5.0 What a difference management makes! Nursing staff turnover variation within a single labor market[1]

5.1 Introduction

This chapter addresses two basic questions: Why does turnover among nursing staff vary widely in long term care institutions, even among facilities located close together, in the same labor market? Second, what difference can management practices make in helping to understand the mechanisms associated with either high or low turnover? The report was submitted to Abt Associates as one contribution to a Congressionally mandated research study on the necessity, cost, and advisability of establishing nurse staffing ratios in U.S. nursing facilities. This research was conducted during spring and summer 2001 by the author via first-hand ethnographic research and interviews in nine long-term care facilities in four labor markets in three states.

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Labor economists typically explain turnover primarily as a function of labor-market choices of qualified workers. If two employers offer similar jobs, employees theoretically should be indifferent between one and the other. Certain institutional characteristics and types of managerial behavior, research has established, can induce employees to stay with a given firm, even in the face of better competitive conditions at another firm (Piore and Doeringer 1985; Baron and Kreps 2000). These characteristics may include offering an accessible internal labor market, so that promotion from within is a possibility, even for an entry-level worker. They may also include managerial practices designed to tie the worker more closely to the firm, either through seniority-sensitive wages and benefits (such as offering increasing paid vacation time or annual wage increases with each additional year of organizational tenure), or in the nature of work organization and teamwork. For instance, workers with motivating jobs are known to demonstrate higher organizational commitment and longer tenure; this is also true of workers who have extensive social ties with their co-workers, those who feel their contributions are valued, and those who have good working relationships with supervisors (Hackman and Oldham 1987).

The rate of staff turnover among nursing staff in long-term care institutions is extremely high, averaging 100 percent for certified nursing assistants (CNAs as they are called in this paper), 66 percent for registered and licensed nurses, 50 percent for Directors of Nursing and 25 percent for administrators (Institute of Medicine 2001). It is important to note that 100 percent turnover does not necessarily mean that every single CNA departs a facility in the course of one year, but that for every nursing aide who stays the full year, for example, two more came and one left, in a similar job at the same facility. Although costs vary, one administrator interviewed for this report estimated the cost of replacing one nurses' aide at "somewhere between $2,000 and $4,000 a person." A careful study has shown the average cost to be about $3200 in 1992 (Zahrt, quoted in Straker and Atchley 1999). This is a lot of money for nursing facilities, and is probably still an underestimate that does not sufficiently account for lost productivity and adequate training time.

High turnover in nursing jobs is plausibly related to higher rates of problems with quality of care, although studies have not definitively proved the relationship. Some providers and unions argue that turnover can result in inadequate, unsafe care, care without continuity, and even denial of care. (Paraprofessional Healthcare Institute 2001). Few longitudinal studies with clear outcomes related to quality have been conducted since Minimum Data Set (MDS) assessment data became available to some researchers. But a 1999 General Accounting Office (GAO) report noted that each year, more than one-fourth of nursing homes had deficiencies that 'either caused actual harm to residents or placed them at risk of death or serious injury' (US GAO 1999:3). While the average number of deficiencies in the U.S. in 1999 was lower than in 1993, at 5.7 per facility, still fewer than 18% of all facilities were deficiency-free (Harrington *et al* 2000). Particularly for residents with dementia, continuity of relationship with direct caregivers is important. One of the few studies conducted with residents themselves defining quality of care identified good relationships with direct care

givers as more important to residents than the quality of food or medical care (National Citizens' Coalition for Nursing Home Reform (NCCNHR), 1985). Knowledge of individual residents' preferences and the ability to notice and report small changes over time is another benefit of longer-term nursing staff. Individualized care, as in the regenerative or "Edenized" models, requires strong relationships between residents and caregivers (Eaton 2000). As noted above, high turnover is also expensive for facilities and the public.

As part of a Congressionally mandated study on the appropriateness of establishing minimum nursing staffing at nursing facilities, this researcher conducted an investigation that gathered information directly from providers and staff about management practices and other factors that might affect nursing staff recruitment and retention. In collaboration with Abt Associates and CMS, a research team selected nursing facilities in each of three states, California, Kansas, and Wisconsin, where detailed turnover information is collected from nursing facilities and available to the public. The investigator interviewed managers, charge nurses, HR and staff development professionals, and front-line nurses and paraprofessionals to determine the cause for high or low turnover. Researchers selected facilities in the top and bottom quadrant of turnover, within the same labor market, within each state. The investigator conducted field studies at one or more "pairs" of facilities in each state.

The goal of this research design was to compare managerial practices in nursing facilities that were located in the same geographic labor market. The idea was to compare 'apples and apples,' in a sense. If workers were likely to stay in jobs at a nursing facility in a local area where similar workers were likely to leave another nursing facility down the street, the researcher team thought it could learn something by comparing the managerial practices of the two facilities.[2] From the research literature in organizational behavior, management, sociology and human resources, it is known that supervisory relationships, staffing levels, wage levels, benefit levels, and even the organizational culture of care could make working in two apparently similar facilities a very different experience (Herzenberg *et al* 1999). This study was designed to delve deeply into the reasons for turnover in a local labor market where CNAs and other nursing staff had real choices of where to work, and why they chose to stay at one facility and not at another. If specific managerial practices can be seen in a close, qualitative study to be related to reductions or increases in nursing staff turnover, then perhaps such practices could be documented and made available to practitioners with the ultimate goal of providing better care at lower cost, as well as more stable jobs to nursing staff members.

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[2] Note that the original idea for this study occurred in conversations with Marvin Feuerberg from CMS director of the 2000 CMS study on nurse staffing in nursing facilities. Alan White and Donna Hurd of Abt Associates worked hard to refine it and make it a reality, and to identify comparable facilities in the three states and four cities. The author is grateful for their help and feedback; of course any remaining errors are her responsibility.

5.1.1 Existing Explanations for High Turnover

Researchers have studied staff turnover in many industries. Typical non-exclusive explanations given by economists and managers for high turnover in direct care nursing facility jobs include the following:

- Frontline workers are marginal job seekers who cannot keep a job, come to work regularly, or perform reliably
- Frontline workers are poor workers, often single parents, who have little support at home for work requirements and therefore often miss work because of an absence of adequate or reliable child care, transportation, etc.
- Frontline workers are workers without a 'good work ethic,' as contrasted with workers of the previous generations
- Frontline workers are typically low wage workers who have lower job commitment and attachment in general
- Frontline workers are often immigrant workers who may have troubles with work status, with the law, with school, relatives who live great distances away, or with other commitments
- Frontline workers are workers for whom serious economic and life problems are only one paycheck away—often without health insurance, savings, retirement incomes, etc. Thus they are not likely to be stable, committed workers since life difficulties can prevent them from attending work regularly or productively.

No doubt examples exist of all of these in the long-term care nursing workforce, particularly of 'marginal worker' issues in the case of recent welfare recipients (partially because of relatively little work experience). **However, the fact that some nursing facilities exhibit extremely low turnover compared to other nursing facilities located just down the street, when they are hiring and employing the same workforce, makes some of these broad explanations of limited use.** The explanations may all be correct at some level, but even given the relatively high levels of turnover in the long-term care industry, it is clear that a great deal of variation exists within the industry and even within neighborhoods. The mean level of turnover in nursing facilities may always be higher than in, for example, hospitals, but the variation within nursing home settings is what is interesting and what requires new explanation. That is the goal of this report.

Managers interviewed in this study from high-turnover facilities tended to see high turnover as inevitable. For instance, one said, "*Most CNAs only stay three to six months. For some reason or another, they move on. Most people on the night shift are employed on more than one job, maybe their full time job has better pay or benefits.*" Managers also offered varying explanations for the difficulty in recruiting workers. One blamed the FBI tests required for nursing staff, and also increased awareness of patient abuse. "*We would have more nurses, but since they passed the bill that they had to be fingerprinted, they stay away. Some of them*

have reformed, something happened a long time ago. Why do they take their certificate? We get a letter in the mail, and then they got to go. This happens when they try to renew their certificate..." As for why there is a nurse shortage, "*We are all doing nasty jobs. They don't make enough money. Right now, it's a lot of things going on. If a patient gets bruised, it's patient abuse.*" Another nurse in a high turnover facility explained that some people's departures encouraged others. "*The pattern... is fast turnover. I need a nurse now. One person left, told the others, it is a chain thing. They tend to follow, especially when it is a friend.*"

The typical explanations for high turnover commonly heard among managers and labor economists do not clearly take the workers' own perspectives into account. This chapter seeks to help remedy these problems in explanation by reporting both managers' and workers' opinions about turnover and retention in today's nursing facilities, and what they say about their own life and work experiences makes them stay at a job or leave it. While it is not a large or 'representative' sample by design, the quality of information attained from the interviews should help us understand the mechanisms by which key nursing facility employees' individual decisions are made.

5.2 Methods: Selecting Geographic Areas and Facilities, Approaching Staff, and Conducting Observation, Documentation, and Interviews

As the goal of the study was to investigate conditions at individual facilities, the research team first identified three states that collected turnover data from nursing facilities in their jurisdiction. These states, Kansas, Wisconsin, and California, are among the very few where individual nursing classification turnover figures are collected and published statewide. If more states collected turnover data at the level of RNs, LPNs, and CNAs, researchers would be able to do broader studies in more geographic areas.

The most recent data available were from 1999. Given the high turnover figures in all levels of nursing facility administration, researchers were conscious that the reasons nursing turnover was high or low in 1999 might have changed by 2001. In fact, in five of the nine cases selected, new administrators were in place in the facilities since the original data were reported. In some cases, this eased access since the newer administrators were making changes to the conditions that had contributed to particularly high (or in one case, low) turnover, and were willing to discuss those prior conditions without defensiveness. More current data would improve both researchers and consumers' access to this important workforce information.

