the same basic staff participation methods and tools designed for the initial field study in 2006. However, the researcher provided significantly more time and hands-on support for the management team in attempting to achieve more consistent levels of staff participation. In April 2010, the staff participation system was placed on hold because of limited progress in staff participation and negative feedback regarding the staff participation system communicated by both managers and employees.

Research at this point shifted to providing leadership coaching and mentoring for each individual leader of the management team. This leadership development support was not focused on the staff participation system but rather on the overall roles and responsibilities of each manager. Individual leadership data was collected from April 2010 to July 2010. Leadership characteristics not observed by the researchers in the original field study were uncovered during the work with individual managers. These leadership data were presented to the management team in August 2010 and represented a major constraint to the staff participation system: *The management team was operating with a strong micromanagement approach where two or three key managers were controlling the organization decision making while the rest of the management team (14 leaders) were left on the outside looking in.* The entire management team concurred that this was the reality of their management team, including the two or three senior managers who were controlling the decision making. It is important to note that the administrator reviewed the

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leadership data prior to the management presentation and readily agreed with the findings. The majority of employees involved with the staff participation system reported to the 14 managers who were left outside of the decision-making processes. This clearly was a major constraint for the staff participation system and contributed to most managers and employees choosing not to participate. These missed leadership opportunities also were the primary root cause for the negative feedback related to the staff participation system.

The management team agreed to develop a new leadership approach that would maximize decision-making participation of all managers. In September 2010, the new management system that focused on further developing each leader was initiated beginning with senior managers. The initial catalyst of the new management system was the facilitation of a documented best practice for leadership development (Wainwright Industries, 1994 Baldrige Award, internal customer feedback process). Internal cus-

tomers feedback from the direct reports of each manager was documented and each manager developed leadership improvement plans responding to the internal customer feedback. This internal customer feedback process provided a personalized “look in the mirror” view for each leader that greatly accelerated the customization of the leadership development process for each leader.

The developing new management system then integrated the leadership development system with employee engagement (staff participation system) and customer value-added improvement (see Figure 2).

Lean methodology, which evaluates value-added and nonvalue-added processes from the view of the customer, was introduced to maximize customer value added improvement. This integrated approach began to spark a noticeable cultural shift in the organization. Lean methodology, particularly the language of nonvalue-added processes, really resonated with the management team. According to one of the managers, “We started looking at everything we did as to whether it added value to the overall goal of caring for the residents and began changing our work patterns to that effect.” Consequently, the admissions process was analyzed and it was determined that the first 8–24 hours of a resident’s stay was a key determinant of longer term resident satisfaction. An admission team was formed and a customer value stream map of the process was documented, which made the staff more aware of ways they could improve their care and minimize nonvalue-added activities. These same tools are now being used by other departments with the same success. Per staff interviews, managers who were previously negative toward the initial staff participation initiative now fight *for* the new management system rather than *against* it.

In addition, the organization has developed a prioritized scorecard of metrics under the categories of census, workforce safety, resident safety, quality-clinical, operational excellence, and financials. Some of this information is displayed throughout the facility. According to interviews with managers, this integrated approach has created a renewed spirit of teamwork, problem solving, and enthusiasm about coming to work. Corporate leaders have approved the approach to be implemented at a second facility. The lessons learned from the original field study site are being implemented at the second facility and will be studied to see if accelerated outcomes can be generated.

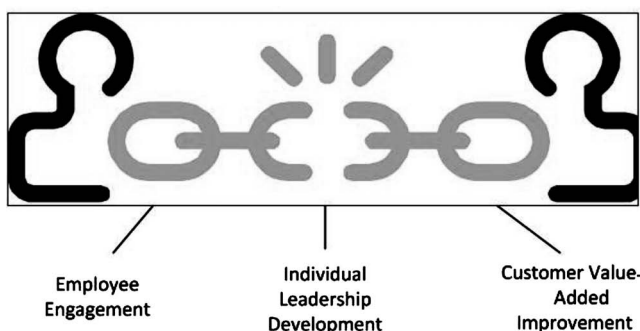


FIGURE 2. INTEGRATED INDIVIDUAL LEADERSHIP DEVELOPMENT, EMPLOYEE ENGAGEMENT, AND CUSTOMER VALUE-ADDED IMPROVEMENT MODEL

CONCLUSION

The initial field study and followup case study demonstrate the real challenge of implementing and sustaining a

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system of continuous improvement that engages all managers and employees of the organization. Although leadership development was determined to be the leading catalyst for sustained change, leadership development separated from the real world, day-to-day job responsibilities of managers can produce only limited results. Throughout the case study research, interventions were built around the staffing grids of the organization, which required 30-minute maximum leadership development and training sessions. *Over time, this allowed for leadership development and staff participation to evolve at the pace of the day-to-day job, or in other words, built into the day-to-day job.* This is a critical factor for sustainability of the continuous improvement system. It also creates a major consideration for organizations looking to replicate the concepts of the case study. Building leadership development and staff participation into the day-to-day job will likely require a 12-month effort for the typical long-term care facility. This timeline will be further analyzed and documented during the work that has begun at a second facility.

From a financial perspective, leaders should consider a customer value-added strategy (Lean), which can create a cultural shift to *valuing every penny* (customer value-added) versus *watching every penny* (cost reduction). The CEO and managers involved in the case study readily accepted the customer value-added strategy as it provided much more hope for improving the organization versus the micromanagement approach of watching every penny. This financial thinking shift to valuing every penny can increase staff participation as well as support transformation away from a blame culture, which has been identified as a key factor in quality improvement (Hill, Kolanowski, Milone-Nuzzo, & Yevchak, 2011; Scott-Cawiezell et al., 2006). Although this challenge is far from a new one, researchers and practitioners continually seek new knowledge regarding ways to help organizations bring about

this needed culture change by design (Yeatts, Cready, Ray, DeWitt, & Queen, 2004). *The bottom line is that each individual leader on a daily basis will make or break any systematic approach to staff participation, continuous improvement, and customer satisfaction.* Researchers recommend additional research in this area and plan to do long-term follow-up with the case study organizations. ☀

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