Leadership: Key to creating a caring culture

Susan D. Gilster, RN, NHA, PhDc

Abstract

The subject of leadership is rarely addressed in the health care literature and the field is essentially silent to the need for leadership in long-term care. In this article, leadership is defined as the art of influencing and engaging colleagues to serve collaboratively toward a shared vision. The leadership model includes passion; commitment; vision; service; education; inclusion of staff, patients, and families; and self-knowledge.

Key words: administrators, leadership, long-term care

Introduction

Leadership is key to the success or failure of any business or organization, including long-term care facilities.[1-5] While there are many issues plaguing administrators today, how they lead and handle challenge will determine their success or failure. Although there are managers and staff who take a leadership role, the administrator is the leader in long-term care. It is the administrator whose license is at stake and who ultimately controls what does and does not happen in a facility.

Health care, specifically long-term care, is in crisis. Increasing rules and regulations, surveys, staff recruitment and retention, declining reimbursement, lower census, and increasing competition are just some of the issues that administrators face today. The industry is in a state of transition as former medical models make way for social programs and more homelike environments. Medical procedures are now considered in the context of quality of life. In times of change and challenge, a truly effective leader is most important.[1,6] When left to chance, in time, administrators who do not lead will fail. The current literature deems leadership as critical to business, but have we prepared administrators to be leaders? Do they have the training and knowledge that they need to accept such responsibility? Are they empowered and given the opportunity and authority to lead?

Susan D. Gilster, RN, NHA, PhDc, Executive Director, Alois Alzheimer Center, Cincinnati, Ohio.

The subject of leadership has received a great deal of attention over the past decade in the business community, but is rarely addressed in the health care literature. The limited material that exists is focused on leadership in acute care, but is essentially silent to the need for leadership in long-term care. When it is mentioned in the long-term care literature, authors typically use the word "leadership," but provide little or no discussion about the nature or development of a leader. In addition, there is no information about how to promote leadership, nor are the leaders identified.

There are many articles in the aging literature that describe new programs, educational interventions, and even "culture change" for long-term care. These efforts are presented in the hope of transforming long-term care, enhancing the care provided, and improving the work environment for staff. While elaborate programs and philosophies are put forth, authors fail to identify the responsible party—the leader. In essence, the implementation and survival of such programs is "up for grabs," so to speak.

In addition, there are new initiatives that identify nursing as the focus for education or training. Although the purpose of these initiatives is to transform the long-term care environment, such endeavors are implemented at the discretion of the administrator. Once adopted, such programs also become the responsibility of the administrator and cannot be sustained without his or her support. Without involving the administrator in the process, these initiatives alone will not change facility operations or transform the long-term care culture.

When one examines textbooks used in the education of future administrators, there are few references to the importance of leadership and leadership theory. Again, the word leadership is mentioned, but it is not defined; neither is any guidance given in establishing oneself as a leader.[4,7] By and large, administrators are left to fend for themselves. They come into a job with the skills that they happen to bring and hope for the best. In essence, leadership is a critical component in long-term care that has yet to be explored.

This article hopes to initiate discussion and exploration of leadership in long-term care and define the

administrator as the leader. We will examine the impact of leadership on the operations of the facility and introduce a model of leadership developed for administrators.

What is a leader?

Over the past three decades, there has been a great deal of information generated about management and leadership, predominately related to business. This material is a generic exploration of management and leadership, and supplies information that can be utilized in long-term care. There are over 9,000 descriptions, concepts, and references to leadership practices.[8] Bennis notes that there are over 850 definitions of leadership.[2] Theories abound as well.[9,10] Despite all of the discussion and theories of leadership, there is no consensus on the definition of a leader or how leadership is developed. Questions remain: Are leaders born or made? What are the characteristics of a leader? How do you learn to be an effective leader?

So, what is leadership? In this article, leadership is defined as the art of influencing and engaging colleagues to serve collaboratively toward a shared vision. While service to others is ultimately the motivating factor for people who work in health care, it takes a leader to guide that work toward a destiny of shared vision. It is the leader who sees the big picture and orchestrates the process. It is the job of a leader to make it happen.

A leadership model

A specific leadership model was developed for administrators in long-term care based on a review of the literature, a 15-year historical case study of a 102-bed facility, and experience in health care.[11-17] The model comprises five components, including a passion or commitment to service, vision, education, inclusion, and self-knowledge. This model is illustrated in Figure 1. Each of the elements of the model is supported in the literature by the works and models of others.[18-23]

In this model of leadership, the importance of a passion and commitment to their work on the part of leaders cannot be underestimated. Passion and commitment are an overarching theme that connects the components of this model. The leader is committed to, and passionate about, his or her work, service to others and the community, the vision for the organization, education for self and others, the inclusion of others, and knowledge of self.