5.2.1 Selection of Geographic Areas

Having picked three states with available relevant data, investigators selected four different types of geographic areas: one suburban (Olathe, Kansas), one medium-sized city (Milwaukee Wisconsin), one rural (Fresno, California), and one large urban setting (Long Beach/ Los Angeles, California). While this study does not attempt to identify a random sample, these cities were chosen to represent a variety of settings where long-term care facilities occur in sufficient numbers to provide at least one 'matched pair' as described above. Investigators wanted to have a back-up facility for each location, in case access was problematic. (This proved wise; during the visits, one high-turnover facility had health inspectors visiting and asked the researcher to leave during this process, although another low-turnover facility welcomed the researcher despite the presence of state surveyors. In another case, a high-turnover facility declined to participate beyond one set of interviews, and another similarly situated facility was chosen in the same area). Locations all had to be sufficiently large to have both above and below-average facilities present, so a number of smaller towns were excluded from consideration.

5.2.2 Selection of Facilities

Investigators created a paired set of comparable facilities (in size and location, using zip code or actual short mileage distances apart as a proxy for co-location). As noted above, selected paired facilities were required to be either in the top or bottom quartile of their state's distribution of turnover statistics. Alan White of Abt Associates and the researcher utilized the overall nursing staff turnover as the main baseline figure, but they also examined Certified Nursing Assistant (CNA) turnover figures in particular, since aides deliver more than 90 percent of hands-on care, and turnover in their ranks in particular is believed to be associated with lower quality care. Certain exclusions were applied to the statewide data set before choosing pairs (see White's chapter for further details): publicly owned and operated facilities, hospital-based facilities, and those with fewer than 75 beds were excluded as non-typical for this study. The research team did not select facilities based on structural characteristics such as ownership, size, Medicaid percentage, acuity level, staffing levels, occupancy, or any other. The final sample included proprietary and voluntary facilities, religious and non-religious facilities, single-owner and chain facilities, and 75 percent non-union and 25 percent unionized facilities, so the researcher visited a range of structural settings.[3] Researchers chose lower limit on beds at 75 and an upper limit at 250 to capture the bed range that includes most facilities in the U.S. Researchers also excluded public sector facilities, because of their generally larger size and frequently different labor market

[3] Though two facilities (both in Wisconsin) were unionized, and the researcher asked to speak to the union representatives in both buildings, no elected or appointed employee union leaders were working during the days when the facility was visited. Since both a high-turnover and low-turnover facility were unionized in this small sample, unionization alone cannot explain the differences found, although in general unionized facilities have lower turnover in all industries including health care (Baron and Kreps, 2000, Kochan, Katz and McKersie 1986). About 10 to 12 percent of the nursing facilities in the U.S. are unionized.

experiences (for instance, in Wisconsin the public sector facilities typically have extremely low turnover, in part because they offer county worker union benefit levels, including pensions and health insurance, unlike most other nursing facilities). Researchers matched facilities in the same local labor markets that were approximately the same size.

Table 5.1 below shows the turnover level contrast in nursing staff between the facilities selected for interviews and visits. The paired facilities were all within a few miles (or less) of each other. Note that the percentage of turnover is that of Certified Nursing Assistants (or CNAs), except where noted.

Table 5.1
Summary of Selected Facilities and Interviewees (in addition to Observation)

Nursing Facilities Selected for Research	Kansas	Wisconsin	California (Urban, Rural)	
Facility A (low)	33%	52%	24%	31%
Facility B (high)	190%	167%	165%	96%

Once the four separate pairs of facilities were identified, the researcher faxed the administrators a letter, attaching a CMS letter of introduction, and requesting convenient dates for a visit of two days. Facilities were encouraged to participate in an introductory letter from Steven A. Pelovitz, Survey and Certification Group Director, Center for Medicaid and State Operations, Health Care Financing Administration. All facility and individual participation was voluntary; and no facility or individual was required to participate. As noted above, one facility declined to participate, so it appears that facilities felt this choice was real. The researcher committed herself to the least possible disruption of patient care and arranged visits for this purpose after consultation with administrators.

Only one facility specialized completely in dementia care, a low turnover facility in the Los Angeles area. Several other facilities had dementia units, however, including one that had early-stage, mid-stage, and late-stage Alzheimer's disease units. One facility in the mid-sized city was located in a self-described "inner city" neighborhood, though it was not far from another facility that was on the edge of the city, also in a low-income neighborhood, but with a more diverse staff and resident base.

5.2.3 Actual Site Choices and Planning of Visits

In two of the four proposed locations, the researcher had to select and ultimately visit a backup facility, but these additional facilities fit the established criteria (and it is the actual facilities' visited CNA turnover rates that are reported in Table 5.1, above). In one case, a facility's manager was out of town for the two weeks before a visit and did not return

repeated calls, and then she decided on the evening of a visit planned by the researcher and the director of nursing that the facility was 'too busy' to have the researcher visit. In this instance the administrator and the director of nursing were interviewed by the researcher after repeated calls, but the administrator declined to participate in the study more extensively, and an alternate local "high turnover" facility was selected for intensive interviews. In the second instance, an administrator made a valid case that his low-turnover facility was not typical because of its role in an integrated health system, extremely high acuity patients and a large number of geriatric-psychiatric cases. After interviewing him, the research team agreed and chose a different low-turnover facility in the area that was also a good match for the high-turnover facility chosen.

After selecting facilities, preparing research materials, and negotiating access, the researcher arranged dates and times for her visits, usually through phone calls with facility administrators. To minimize disruption to patient care, the investigator stayed a maximum of two weekdays in each facility, though she always stayed over either two or three shifts. No weekend visits were scheduled. The researcher sought to collect relevant archival data related to the cost of turnover at the facilities, but in general found that administrators and business managers routinely do not track the cost of turnover, or know their own rates of turnover as reported to the state. The researcher also collected local labor market information such as classified ads and recruitment materials.

For purposes of this report, all facility identities were confidential, as were all individual identities. Specific characteristics of the individual facilities and interviewees are described accurately but not so as to violate confidentiality. Names were changed to preserve this confidentiality agreement with interviewees.

5.2.4 Visits, Observation, and the Interview Process

The full site visits typically began with individual interviews with the administrator and director of nursing, then the researcher followed up with staff development and human resource directors, charge nurses and other nursing staff, schedulers, and certified nursing assistants on all shifts. The interviews were semi-structured, using a series of questions outlined in the summary memo attached as Appendix C-1, but adjusted for each particular location, person and position as appropriate. Appendix C-1 includes an outline of the visit process, and some types of questions asked, as well as a list of additional types of individuals interviewed in the course of the study.

The researcher began by asking questions about staff shortages, recruitment and retention costs and experiences, and about the management philosophy and practices in each facility. The researcher asked about the personal and professional background of key leaders and of the nursing staff, including how they had become trained in nursing and how they had each come to the particular nursing facility, shift and role they occupied. Based on a knowledge

of the research literature, the researcher investigated the organizational 'culture or philosophy of care' and work organization, whether medical, social, or custodial, or even partially 'Edenized' in a few cases. The researcher asked about second jobs, about transportation and child care issues, about what each employee liked and did not like about her particular job and the particular facility, and about prior jobs and comparisons to other nursing facility or health care experiences.

When staff members were not available, or when the researcher had interviewed sufficient staff members on a shift or unit, the researcher conducted ethnographic observation, for a total of about 25 hours in addition to interview time. Each facility that permitted access was visited for between 20 and 24 hours; the two facilities that limited access were visited for about 8 hours each, and the one facility that denied broader access was visited for 2 hours for an interview and observation. In a few cases, groups of nursing staff were interviewed in informal sessions, as in a break or meal room, or at the end of a shift. In this type of interview, the researcher learned less about individuals, but more about their interactions and collective opinions. The researcher also spoke in limited depth to a total of about 35 residents, but these were not formal interviews. The researcher obtained useful and interesting information from residents, mainly through casual discussion while waiting in lounges, lobbies, dining rooms, etc. The researcher asked about the specific experiences they had had in this facility, and with staff, but did not conduct any structured interviews with residents. Sometimes the researcher asked them about their lives in and out of the nursing facility, and occasionally the researcher offered assistance when it was needed and not provided by staff (getting a sweater or a drink, for instance). Some residents volunteered information about the aides and nurses they knew. The researcher debriefed the entire visit with the administrator or another management person before leaving the facility. The researcher sent the draft report back to each facility for comments or corrections, which were incorporated before the final report was submitted.

The total number of employee and volunteer interviews conducted in approximately four weeks of field research was 159 (plus one group of 8 CNAs), broken down as indicated in Table 5.2 below (see also Appendix C-2 for a complete chart of the individual position holders interviewed in each facility):

Table 5.2
Summary of Selected Facilities and Interviewees (in addition to Observation)

Kansas (n = 45 interviews)
Facility 1 – Kansas (low turnover) - 25 interviews. Religious non-profit chain facility. New administrator.
Facility 2 – Kansas (high turnover) - 18 interviews. For-profit chain facility. New administrator.
Facility 3 – Kansas (high turnover) - 2 interviews – Administrator and Director of Nursing (*administrator would not permit interview of additional staff*). For profit chain facility.

Wisconsin (n = 31 interviews)
Facility 1 – Wisconsin (low turnover) - 7 interviews, all individual; *administrator did not keep initial appointment and HR director refused admission until administrator returned 3 days later.* For profit unionized chain facility. New administrator
Facility 2 – Wisconsin (high turnover) - 24 individuals plus one group of 8 CNAs For profit unionized chain facility. New administrator

Los Angeles (n = 29 interviews)
Facility 1 – Los Angeles Area (low turnover) - 20 interviews – Not for profit chain facility
Facility 2 – Los Angeles area (high turnover) - 9 interviews (*administrator refused return visit because of health officials in the building investigating a complaint)* For profit chain facility. New administrator

Rural California (n = 54 interviews)
Facility 1 – Rural California (low turnover) - 32 interviews – Community non-profit facility, affiliated with community hospital.
Facility 2 – Rural California (high turnover) - 22 interviews – Privately owned for profit facility.

Interviews ranged from 10 minutes to more than 90 minutes, with an average interview length of around 20 minutes for line staff, and 45 minutes for administrative staff. Most (approximately 75 percent) of the interviews were taped, except where interviewees declined to be tape-recorded. Written consent forms were obtained from each interviewee; all interviews were conducted under guidelines submitted to and approved by the Harvard University Human Subjects Research committee. After each site visit, the researcher wrote detailed field notes, transcribing interviews where appropriate, and completed a draft analysis. The researcher began the fieldwork on May 21, 2001, and completed it on July 28, 2001. The researcher drew from hundreds of pages of interview and observation notes to abstract information for this chapter.

5.2.5 Deliberate Variation in Turnover Patterns

The variation in turnover was by design significant within each "pair." In all cases the high turnover facility had at least 100 percent turnover in its certified nursing assistants (CNAs) in 1999. The low turnover facility in each pair frequently had less than 40 percent turnover in 1999. In most cases the low turnover facility administrator was conscious of having

unusually low turnover. In one case, a sizable portion of the management staff had been at the facility for more than 10 years. The administrator had been there 14 years and still felt himself relatively new. In another case, the top managers knew their facility had relatively low turnover, but were still troubled by their level of 30 percent or so, which is in fact high compared to the national average for all industries, which (excluding layoffs) hovers between 10 and 20 percent. This administrator was surprised to find that they were doing better in this regard than other facilities, and she asked for permission to report the visit by the researcher in her newsletter, since like many nursing facility managers, she rarely received positive feedback on her work and wanted people to know that the facility was doing 'something right.'

5.3 Findings

Many specific managerial practices differed characteristically between low-turnover (LT) and high-turnover (HT) facilities (LT and HT are used henceforward in this chapter). Overall, however, five areas stand out as distinguishing facilities with low nursing staff turnover. The five patterns found in this study to be associated with lower nursing turnover are:

- High quality leadership and management, offering recognition, meaning, and feedback as well as the opportunity to see one's work as valued and valuable; managers who built on the intrinsic motivation of workers in this field
- An organizational culture, communicated by managers, families, supervisors, and nurses themselves, of valuing and respecting the nursing caregivers themselves as well as residents
- Basic positive or 'high performance' Human Resource policies, including wages and benefits but also in the areas of 'soft' skills and flexibility, training and career ladders, scheduling, realistic job previews, etc.
- Thoughtful and effective, motivational work organization and care practices
- Adequate staffing ratios and support for giving high quality care

The next sections of the report expand on, explore, and explain these findings through making reasonable inferences from the data collected. Frequent use is made of examples and direct quotations from workers and managers interviewed during the field research. First, however, is a description of the typical high turnover facility versus the typical low turnover facility.

5.3.1 Typical High vs. Low Turnover Facility Profiles

In most cases, the low turnover facility visited was easily distinguishable as a better place to live and work—these facilities had less odor of urine and feces than high turnover facilities, in the most immediate impression upon entry. The researcher also typically noted residents

wearing fresh unstained clothing who were clean and well groomed, saw individuals demonstrating few behavioral problems that disturbed other residents, and observed few people wandering aimlessly or sitting lined up in wheelchairs by nurses' stations. Residents in low turnover facilities appeared attuned to particular staff members, calling them by name, and were also likely to speak to visitors in a way that made clear that they felt safe, not frightened, even when they were confused. This is not to say that the low turnover sites were on average better decorated or fancier facilities—in fact, one had such a plain waiting room that it could have been a bus station except it was far too small. Only one selected facility was religious in its ownership and mission, and the staff members there wore nametags that spoke of their mission to care for others in Christ's love. Most could not be distinguished by their furniture or formal decorations, but by the actual activities, level of interaction, comfort level of residents and visitors, and obvious presence of staff.

On the other hand, the high turnover facilities had a more desperate and chaotic air about them, no matter what time of day or night they were visited. Staff were rushing around (or difficult to find in empty corridors), residents were calling out, crying, and even screaming, call lights were typically buzzing, flashing, or ringing with no one appearing to pay attention, very few smiles were in evidence, and at times entire parts of the buildings seemed to be abandoned by staff. In these facilities, employee break rooms were gloomy, dark, and dingy (more than one with old furniture stacked, and stained falling ceiling tiles), dirty dishes were sitting in carts in the hallways, soiled linens were usually not covered, and odors ranged from the merely unpleasant to the almost unbearable.

Administrative knowledge of variations in nursing staff turnover was in general lacking. "Our turnover is not too high," said one administrator. "In one month, we lose 8 or 9." This was on a staff base of 90, putting the facility turnover rate at almost 120 percent per year if this was accurate. In the month of April 2001, for which the researcher reviewed the records in this facility, there were 6 quits and two terminations, both "for attitude problems." So the administrator's estimate seemed accurate. The quits were half labeled as "no call no show" and half as "found another job." The administrator at this high-turnover facility told the researcher that she would not *usually* hire back someone who had quit by being "no call no show" three times, but it depended how desperate she was. The researcher told another administrator that two years previously, the facility had 100 percent nursing turnover. She said, "I don't know! I don't think it is that high..." After reviewing the records, she agreed that it was at least 100 percent then, and still was.

The researcher found one exception to the pattern described above among the four low turnover facilities visited. The inner city nursing facility did not have a calm or positive interactive feeling about it. Rather, everything was threadbare (this was a corporate for profit facility), from the residents' clothes to the furniture. The facility was unwelcoming in general. There the administrator did not keep her confirmed appointment with the researcher, who had to call the HR director (supposedly left in charge) five times before she

agreed to be interviewed herself, but not to allow other interviews until the administrator returned several days later. (The administrator had been 'pulled' to another facility where problems threatened, but left no note or instructions for her subordinates in charge.) In this case, the investigator spoke eventually with a number of long-term employees, but learned they were long term because they felt resigned and not as if they had any other options—a kind of 'continuance commitment,' where they felt stuck rather than affirmatively deciding to stay (Meyer and Allen 1997). Some stayed because they had known other staff and the residents for a long time, and the facility staff had become their second family. Others stayed because some small perquisite of longer service (such as an additional week of vacation after 10 years) did help keep them tied to one workplace. But this was unusual; staff in other low turnover facilities stayed for more positive reasons of affection or loyalty, they told the researcher.

A parallel exception to the generally gloomy managerial outlook among the high turnover facilities was found where the administrator was new and had been in charge for less than 3 months, though she had worked as a social worker at the facility for more than 10 years previously. Because she was new in the job, she felt she could make changes, and the employees interviewed generally thought her changes were headed in the right direction. So this was a high turnover facility (in the past) where, if the proposed changes were successful, one would expect turnover rates to fall in future years.

In general, however, if a visitor walked blindfolded into the selected pair of facilities in each community and sat in the lobby or dining room for less than one hour, he or she could have accurately predicted which was the 'high turnover' (or less desirable) workplace, and which was the low turnover (or more desirable) workplace. For the most part, although this was not able to be confirmed by data analysis of reliable quality or clinical outcome information, the better workplace was also likely to have been a better place to live as a resident, in the researcher's view. Employees interviewed also agreed—sometimes employees explained that they had stayed in a job at a particular facility because "it is clean" or "they care about the residents here." Employees generally indicated they hated to work at a place where residents and employees are miserable. In one case of a high turnover facility where several residents appeared dirty and disheveled, with food stuck to their clothing, employees seemed to sincerely believe that ALL nursing facilities were like this one, and there was no difference between them. However, in the low turnover facilities, a significant number of employees reported that they had worked elsewhere in the long term care system in that community or others, and believed that the place they presently worked was a better place to work and to live. They could make distinctions that were rarely made by nursing staff in the higher turnover facilities, at least in this study.

The next section of the report provides more detail about the five key management practices associated with the low turnover facilities, compared with their absence in the high turnover facilities. The five practices can be summarized as: high quality leadership and management,

valuing and respecting the caregivers themselves. basic positive HR policies, motivational work organization and care practices, and adequate staffing ratios and support for high quality care.

5.3.2 Five Key Positive Management Practices Associated with Low Turnover

The five key positive management practices found in this study to be associated with low turnover were:

(1) High quality leadership and management, offering recognition, meaning, and feedback as well as the opportunity to see one's work as valued and valuable;
(2) A culture of valuing and respecting the caregivers themselves as well as residents
(3) Basic high performance HR policies, including wages and benefits but also in the areas of 'soft' skills and flexibility, scheduling, realistic job previews, etc.
(4) Thoughtful and effective, motivational work organization and care practices
(5) Adequate staffing ratios and support for giving high quality care

First, low-turnover facilities had a significantly higher quality of leadership found in management ranks, especially administrators, directors of nursing, and either staff developers or charge nurses. In the low turnover (LT) facilities, frequently the administrators had been in place for a long time and were well known and well respected across classes of workers. In high turnover (HT) facilities, a revolving door of leadership was evident, including either directors of nursing (DONs) or administrators (NHAs) or both. Often these leaders in both settings promoted distinct 'cultures of care,' sometimes with an innovative bent.[4] In homes where previous turnover statistics were high, in two cases, new administrators had been hired who were taking actively different stances toward the work, care, and patients than their predecessors. In these facilities, a very cautious attitude of optimism about improvements was tangible. Also, leadership style seemed to 'cascade' down to managers, and supervisors. One high-turnover administrator, for instance, was unable to get her charge nurses to agree to act as supervisors even though they were legally and technically the CNAs' supervisors. This was a mystery to the administrator, who threw up her hands. Something about the particular size and management structure typical of nursing facilities seemed to make them very vulnerable to poor leadership in the top one or two positions, but also very responsive to strong leadership in those same roles (though it seemed to be faster and easier for a good facility to turn into a marginal one than vice versa, at least according to the managers and workers interviewed here).