Each of these components will be considered in the context of long-term care, citing examples to illustrate how they may be implemented in a facility. The facility contains 102 beds and provides a continuum of dementia care. Levels of care include a day program, a short-term respite program, and four distinct, self-contained units, ranging from assisted care through skilled care. Each unit is physically unique, differs programmatically, and operates with varying levels of staff. Although this

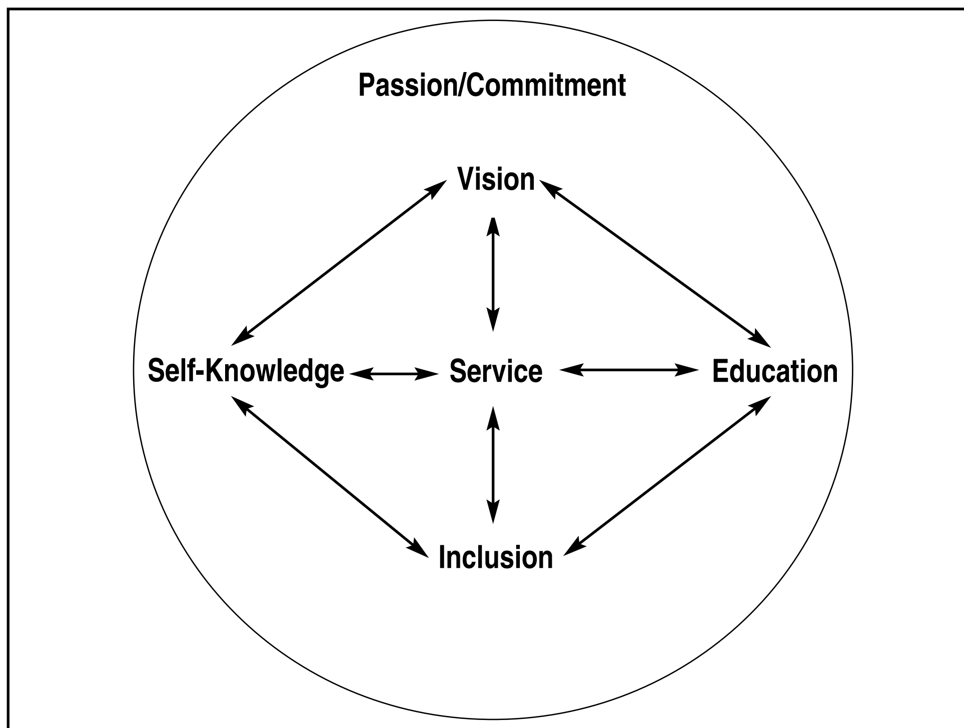

Figure 1. Leadership model for administrators in long-term care.

model was developed through experience in a dementia-specific facility, these concepts and practices can be applied for any long-term care setting in which the focus is on service, quality of life, and quality of care.

Commitment to service

In this model, service is the driving force behind all decisions and program development. The development of a project aimed at serving all customers promotes a feeling of significance in the work. The leader has a sense of personal ownership in the vision and sees it as an opportunity to make a difference in the life of another human being. This commitment to service in long-term care is about not only serving the residents, but also the family members, staff, volunteers, visitors, and the greater community.

In practice, this commitment to serving residents considers their needs and desires in making decisions. It entails asking questions about service from a new perspective, an individualized or person-centered perspective. How would I want the living room to look if I had to live in it? What would I want the food to taste like if I had to eat it? What type of activities and events would I enjoy? How would I want to be treated?

Families of the residents are an important part of the work we do as well. It is critical to be of service to them, too. Take the time to listen and talk to families. Provide them with information and education to enhance their ability to understand the needs of their family members and how best to provide those in this new environment. Support families in decisions they need to make. This involves spending time with families prior to admission into the facility to determine their needs and ensure that they can be met. Preadmission assessments are critical for gathering information and assisting residents and families in the transition. Be proactive, encourage questions, calls, discussions, and meetings, and respond quickly to family concerns. Families want to be involved and to know that someone cares enough to spend time with them and to listen. Serving families includes being open, flexible, and accommodating to their needs as well.

Leaders are committed to serving staff. When staff members perceive that they are cared for and valued, they will demonstrate that care in the work they do and their dedication to the facility. Routine forums for communication ensure that staff is heard and their input is valued. Spend time with staff and get to know them. Respect and value each individual employee.

Staff needs to be supported in difficult and traumatic situations. In times of crisis, the leader is there, no matter what time of the day or night the situation occurs. For instance, an unexpected loss of a resident, or an incident with a family, is reason enough to check and see that the staff is doing all right. Staff desire, and require, support from their leader. Sometimes staff members will need a shoulder on which to lean, and when they do, it needs to be available.