Second, a culture of valuing and respecting caregivers, and the realities of their lives, was dominant in the low-turnover facilities. This emerged in several ways, such as bulletin

[4] Note that the concept of a management 'philosophy of care' was developed in the researcher's earlier writings referenced earlier, while 'culture of care' is a term used in the Pioneer Network and other circles where innovative leadership and management cultures at nursing facilities have been encouraged and shared.

boards recognizing long service (one had 5, 10, 15, 20 and 25 years, with photos of the staff, their names, and also a list of the 4-year staff who were just about to achieve service of five years). This same facility had a bulletin board with photos of new staff, and also posted an information sheet each one had filled out, about his or her background, family information, and things he or she wanted others to know about him or her. Clearly being a worker in this facility was to 'be somebody.' It was interesting that new residents also had a bulletin board with photos and descriptions in that facility. In contrast, in a high turnover facility, the administrator said she would "*never hire a CNA with a resume—that person is a 'wannabe' who will cause trouble on the floors. They think they are MORE than a CNA.*" The same administrator said, in speaking of CNAs' concern about contracting AIDS from patients, "*I do not tolerate stupidity very well.*"

This culture of respect extended to the needs on the job (whether supplies, assistance, etc.) as well as off the job (flexible scheduling, emergency loans, etc.) When aides needed to change their schedules in one facility, an administrator said, "*I let them. I am willing to pay the overtime to someone else. We don't fuss about the overtime. It's more important that they be able to take care of their families and themselves.*" Hardly anyone had left the staff in the last year because they were unhappy with the job. In general, relationships were valued in the low-turnover nursing facilities –between workers themselves, between residents, between workers and residents, and with families. This quality was noticeably absent in the high-turnover facilities.

Third, low turnover facilities applied a variety of basic positive or 'high performance' human resource (HR) policies, including those related to wages, benefits, and total compensation but also in the areas of 'soft' skills and flexibility, training and career ladders, scheduling, realistic job previews, etc. (Appelbaum and Batt 1994). This chapter describes compensation issues first, and then highlights other policies that were less costly to implement but seemed to have a larger effect on workers' lives. Some classic HR principles having to do with attracting, selecting, and retaining workers were seldom followed in the high-turnover facilities. Further, workers were rarely given a realistic job preview or an adequate orientation. This increased early turnover. Even where some workers stayed longer, a sudden and apparently arbitrary change could upset them and cause them to leave.

Fourth, a set of "care practices" related to the motivational organization of work and effective care giving clearly made some of these nursing facilities better places to work than others (and also, probably made them better places to live, although this study was not designed to measure that outcome). These included consistent assignments between residents and aides, sufficient staffing, careful attention to emotional and religious passages in life, organizing eating and bathing in ways that rarely caused conflict and distress for residents or caregivers alike, involvement of aides in care planning meetings (though this was rare), or at least seeking their input into the decisions about care for residents they know well, and celebrations. In general these practices were more likely to be linked to decentralized

decision making and an absence of arbitrary changes without involvement or explanation of nursing staff.

Finally, a critical variable was having a sufficient staffing ratio, and other practices that encouraged high quality care. While managers often complained that there would never be felt to be enough staff, objectively different staffing ratios existed in high turnover and low turnover facilities. In the workplaces where people stayed longer over time, aides had 5, 6, or 7 residents to care for on a typical day shift; in the high turnover facilities, their assignments were more typically 8, 9, 10, or even 12. When someone called in, especially on evenings or nights, aides studied in these brief visits had 20 or even 30 residents to care for. This did not only extend to CNAs. The licensed nursing staff also found themselves short. In one high turnover facility, the RNs worked 14 hour shifts one day and several came in the next to do another 12 hours, because no one else was available to work. One director of nursing in a high turnover site had quit her facility after working as the only RN in the facility for 17 months. She had been on call 24 hours a day and 7 days a week for nearly a year and a half, as every facility is required to have an RN on call at all times. Only after getting a written agreement to hire two other RNs, both assistant DONs, had she returned to the (still high turnover) chain-owned facility. Not surprisingly, other staff in that facility also reported being short-staffed.

Both for paraprofessional and licensed staff, the issue of having enough staff was described as basic. The most common answer to the researcher's question, 'what would make people stay in nursing?' was "more money, more staff." Or even more often, the researcher heard: "more staff, more money." Not having enough staff on payroll and on daily work shifts turned in these cases into a circular problem—with fewer staff, the ones who were there worked harder and more quickly burned out; they may have experienced more injuries because there was no one to help them lift heavy patients; and they also described that they felt more entitled to call in themselves the next time they didn't feel well or had a personal emergency. Eventually people described that they usually left this kind of situation where they were always working short, and could never predict who they would be taking care of next, and then the shortages had intensified. In lower-turnover facilities, the researcher noted that longer-term relationships and a personal history between nursing staff members existed, so they were more willing to cover for each other, to come in and work on someone else's scheduled day, or to trade off, in part because they knew that person would still be around to trade with them when they needed a favor in exchange. Sociologists or political scientists might call this 'social capital,' but nursing home workers called it common sense.

5.3.3 Support for the Findings: Inferences from the Field Data

The next sections of the report expand on and exemplify the findings through making reasonable inferences from the data collected in the nursing facilities. Frequent use is made

of actual examples and quotations from workers and managers interviewed during the field research. Actual quotes from workers or managers are italicized for clarity.

High Quality Leadership and Management

Snapshot of leadership in a high turnover home: "*Apparently the previous administrator didn't speak to people. He just walked around the building and didn't speak to people, even the department heads.*" What happened to him? "*He was promoted, to the corporate office, to be president of a division.*" - *Administrator*

Snapshot of leadership in a low-turnover home: "*The staff will be a mirror of the supervisors. If the supervisors treat the staff with dignity and respect, and hold them accountable, that empowers people.*" - *Administrator*

Strong positive leadership was the first necessity for a high-quality, strong-culture, low-turnover nursing facility, in the observations gathered here. No one person can turn a place around or make or break a place alone, but that person can be the spearhead of a team, and can gather good people around and hold them accountable. In typical nursing facilities, there are no more than one or two key leadership positions, in most cases, though other key roles are also important. The administrator and director of nursing are the two major people to whom most staff look for leadership, both by example and by conscious management tactics. In rare cases, a human resources director or a staff development person or a key long-term nursing employee can also be a crucial "link" in a chain of culture and practice that serves to attract and retain employees.

The elements of leadership and management found to be most crucial in this research can be summarized as mission and culture, setting priorities and developing trust, accountability and standards, communication, commitment, and providing leadership at all levels, including supervisory.

Mission and culture

In previous work the investigator identified a factor called "philosophy of management" as a crucial factor in yielding high quality outcomes in nursing facilities. In looking for concrete manifestations of such a philosophy of management in the high-turnover and low-turnover homes, a logical place to start was with the mission statement, or the goals of the organization if not a formal 'mission.' In each facility, top managers were asked about the mission of their facility, and how it was reflected in practice, if it was. In one low-turnover facility, not only the administrator but the Director of Nursing, the staff development director, and the human resource director actually brought their mission up before they were asked about it. The administrator said,

"Our mission is to be Christ-centered, community-centered, resident centered and staff centered. We do daily devotions and church services on Sunday. There is a "STAR" program-- for Steps Along the Road (like the Good Samaritan)-- for staff. We have a part-time chaplain, who conducts stand up devotions, short ones, on the floor, for staff or residents. We start all meetings with devotions and prayer, and morning report, and committee meetings. We look at the residents and families as a whole, and pray with them, talk with them, spend time with them, talk about Christ, talk about difficult times."

While not everyone would feel comfortable in such a religious environment, it was clear that the religious mission imbued the caring work of the facility. The Director of Nursing said in a separate interview, *"Our mission is to provide services for the elderly, to minister holistically, spiritually, medically, socially, everything. I hope this is carried into the practice here. We have a saying, "In Christ's love, everyone is someone," and that is especially true for CNAs. I believe it."* Closer to the front lines, staff stated the mission more simply, as for example, *"Our mission is to share God's love, in word and deed by providing care..."* Most staff wore nametags that included a summary of the facility's mission, including the phrase, 'In Christ's love, everyone is someone.'

I asked about hiring practices and their relationship to the mission. The HR director said, *"We talk about the mission a lot in interviews. We are limited in what we can ask, but we let them know we expect them to act in a Christian way, with a lot of respect. And of course we try to act in that way toward them. If we act that way toward the staff they will act that way toward the residents.* When staff were asked about whether the religious environment made them uncomfortable, no one said it did. One said, "I'm a Catholic and I believe in the same thing, just not the same church." Another less religious nurse said in response to the question of her comfort level, *"This is the best place I have worked. It is clean, they treat people decently, they are more concerned about the residents. I quit a job at Facility X, where the administration did not treat the residents well. I couldn't take it. Here I feel I can live up to my standards."*

In contrast, in a high-turnover facility, neither the administrator nor director of nursing had a response for the question about their facility's mission or goals. The administrator eventually found a formal mission statement after 15 minutes of searching in a file drawer. The mission statement spoke of delivering "high quality cost effective care in a cost effective manner." Employees interviewed in this facility had a sense of the importance of cost issues, but not as much of what 'high quality' meant. So in part the mission statement was implemented in the facility's day-to-day operation, but it did not appear to guide employees in any sense of a goal greater than themselves. This is not to say the people there did not care about residents, simply that they did not have a common way to talk about their work together, or as larger than themselves.

Another way that facility mission or culture was expressed was in how the leaders handle difficult or emotional moments, particularly deaths in the facility. In this area, culture in some facilities was being changed to honor the person who has died. In a traditional facility, very often death was either covered over (sometimes a body is literally hidden in a special kind of stretcher and rolled out to an ambulance while everyone's doors are closed), or spoken of only in hushed tones as word goes around. In contrast, in one low-turnover facility, the director said, "*We also do bedside memorials, a service then and there when someone dies. The family can participate. If someone dies at 2 am, very often people need to have a service at that time. It provides a nice closing for staff. Of course we also have a monthly service for those who have passea away. But if someone dies at 2 am, it is more traumatic. The nurses can conduct them. Different people can. I will do it as the administrator, if I am there.*" These small things made a big difference to employees. One of the hardest things about working in a nursing facility was the death of your patients or residents, people for whom you have cared and with whom you have had a relationship. To have that person's life honored, and your part in it recognized and valued, was a healing process, according to staff interviewed in this study.

Sometimes administrative staff and managers themselves have gone through a personal experience or transformation that led them to take on this kind of job. This often helps them communicate with others and convey a sense of mission and importance of the work. One director said, "*I had some experiences that changed my philosophy. I was truly honestly committed to making a difference in the community and my life, and I thought I would, here. We know who we serve from the resident standpoint, and we know the staff, and we work with the community, all the families. No one wants to be in a nursing home, so there is a sense of the underdog in it too.*"

Culture communicates itself to residents and family members too, and can help attract or repel staff. One RN who had become the staff developer said of her low-turnover facility, "*I came here six years ago, because her grandmother was a resident and was dying. I was impressed with the compassion. At the time I worked for a for-profit. I thought I could make a difference. Here it is focused less on making money, and not the same goals.*"

Setting Priorities, Developing Trust

One administrator, who is new to a bad situation, describes his approach as one of management by being a member of the staff. "*I spend as much time as I can on the floors. I am a soldier, not a general... We should spend our money on more money for staff, not on agency or corporate offices or furnishings.*" Every day decisions are made in nursing facilities that reveal the priorities of the leader more loudly than anything he or she says. Building trustful relationships is a challenge in any organization, but particularly in nursing facilities with poor histories, and with employees who have little positive experience with bosses or supervisors. One administrator described a turnaround setting where gaining staff trust (and community trust) was essential to his success.

"In New Mexico I went from 20 deficiencies to zero deficiencies in 1.5 years, and kept it for two consecutive years. That was 80 beds, so there was more time. The.New Mexico facility, if you were white, you were not trusted. It was a poor community. They had $10,000 in the bank, one private pay patient, 1 Medicare patient and all the rest Medicaid. I had to buy the community back in. I told the staff my plan. I wanted them to help out on indirect costs. I put the ball in their court. They had to be satisfied as well as the facility. When I left, the bank account was up to $750,000. The staff trusts you (or not). You can accomplish anything you want if the staff trust you."

Accountability and Standards

Strong leaders emphasized that their job was to create accountability as well as to empower staff. They did not try to be liked by everyone, although good ones often were. One administrator recalled his arrival in a facility: *"I wanted to 'listen to the staff.' This staff takes pride in the facility. So many staff are 'bleacher people,' they sit in the stands and point, but do not change themselves. They are not accountable on attendance or anything. The first month I came here, I took a beating. I required and enforced attendance. But you have to get it."*

Good managers hold staff accountable, but do not give up on them when they err. *"The staff is more devoted to the residents. Human beings make mistakes. We have to be proactive, and focus on correcting them. Punitive practices don't work. They will not change people and they will drive people out of the industry. Good people are driven out because they can do a lot of other things."* This director of nursing was able to keep people and still keep standards high.

Another administrator in a low turnover home was very realistic, but uncompromising on standards of care. She also saw the link between care standards and retention. *"You have good aides. And bad aides. You have to hold people accountable to get a stable staff. You have to hold to standards, or the good people take on extra. You have to make that clear. I changed the Director of Nursing here. I hold them to the right thing. I want everyone brought up to standards. We have to decide what our standards are. The state's are only a minimum."*

CNAs were troubled by poor care given by other staff, and they held managers accountable. *"I enjoy being a CNA. I just want people to be... to give them the full benefit. This is what I want. If it changed I would stay permanently. I will be looking at another facility pretty soon."* Where does the responsibility lie? *"I don't know. The bosses, or the coordinators here. The AM shift is just leaving them for the PM shift. The first shift should... they should be taken care of. When that happens, you have a lot of work to do, even with 10 residents. The boss or owner needs to get on top of these people!"*

Poor quality care is not hard to observe, even for a non-expert. In one high-turnover facility on the evening shift, the researcher observed care for one hour on the evening shift, sitting near a nurses' station in a public area, and describes here only one example of a person whose care was clearly not adequate. If the administrator, manager, or director of nurses were on the floors regularly, it seemed that someone should have noticed this individual. Even a charge nurse presumably could have been responsible to take care of several of these issues. These concerns had not arisen in one shift or one day, but over a good deal of time. The researcher's field notes follow: "*Observed a woman in early stages of dementia, dressed in stained and soiled shirt with food spilled on it (but not recently, it was long dried and in several layers). Her fingernails had not been cut in several months and were extremely long and dirty. Her teeth were unbrushed and she had numerous 2-inch whiskers sprouting from her chin.*" While these are only external grooming observations, they do not lead to confidence in the quality of clinical care. In this case, as in most cases of poor care, the researcher would identify not only a failure of nursing staff, but also of leadership and management.

Communication

Regular communication across shifts and units is a sign of a stronger and more communicative culture, where staff members feel they do matter to the leaders of the organization. Good managers try to learn what their staff members are feeling, especially front-line staff. That means talking to them, walking the floors, helping them, and using tools like surveys. They know that pride in the job is crucial to getting a good job done. "*We did a survey, and asked people if they were proud of being a CNA. One-third said they were proud of it, and two-thirds said they were NOT proud. That is a problem! People work here because of their hearts...*" He learned that he had to do more to help people feel proud of the work they did, and instituted a recognition program after the survey.

It's hard to explain how isolating working a nursing facility can be, especially for those on non-daytime shifts. Even for day shift workers, if administrators or nursing directors are mostly in their offices, most staff rarely see them. In contrast, one administrator explained, "*I met with each staff member when I first came here, for fifteen minutes each. I wanted to get to know each individual. I asked them all if there were one thing they could change, what would it be. I talked to all of them.*" Then he held a meeting and explained how he was going to act on the suggestions he had received. In contrast, in a high-turnover home where three nursing staff on the 11 to 7 shift were interviewed, two of them had never met the administrator or the director of nursing, despite at least a year of service.

Often problems in nursing facilities arise because of a lack of communication between shifts or units. This is particular true when changes are made. For example, one long-term aide in a high turnover facility had just quit because the shift hours were changed by 45 minutes in the am and the division of duties between overnight and day shifts on the 'get ups' was not well handled. They were expected to do the same work with 45 minutes less, but could still

not start getting people up before 5 AM, which was the same time they started before. This issue could probably have been worked out with an effective problem resolution process or better communication between supervisors or shift managers, and a long-term employee would have been retained.

Consistence and communication are linked. In one facility, the scheduler and HR persons both explained that they had a system for giving out pay increases and assignments that was viewed as very consistent by staff, because of a union contract. In the two unionized facilities, at least some regular communication between workers and managers was scheduled to happen. While having a union could contribute to lower turnover (and does on average), this was one case where a concrete practice existed due to unionization that increased employees' sense of fairness.

Commitment and Longevity

One way that managers and leaders develop and express their commitment is by staying in the work of nursing care. At one low turnover facility, the 10 department heads had a total of 147 years of service, or on average almost 15 years' each. At another, the administrator with 14 years' experience was one of the more recent arrivals on the senior staff, the most senior of whom had been working the facility nearly 35 years. This was very different from high turnover places, where in three of the four facilities visited, the administrator had been in place less than six months, and very often other leadership staff had changed frequently as well. Longevity was no guarantee of good quality in a manager, of course, but there was a striking difference in short and long-term career patterns. The one exception was that in one non-profit chain, administrators were consciously moved from smaller to larger facilities as they learned their jobs, and were felt to be able to handle larger responsibilities. So a newer-service administrator was interviewed in a low-turnover facility, in that case and for that reason.

Managers did not always have to have long service to be good at making necessary change. Sometimes a non-traditional background was useful. One administrator of a high-turnover facility, on the job for only 90 days, had worked for five companies and the Catholic Church in the last seven years, and had parted ways with all of them. He might have been another short-termer, by most odds. But he had a chance of succeeding, perhaps because he knew what did not work. Another administrator with long service had started his work life as a drama student waiting tables, and one of his customers turned out to be a nursing facility owner. He had recruited him fifteen years earlier and trained him as an administrator. This person also had unorthodox views about nursing care and staff management, but they were working well in the facility he was administering.

Commitment was another value that emanated from the top down. On administrator explained the value of staff stability to good care and to building a strong culture. He challenged everyone to make a serious commitment to stay with the facility and reorganize

the care systems. "*If there is a contained neighborhood with 20 residents, the staff is stable, they know their needs. I told them in my meetings with them, managers as well, to "commit or quit." If they can't commit, I can understand that, but they need to move on. We need to change for the better. Best of luck, but you have to quit or buy in.*"

Leadership at All Levels

The change process was not easy, and many nursing facilities required dramatic changes to improve their performance. New administrators and DONs came to good and poor quality homes all the time, and had to take on the challenge of making positive change. That might have meant that some people were required to leave, but it also meant that others must have had a reason to stay, and learned to feel good about the work they were doing. One example of a manager showing commitment to staff well being was the administrator quoted below who, as part of a turnaround, worked on improving safety for staff and for residents. Even for such a positive goal, not everyone approved. But in the end it appeared to have worked, he said, because he demonstrated positive concern for the workers and residents through his investment in the tools they needed to do the job safely.