Commitment to a vision

Much of the leadership literature points to the need for a vision—a clear picture of what you are dreaming of creating.[1,22] It takes shape in the facility's vision and mission, expressing the values and guiding principles of the organization. The vision addresses what the facility wants to be and how the facility intends to serve. The leader committed to a vision looks at the whole organization and all that it touches, internally and externally. To the leader, the vision is not just words on a piece of paper, framed and hung in the hall or written on the back of a business card. The vision is experienced in the activity of those who work in the facility every day.

The vision and mission for the facility are best developed with the input from all staff, all shifts, and all departments. Once developed, the vision should then be reviewed annually by all staff. A vision is kept alive through ongoing discussion, examination, and openness to change. Thus, the vision and mission statement will evolve over time, gaining new objectives, not envisioned at the start. The mission statement established five or 10 years ago does not necessarily express who you are and what you do today. Through this ongoing process of reinforcement, review, and change, the leader continues to convey the facility's purpose to staff.

Commitment to education

This leadership model embraces the leader's commitment to education as another important component to a successful facility. Everyone touched by the facility is involved and included in education and support programs. This includes residents, families, staff, and the community.

Residents, even those with dementia, can learn and feel valued and supported. Residents come to a facility in various stages of physical or cognitive impairment. Until they demonstrate that they cannot learn, they deserve to be encouraged and to participate in new things. Despite what many have been led to believe, older adults and even individuals with Alzheimer's disease can learn.

In addition, the leader in long-term care has the opportunity and responsibility to educate families. Monthly family meetings are an opportunity to educate families about long-term care, chronic illness, and what they can expect to occur over time. Armed with this

information, they are better able to understand the process and, consequently, make better decisions. The meetings serve to communicate as well as to educate.

The leader committed to education sees staff education as an opportunity to facilitate knowledge and growth for employees. An initial orientation enhances skills and facilitates a better understanding of the work done by staff. The length of orientation should be dependent on the needs and skills of the employee as well as the complexity of the job itself. Ongoing educational programs continue the growth and serve as a means of communicating with staff and receiving valuable feedback.

Critically important is that, as leaders, administrators in long-term care also take the time to be educated themselves. Administrators seem to become very isolated in their facilities and do not reach out. Somehow they miss the tremendous amount of ever-changing information that is available. Self-education through reading, attending meetings and seminars, and learning from others in the industry and field are an important part of the job.

Commitment to inclusion

Commitment to inclusion in this model refers to including and appreciating the contributions and input of others as part of the team. A leader committed to inclusion respectfully listens to and considers the ideas and concerns of others in the decision-making process. Residents, families, and staff need a forum for voicing their concerns. Routine meetings as well as informal opportunities ensure this and provide a mechanism for important feedback.

The leader includes residents through the development of an individualized philosophy of care. Residents are at the hub of all decisions and programs. The leader communicates this philosophy routinely to keep the resident as the focus of the work and the facility.

The leader in long-term care also encourages family involvement in the facility and lives of residents. Families, as part of the team, provide vital information that will facilitate greater success in resident care.

This inclusive philosophy of leadership promotes the concept of a flat organizational chart and emphasizes to staff that we are all in this together—we are a team. This philosophy supports the belief that everyone is equally important, but with different roles and responsibilities. It consists of soliciting ideas, listening to all staff, and encouraging feedback through communication, meetings, and surveys. Inclusion involves all parties working together, moving forward as one, toward the vision.

In practice, inclusion means getting involved and helping, whatever that means at the time. Leaders do not ask staff to do what they are unwilling to do themselves. They work side-by-side with staff in any department when needed. Sometimes that means giving up a day off if the staff requires assistance. When the staff needs help to care for residents, it is "all hands on deck," no matter the title or role. It is about supporting the vision together.

The leader also uses routinely scheduled meetings with all staff, and from all departments, involving them in discussions about vision, direction, plans, policy changes, and problem solving. Meetings are a way of keeping staff informed and facilitating participation and "ownership," which also gives staff a sense of direction for themselves and the organization. Not only does this approach promote the perception of inclusion, but it also contributes to building a cohesive, interdisciplinary, interdepartmental team.

Commitment to self-knowledge

Commitment to self-knowledge is important in effective leadership.[18,19,21,23] Self-knowledge is the awareness of who you are and what makes you "tick." It is knowing what is important to you. Being in touch with yourself also involves being honest with yourself in everything you do. The result can enhance the ability to take risks, and to be innovative and decisive.

The leader committed to self-knowledge realizes the importance of maintaining oneself daily, especially through difficult times of transition. This may involve taking some time away, meditating, or reflecting. The leader uses this time to think, plan, strategize, and establish goals, avoiding moving from item to item, crisis to crisis, day after day, with no time to think or plan. A leader, in touch with him- or herself, has self-confidence, trust in his or her own ability, and learns from mistakes. It is the willingness to continue to learn new things and new ways of doing old things that makes a leader effective.