> *I had to look at who we were hiring. What were we getting for applications? The staff had lots of problems in life, and this was consistent.... We created our own turnover. We took back the NA training, and we needed to build up the staff internally... We made it worker friendly as far as safety. It was the first long term care facility to be a total lift-free environment. I was spending $500,000 a year on workers' comp. I got a safety specialist in once a week. I got 17 lifts, state of the art. I integrated them with scales and bathing. The staff hated it at first. I had tough aides, who would not buy in. By the end my workers' comp was down to $17,000, and the aides would take people on tours of the facility, people like you who came. They were my strongest supporters. You have to create pride...*

Managers also had to allow room for innovation and creativity. One LPN explained, "*I wear bunny ears to work on Easter and the residents love it. This year I didn't wear my bunny tail because we have a new DON and I didn't know how it would go over—but I always wear bright clothes when I can [on casual Fridays], because the residents look forward to my sparkles and t-shirts.*" One resident said, voluntarily and out of the hearing of this nurse, "*She lifts up my spirits whenever I see her!*" Yet even a new nursing director's presence had meant that she was less free and more worried about being her true "self," even though she knew residents liked this.

The Supervisory Level: What Makes a Good Supervisor?

> *"Nurses were not meant to be supervisors. They are always saying, I didn't go to school for that."* -- Administrator in a high-turnover facility
>
> *"I try to get the licensed people to do write ups but they won't. Why not give it to the CNAs? The licensed nurses aren't really supervisors. At the first [meeting I held), the CNAs and Housekeeping were saying, "We don't have any supervisors." This one, who is really outspoken and mouthy, she said it. And they all agreed. I told the licensed nurses, this is really sad. They are begging for you to be their supervisors."*—Administrator in a high turnover facility
>
> *"I am not a shouter. I get pissed, when the charge nurses do certain stupid things. I'm lucky if they are passing meds right. How can they be supervisors? They are getting younger and younger, and they party with the CNAs, and expect they can be friends. The next day they tell them to do something, and they won't do a thing. I tell them not to do that. They have to be respected..."* –Administrator in a high-turnover facility
>
> *"I try to keep good CNAs."* How? *"By compliments and positive encouragement, not talking down to them. I make them feel important. I make them feel what they do is valuable. I say thank you at the end of the day, when I do rounds at 10 pm. I'll say, the unit looks nice, I've noticed."* Have you noticed changes in the CNAs? *"They want to do better. I try to say to them, 'You know, when you were off yesterday, so and so didn't look as nice.' It makes a big difference to them... It's even at the professional level. When [the Administrator] comes down, and says 'Thank you.' It's not all the time, but the recognition..."* – Charge nurse RN in a low-turnover unit in a high-turnover facility

One nursing assistant in a high turnover facility spoke of the problems it caused her when a supervisor did not do her or his job with other CNAs. *"We could use some better employers."* What makes a good employer, or good supervisor, she was asked. *"Abide by the rules, and be stern. Make sure people do their jobs. Put your foot down sometimes. They have authority, but they don't use it..."* Why is it a problem for you as a CNA if the supervisors don't do their jobs, the researcher asked. *"When other people call in, that's a problem. Some people come and go, sometimes because the supervisors don't know how to talk to people—as if they are not human, as if we don't mean anything. Sometimes they can't take the shame of that."* She explained that if someone else did a poor job with a resident she was caring for, then she had to deal with the bad effects on the resident when she returned for her shift. The resident, in a dementia unit, was angry and stubborn, she said, if someone had been mean to the person. *"They may not know how to communicate, but they*

know when someone is treating them badly. And then it takes me all shift to get them calm again."

In another high-turnover facility many miles away, an aide on the evening shift said almost the same thing about the need for managers to uphold standards for all employees.

"It's a pretty good facility, but they should pay a little more attention. It would help out a lot. Especially when you ask for help, and you do not get help. I don't think I will be here too long. You need to have support. It's really stressful... I like being a CNA That's what I'm here for, to help people, to help these older people. Not to see them not getting their needs, what they need. If they are soaking wet and dirty all the time, it's frustrating." (Emphasis indicates spoken intensity)

This problem was found in this study to be endemic to nursing facilities. Nearly everyone agrees that, *"Nurses are not taught to be supervisors. They take their boards and they go on the floors. You learn, over time, like I have, supervisor skills. But they are not taught them."* Add in the complex dynamics of age, race, and class (often nurses are younger, most often white and native-born or Filipino, and nearly always have more formal education than those they are supervising, but may have much less actual experience in nursing or taking care of disabled or elderly people), and you have a potential disaster that is already happening in most US nursing facilities. Most CNAs have little respect for their supervisors and most supervisors little respect for their CNAs. One administrator was quoted above as calling some CNAs "wannabes, who think they are MORE than a CNA" Even people who have been CNAs don't always respect the workers. Where there are exceptions, they are relatively rare, at least in this study.

Another aide explained what made a good supervisor. *"We have a good nurse,"* she said of her current charge nurse. What makes a good nurse? *"If they are open and can talk to you, give you compliments when they are due."* Note that the aides do not want 'empty' compliments, or else they feel it is insincere or their work is not really being noticed. *"Don't get me wrong,"* says one CNA in a group, the voice of realism with four years' experience at the facility *"Some of them really have attitudes." "Yes, they treat you as if they are a whole lot better than you because you are ONLY an AIDE,"* says another person, and they all agree. *"Everybody is different," says the first CNA "Some don't want to be there either. Some of them are lazy too."*

One aide answered, when asked, how could the job be better? *"They could help by just hiring good people. I had to work with some really bad people at the beginning. I walked off the floor crying, because of how I was treated by them ... the first floor has good teamwork now. We help each other, we eat together, and we go back and forth together."* Another new CNA described a good nurse supervisor as *"when they are our support, and they understand what we're going through and our frustration, and they show us how to treat the patients and*

how to do things the right way. I would stay longer if the employer has more CNAs to help out and more communication and support for me. We need help dealing with these challenges."

The most common answer about what makes a good supervisor on the units was a willingness to share the work, including a willingness to get one's hands dirty. On DON said, " *They are good if they are very involved with resident direct care. They need teaching and reinforcement. They have to be able to show the aides the right way. They have to be able to make the aide feel a partner, whose opinion is valued. Nurses also like the patient contact. 95percent like one unit as opposed to moving around, but I move them around.*" Another administrator, newly hired at a high-turnover facility, said, *"I tell the staff, I spend more time with you than with my own family. I will respect you and in return I demand respect. If I can pick up a wad of poop off the floor, you can too. If I see it, I'm not going to call for someone else to come get it. And, I will reprimand you behind closed doors. I will treat you the way I want to be treated, and I expect the same.*" This was in contrast to supervisors who dressed employees down in front of others, and embarrassed or shamed them, sometimes to the point where they would leave and never return.

The second most common agreement about what made a good supervisor was that the good nurses had faith in the CNAs. This was a contrast to the many places where nurses complained of constantly looking over the shoulders of or going 'behind' CNAs to remind them of their duties. One aide said, *"The charge nurses on this floor are really good. She talks to us at our level. She does not try to be the heavy boss. She listens to us. We respect her and she respects us. She believes in us, she knows that we're OK.*"

In general, managers at high and low turnover facilities agreed about the dire need for management and leadership training for their charge nurses and LPN supervisors. One administrator said, *"I would like to have an RN working with the charge nurses. The LPNs have different training. They want a lot of direction. Their problem solving skills are an issue. They make good assessments, but want to check in. They don't want the responsibility for a decision. They don't have the managerial skills of the nurses; they don't get the training they need. There is a great need. A couple have been in management positions."* This was a universal concern among the interviewees for this study.

One Person Can Make a Difference

Good supervisors in this study actually thought carefully about how to retain their staff. They could do this even in a generally unfriendly environment. In one high-turnover facility, the researcher stumbled on a low-turnover unit, a middle-stage dementia unit where the staff had all been there for more than one year, and many for longer. The reason? There was one key charge nurse, who described herself as someone who believed "*all people are equally valuable, we just have different jobs to do.*" The staff who worked with her had her home phone number and were welcome to call her if there was a problem. They always phoned her

if they had to be out, and made arrangements to be covered, avoiding the general facility scheduling system, which had been described as a 'nightmare' to the researcher. They felt committed to her and to the residents on the unit. How did she do it? She is the nurse last quoted in the text box at the beginning of this section.

Summary

In summary, good leadership and management were found to be essential to apparently well-functioning, demonstrably low-turnover facilities in this study. While there is no single quality that defined a good leader or manager, someone with a strong vision or mission and sense of goal, someone who set standards and kept others accountable, someone who listened to others and spent time on the floors, someone who valued the contributions and work of others but also demanded commitment and high performance, and someone who tried to create a chain of positive supervision all the way to the front lines, as well as being open to new and non-traditional ideas, seemed to be someone who would have a good chance of succeeding in developing a low-turnover facility.

5.4 Valuing and Respecting Caregivers and Their Needs

Valuing and respecting caregivers and understanding and responding to their needs was the second quality found in this study in every low-turnover facility. This second finding was linked to the first. Good leaders and managers were certain to value and respect the nursing staff, especially the direct caregivers, and their needs. This became obvious in certain clear contrasts between high and low-turnover facilities.

5.4.1 Recognition

"I ask them why they are interested in the job. If they say 'the pay,' I am not so interested, because I've done that job and I know you're not paid what you're worth. It's a grunt job. If that's your reason, you won't last." -- HR director, *high turnover facility*

"We recognize years of service, 1, 3, 5, 10, 15, and 20. I hand out free lunch tickets, or get pizza or donuts from the nurses, to say thank you. In June we will have a luncheon for National Nurses' Aides Week. But I think they should do more. At two weeks, on a payday you should get something, at four weeks, something else, at 120 days, a T- shirt. But they should do more. Now at one year you get a pin. But that's not enough. It could be a different person each time, giving it to you. At six months you could get earrings-- the women are easier than the guys. But you could get popcorn and a movie pass. Little incentives, appreciation."—HR director, low turnover facility

Outside the Director of Nursing's office there is a display cabinet, the [Facility Name] Hall of Fame. It has names of all workers who have been working there more than four years. The names are written in large black ink letters on colored construction paper and grouped by seniority-- with different colors representing different departments. The first group is from five to ten years (those with more than four years are listed in the lower left hand corner, to be added in the next year)... and there are 23 employees listed, all but five in nursing. Then there is 10 to 15 years and there are 10 employees listed, and 15 to 20 years, where there are 17 listed, most in nursing in all these categories. In over 20 years there are 6 people, 3 from 20 to 25, 1 from 25 to 30, 1 from 30 to 35, and 1 from 35 to 40! "We proudly honor our long term employees," is the statement at the top of the display.