Conclusion

Long-term care is in a state of transition and crisis. It is up to the administrator, the leader in the facility, to set a new direction for the industry. Administrators must step up and accept the responsibility of leadership. The model presented in this article is a starting point for transforming leadership in long-term care, but it is up to each individual administrator to make the choice to be a leader. In doing so, leaders must be clear about who they are and what they want to achieve. Determine your passion. Make service the foundation of your vision. Include, educate, and support your team. Know and care for yourself and others. Not only will this transform long-term care, but it may very well transform your life and the lives of those you touch.

References

1. Kouzes JM, Posner BZ: *The Leadership Challenge: How to Keep Getting Extraordinary Things Done in Organizations.* San Francisco: Jossey-Bass, 1995.
2. Bennis W: *Leaders: Strategies for Taking Charge.* New York: Harper Collins, 1997.
3. Maxwell J: *Developing the Leader within You.* Nashville: Thomas Nelson, 1993.
4. Allen JE: *Nursing Home Administration.* New York: Springer, 1997.
5. Thomas WH: *How Someone You Love Can Still Enjoy Life in a Nursing Home.* Acton, MA: Vanderwyk and Burnham, 1996.
6. Fulton R: *Common Sense Leadership: A Handbook for Success as a Leader.* Berkeley, CA: Ten Speed Press, 1995.
7. Davis W: Organizational management. In *The Introduction to Health Care Administration.* (6th Ed.) Bossier City, LA: Professional Printing and Publishing, 2000: 25-32, 34-38.
8. Annison MH, Willford DS: *Trust Matters: New Directions in Healthcare Leadership.* San Francisco: Jossey-Bass, 1998.
9. Hein EC, Nicholson MJ (eds.): *Contemporary Leadership Behavior.* Boston: Little, Brown and Co., 1982: 67-102.
10. Longest BB, Rakich JS, Darr K: *Managing Health Service Organizations and Systems.* (4th Ed.) Baltimore: Health Professions Press, 2000: 771-802.
11. McCracken AL, Gilster SD: Developing a viable residence for persons with Alzheimer's disease. *American Journal of Alzheimer's Care and Related Disorders and Research.* 1991; 6(1): 39-43.
12. Gilster SD: Developing the first Alzheimer facility in the United States. *Carers, Professionals, and Alzheimer's Disease.* London: John Libbey and Co., 1991.
13. McCracken AL, Gilster SD: Desires and perceptions of staff concerning work performance in a dedicated Alzheimer's facility. *American Journal of Alzheimer Care and Related Disorders and Research.* 1992; 7(4).
14. Gilster SD, McCracken AL: Mechanisms for decreasing staff stress and providing support in a specialized Alzheimer facility. *Journal of Long Term Care Administration.* 1995; 23: 12-16.
15. Gilster SD, Accorinti KL: Mentoring as a means of staff training and retention. *Provider.* 1999; 25(10): 99-100.
16. Accorinti KL, Gilster SD, Dalessandro JL: Staff programs focus on reducing turnover. *Balance.*2000; 4(5): 12, 14, 28.
17. Gilster SD, Accorinti KL, Dalessandro J: Providing a continuum of care for persons affected by Alzheimer's disease. *Alzheimer's Care Quarterly.* 2002 [in press].
18. DePree M: *Leadership is an Art.* New York: Bantam, 1990.
19. DePree M: *Leadership Jazz/Max DePree.*New York: Bantam, 1992.
20. Greenleaf RK: *Servant Leadership: A Journey into the Nature of Legitimate Power and Greatness.*Mahwah, NJ: Paulist Press, 1991.
21. Jawarski J: *Synchronicity: The Inner Path of Leadership.* San Francisco: Berrett-Koehler, 1996.
22. Senge PM: *The Fifth Discipline: The Art and Practice of the Learning Organization.* New York: Bantam, 1994.
23. Blanchard K: *Heart of a Leader.* Escondido, CA: Ken Blanchard Co., 1999.

Make your thoughts known!

Write *American Journal of Alzheimer's Disease and Other Dementias*!

The *Journal* welcomes letters on subjects related to all aspects of dementia care, management, and research. Letters in response to articles in specific issues of the *Journal* are especially welcome, but, to ensure timely publication, they should be sent soon after distribution of the issue in question.

You may send your letter by mail, fax, or e-mail.

Letter to the editor
American Journal of Alzheimer's Disease and Other Dementias
470 Boston Post Road
Weston, MA 02493

Fax: 781-899-4900

E-mail: alzheimers@pnpco.com