--Field notes from researcher at low turnover Facility in Kansas

In addition, in this facility was found a wall display with new staff and new residents. The new staff bulletin board had Polaroid photos of five employees, each attached to a "welcome" sheet where they have filled out their name and where they are from, as well as something they want others to know about them. One person had written, "I am married to the most wonderful woman in the world... tell her I said so" and another "I like soccer and reading." The resident bulletin board has longer two page typed introductions, along with photos of the residents. It was a simple thing, but it was not evident in any other facility visited for this study. Another feature of this facility were posters of art by children of employees, often portraying an elder person that they know. The researcher later realized this is part of a planned activity that involves staff as well as residents. Some of the pictures are quite powerful, both in color and in whom they portray, such as people in wheelchairs... the residents' paintings tended to be landscapes.

Besides all this, the HR director explained, "*I have a staff appreciation and retention committee, which is not about recruitment, but has workers from each department. They do special things, small things. On Easter, they had drawings, and candy, and if you had a certain number in your candy basket, you won a price. We spent money two years on a Christmas party and prizes. For nursing home week, we had games, and roulette. We do share it with the safety committee.*"

These examples, as well as others cited throughout the study, seemed to speak for themselves about the power of positive recognition and feedback of people's work. In the high-turnover facilities, there was a sense of anonymity about the staff, who seemed to come and go both daily and at longer intervals, very quickly. At the facility described above, staff recognition was almost over-determined—new staff were recognized, senior staff were recognized, staff children were recognized, and this was all evident just on a few walls. It is not surprising to find that the managers of this facility thought consciously about the value of the workers and residents, and how to express that in multiple visible ways. But it was a rare thing to see it so openly acknowledged.

5.4.2 Scheduling

Schedules, as much as any other single item in a nurse or aide's life besides her assignment, determined what her life will be like, both at and outside of work. One of the biggest areas of contention, and a problem area for attendance and for continuous employment, were problems related to scheduling and showing up at mutually agreeable times. Clearly one problem was that this work is required to be done 24 hours a day, 7 days a week, 365 days a year. No matter what was going on in anyone's life, the nursing facility had to be staffed and someone had to be in charge. Failures to meet management expectations of showing up every single day as scheduled were probably the most common reason for nursing staff discharge, rather than a failure to do the work well.

Yet despite how vital this was everywhere, the researcher found quite distinct practices in high and low-turnover facilities. In some places the scheduling was almost random, or delegated to a receptionist, as if it were just a matter of placing people's names on a piece of paper. Yet, scheduling was anything but this. Unions had spent many days negotiating scheduling issues in nursing facility negotiations. There were questions of holidays, vacations, overtime, regular work days, patterns of work days, notice of schedule changes by the employer and the employees, weekends (or weekends off, that rare commodity available mainly to a few managers), and many more. Where no union existed, these things were decided by a variety of people and frequently changed.

In the facilities with low turnover, scheduling was usually resolved in some way that most people felt to be satisfactory, with sufficient notice, and patterns, so that people could rely on it. But even there, problems arose because of the circumstances of nursing facility employees' lives—inconvenient school holidays, sick children, immigration or legal problems, and many other issues. In the high-turnover facilities, schedules were more likely to be seen by everyone as chaotic, a place where you had to get your own as best you could, in a world of dog-eat-dog.

Nursing facility organizational research literature has suggested that self-scheduling is the preferred way to resolve scheduling for CNAs. The most common way in practice, as observed here, was to give the job to one individual, who then became the most harassed and at the same time the most powerful person in the facility. All the high-turnover facilities had a full-time scheduler to take care of this huge area of responsibility. Imagine what happened when the scheduler scheduled herself off! Following are some examples of contrasting scheduling experiences in high and low-turnover facilities:

The Inflexible schedule: "*This is my set schedule that you need to work,*" said one DON, "*because there are days that nobody wants to work. Every other weekend, everyone would like to have that. If once posted they need a day off, they have to find their own replacement,*

put it in writing, and sign it, so they can be accountable... I try to post it at least a week ahead." DON in a high turnover facility

The Flexible Schedule: *"We try to be flexible with people's schedules. If they need time off, for a doctor's appointment, or a sick child, and someone else wants to work it, we don't kick about the overtime. It all works out, and it's more important for them to be able to take care of things in their lives."* -- Administrator in a low turnover facility

Complexity and Ambiguity: *"I think they should be careful, about being too strict on absenteeism. These are single mothers with three children, middle aged, and single. They try to be there, but you have to sometimes cut days away. They have this attitude here; your personal life is not my problem. You being here is my problem. Well, for 75percent that may be true, but with some people, you have to be flexible enough and do the best you can without lowering expectations. With all the break-up of the home out there, the workplace should feel secure. You should not be anxious that you are going to get the cold shoulder if you call in."* – HR director in a low turnover facility.

Favoritism: *"She (the charge nurse) likes K---, because she worked with her at another facility. Now K--- says she is pregnant and can't do any lifting. There IS no light duty here. I used to work when I was pregnant too, until I was eight months pregnant. I used to do doubles all the time. Now I don't volunteer to do it, since she started her attitude. She ain't going to give us no more Saturdays and Sundays. The kids go to school Monday through Saturday, so weekends are the main time to spend with them. I requested July 4 off one and a half months ahead, and she didn't give it to me."* - CNA in a high turnover facility

So the first issue about schedules was whether they were rigid or flexible. If they were flexible it did not mean there was no schedule, just that people's complex personal issues could be addressed without a huge problem in most cases. The flexibly scheduled facilities had the least absenteeism and turnover, as reported by managers. The rigidly scheduled ones all had difficulty with this, and tended to become more rigid in response. A second issue about scheduling was how absences were handled, whether planned or unplanned. Most facilities in this study had stopped using agency staff, because they found them both to be more expensive and less reliable than was acceptable. "Even the agency staff call in," lamented one DON. And one administrator said, "We spent $80,000 on agency staff last year. It was bankrupting us." But without agency costs, the facility must spend some of that money on overtime to fill in empty slots, or else go continually short staffed (see below). As one administrator above said, he allowed overtime and this gave him the flexibility he needed. In other cases where no overtime could be incurred, the schedule continued full of holes. Even a bad attitude by a manager can result in employees' refusing to volunteer for overtime, as seen above.

A third common issue or concern was who the scheduler was, and how most people related to that person. If the scheduler appeared to act with favoritism, the facility's morale sank quickly to the depths. If the scheduler was rigid, turnover and absenteeism became even more common. No two low-turnover homes staffed exactly the same way, but it was more common in low-turnover homes to have a regular schedule that was always posted well in advance, and to have a voluntary sign-up sheet for additional hours. Many workers, because of their need for additional income, were willing to work extra shifts when they could. Many immigrant workers were sending money home and actively sought out extra shifts. Also, many workers had more than one job. For example, one LVN had worked at another nursing facility as a weekend relief worker for seven years. She worked every other weekend at her first job, and then the weekends in between at her second job, plus all the days in between that she could. Some facilities offered self-scheduling, but only at the unit level and because a particular charge nurse was willing to do this. In those cases, workers felt more responsible to each other, and to their residents, to come to work on the shifts they had committed to work.

Scheduling was also used as a punishment. One 23-year-old male CNA interviewed. was approaching his first anniversary date with a high turnover home. He worked the second shift, which did not work well with his wife and three children, who were 4, 3, and 1. Sometimes he had to be absent to take them to medical appointments or to cover for his wife when her employer abruptly changed her schedule. He had put in an application for the first shift, or day shift, and had been told it would be honored when there was an opening, but had just heard that two new employees with the same credentials had been given day jobs. When he asked the scheduler why this was the case, she told him that his absenteeism record was a problem and so he was not being moved. This is a vicious cycle, because at least in theory his absenteeism was aggravated by being on the second shift, and would continue until he got a first shift job. Using scheduling as a form of discipline was a hated practice among CNAs.

Scheduling was complicated by transportation and childcare issues. At two facilities visited in two different states, no bus service was available after 11 pm. So in one case employees had to clock out and be on the bus stop outside by 10:30 pm, and therefore lost pay (and the facility lost coverage) because of transportation problems. Workers whose buses got them to the job early were forbidden from clocking in and working, however. One aide was forced to quit because her sister's car broke down, and she had no alternative source of a ride. In another example, a CNA said, "*I am partly working toward my LVN. It's really in my heart to do. If there was help with childcare, and hours changed to accommodate... a lot more people would go into nursing. I heard that in some cases because the nurses need to get their kids to day care, they will accommodate the nurses, and change hours for mothers. You can't get them into day care and get here before 8 am.*" Remember that most day shifts started at 6:30 or 7:00 AM for nursing employees.

5.4.3 Respect vs. Contempt for Caregivers

Q: What were the issues in the union drive? -- Researcher A: "*Money and respect. Actually, more respect.*" -- *Administrator*

In high turnover facilities, attitudes toward the paraprofessional staff were quite negative, on the whole. This was in contrast with low-turnover facilities where much more egalitarian language and approaches were used. Here are three examples of very negative attitudes toward CNAs in particular:

"Some CNAs were scared [of having AIDS patients in the building]. I had to ask them, "Are you planning on having sex with the individual? Because if you are, you'll get fired anyway. Or, are you going to be drinking breast milk?" It just doesn't happen in nursing homes. I have a very low tolerance for stupidity." -- Administrator in a high turnover nursing facility

"I look for how much they brag on themselves. Usually it means they are covering up for bad performance. I try if I can to get a good picture of their attendance at the previous place. I look for whether they are polite in the interview, because then I hope they will be polite with the residents. I look for their appearance and mannerisms."-- Director of Nursing, high turnover facility

"I will tell you one thing, though, from past experience. When I see a CNA with a resume, that's a dead giveaway." To what? *"They are a wannabe. In their mind they are MORE than just a CNA. And that person will cause you trouble on the floors. You wouldn't hire someone who came in a uniform for the same reason. They think 'too much' of themselves."* – Administrator in a high turnover facility.

These attitudes were in start contrast to those reported above, either at the religious facility, or by the positive supervisor. One RN who had worked as a CNA before her nursing training explained that the attitude toward direct hands-on care giving was not only expressed in the professional world, but also was reflected in her family: "*CNA is the killer profession. I was an aide for two years before I went to school. I was physically tired all the time. They start at ten-something (dollars), but then they don't go up (in wages). And there is no prestige for the CNA. My father was embarrassed when I went to work as a CNA, as if I had become a stripper or something. It's physical work, toileting, and other things people don't usually like to do....*"

VALUING CAREGIVERS AND THEIR SPECIAL GIFTS: An Example

Feeling and Being Needed: *"But people really need you here. I bring lotions to work for them, and powder... little soaps and perfumes, mints and aftershave for the men. I find hair bands for the ones with long hair. They know that I do it. I am not supposed to bring them anything. A lot of the women like that, to smell better, and a lot of the men, too. I just do it because I want to. I don't ask anything from anybody for it. I don't take anything. It's a gift. It helps me to do my job better. If I can make them feel comfortable, then I'm comfortable..."-- a C.N.A*

5.4.4 Lives Outside of Work

Another factor that distinguished low turnover from high-turnover facilities was an understanding by one or more key managers and leaders of something of what employees' lives were like outside of work, especially CNAs' lives. Since Tellis-Nayak's article on the home lives of nursing aides (1989), and with the exception of a few ethnographies, little has been written that accurately portrays the difficulty of these low-wage workers' lives outside of work, at least little that has made an impact apparently on the nursing facility managers' consciousness. Here are but a few examples:

"I couldn't find anything else, so I came back to be a CNA. You make a lot more money in the Bay Area. I have four kids, who are 19, 15, 10, and 4. I worked since February on the PM shift. I worked days while I was in school. on the first floor. There are some harder floors. If you can work first and second, you can work third. The residents are more alert, which means they are more on their lights. But you can talk with them, laugh with them, and most are ambulatory. Once you work up here, you love this floor. I got blessed." --- A CNA with difficult home circumstances

The night shift: " *I am on PMs. I used to do the night shift, but my children were having a hard time. The youngest was keeping them up at night and they were too tired to go to school. They still have to watch him, but he was not going to sleep. He is only three years old. But he would wait up for me to come home and not sleep." How old is the oldest? "She's 27. She has to take care of all the younger ones."* – Certified Nursing Assistant in a low-turnover home.

Lack of future: *"I don't want to be a CNA all my life. I'm good with the people, and caring, and considerate. I am compassionate. I want for them to be treated... like you would your parents."*

Ambition discouraged: *"When we think of medical or think college, they tell us we can't do it, especially as a single parent. I have three boys, 13, 12, and 5. But they need to let people know it's not impossible. It's a really faraway dream. When I got my GED, I put a lot of bills*

on the back burner, but you need a house, electricity and water. There is lots of going to school during the day and working at night. I was gone at night, and when I was [home] I was grouchy. The kids give me a lot of encouragement. I am mostly leaving my kids alone though, and I don't like that". – A CNA

Attachment to residents; dealing with death: *"It's hard work, physically and mentally. When you lose a patient—I used to go to the funeral home. Now I don't. It just tears you up. You get attached to these people, you can't help it."* Charge nurse LPN

"And sometimes, you have to deal with the death of someone. You don't want to see another one you care about, pass away. We lost one today." Were you close to him? *"Oh yes. I called him my chocolate man. He was in the hospital but I didn't know he was going to pass. His sons came, and we talked to them. They were nice, but some of the family are very rude to us."* Do you go to the funeral? *"No, it's kind of a family thing. We talk about him here, and that helps a little bit."*- CNA describing a death on her shift

Understanding the residents' experiences: *"If there were more staff, you would have time to know that person, to laugh and to love. How many people want a roommate 20 or 30 years from now? In college, what do you get to bring? Not much. But these are people with a life. In this facility, Organization S put its money into the resident's place. They are getting individualized rooms, semi-private rooms with walls, spacious, many to live in, and not a common area. The for-profits put their money into a plush environment that the families see, and it's awful where people live. Here, they have no chandeliers".* – RN, HR Director

5.4.5 The Workforce: The Vast Influence of the Immigrant Experience

It is impossible to write about the nursing facility workforce without writing about the immigrant experience. In the heart of suburban Kansas, at least half the workers interviewed were from Africa (Kenya, Ghana, and Nigeria, for the most part), Mexico or Central America, or the Philippines. Nurses too were often from Africa and the Philippines. The other half was local Anglo and African-American poor and working class individuals. In Wisconsin, workers from Africa, Central America, and the Philippines also were working in facilities, but the base population was African-American Wisconsin or Michigan born (for aides) and white Wisconsin born (for nurses). In California, the entire workforce was darker-skinned, with far more Chicano/a and Latin American workers as a percentage of the workforce, but apparently relatively few undocumented workers in nursing aide jobs. Many Filipinas and a few Filipinos, and some African-Americans, filled the aide and nursing jobs. Most of the white women observed or interviewed were in management or RN jobs. In the rural community, most workers were local in their origins, but that was also true in the city community. It seemed these particular labor markets combined local and international markets, without ever becoming regional or national.

The workers from Africa were mostly students who had come to the US to study computers, engineering, or other technical subjects. Many of them were in college and were working in nursing facilities because the jobs were easy to get, and had long hours including night hours when classes were not taught. Ironically, most of them came from middle or upper class backgrounds in Africa. One man I interviewed spoke German, French, and English in addition to his native language. Others came from government employee families or occasionally a retail family where other sons or daughters were left to work in the family business. This made it especially hard for them to be treated as lower class or poor workers, which occurred during their nursing facility work experiences. They will certainly work in nursing facilities for as short a time as possible, but many had been there more than a year already. One had switched his major to nursing after seeing how many nursing jobs existed and how much more they paid in the US.

In California, Hmong workers interviewed were second-generation, born in the U.S. and just beginning formal schooling above high school. The Mexican and Central American workers had rarely finished high school in their own countries or in the US. Some US born Mexican-American workers had finished high school and hoped to be nurses, while more African-Americans were discouraged and said things like, "I wanted to be a nurse and this was as far as I got." Very few workers came from the Middle East or East Asia, but every facility employed Filipino nurses in this study. Some were working as CNAs or as medical technicians (CNAs who can give out medication) while they studied for their nursing tests or awaited test results. The Filipinos had to be sponsored by a nursing facility to get visas, and most had three-year contracts.

Most lived in a close-knit community with other Filipino nurses within walking distance of the facility. They were likely to work lots of overtime, and to send money back home. Most planned to stay, and to go to work at hospitals as soon as their contracts were up. Hospitals are not hiring from the Philippines just now, but nursing facilities are. Most of them have hospital backgrounds because there are virtually no nursing facilities in the Philippines. The facility may assign each one a Preceptor, most likely another Filipino nurse to help them make the transition. Why do they want to go to work in a hospital? "*I feel more like a nurse there. Here I feel like I'm babysitting old people.*" What was your background in the hospital? "*Cardiac care. I had no dementia or geriatric training.*" One Filipino man had come to the U.S. with his RN wife, and the two later divorced. He had come to work in the same facility she did, and was working as the night supervising RN when he was interviewed. Will you go back to the Philippines? "*I have not seen my family for seven years. But yes, I will go back there when I retire, because someone will take care of me, even if I have no immediate family. I do not want to get old in the United States*," he said.

5.4.6 Summary

Valuing and respecting caregivers, as opposed to having contempt for them, not surprisingly resulted in stronger, more positive relationships and less turnover. Yet this seemed to be very difficult for some people in the institutional culture of long-term care. For others, it seemed to come naturally, or through a lifetime of learning. In cases where administrators sometimes advanced people salary money if they needed a car or an emergency operation, workers stayed longer and felt more loyal. In cases where they were on their own, no matter what happened, and they were treated as interchangeable, they acted much more individualistically and from the managers' point of view, much less responsibly. Yet, as has been suggested, these individuals were not fundamentally different 'kinds of people' with different 'work ethics.' They were, however, acting in a different organizational and human setting, being treated differently and being trusted and valued at a much higher level.

5.5 Basic Positive Human Resource Policies: Wages, Benefits, Orientation, Training, Scheduling, etc.

At a High Turnover Facility:

"CNA vacancies, they are like a rotating door, that is always open." - *Administrator*

At a Low Turnover Facility:

"It's not just the pay scale; it takes a special kind of person." - *CNA*

5.5.1 Compensation

A labor economist would expect to find facilities with low turnover paying more than facilities with high turnover, and might expect workers to move to facilities with the highest wages and stay there. However, this did not appear to be the case in these paired comparisons. In Kansas, the high and low turnover facilities were paying very similar wages, with the high turnover facility paying more to start. In California this was also true at all sites.

Competition for workers on the basis of wages could be cutthroat in the nursing facility industry if there were no other reasons for people to stay at a facility. One administrator at a high turnover facility told me that the facility 'around the corner' had started 'paying for experience,' and offered up to $10.00 an hour to nursing assistants to start. This was clearly an attractive policy, since aides rarely feel they get credit for their experience. In contrast, her facility had been offering wages of $7.75 an hour to start, and she had raised them after her arrival three months earlier to $8.00 an hour, with an additional 50 cents after 90 days. But this was still far below the rival facility. Still, at the low turnover facility studied for this report, start rates for aides were between $8.00 and $9.00, not very different. One

discouraged staff developer at a high-turnover facility said, *"Some three or four [CNAs] quit to go somewhere that pays more money. It's about money, even if it's not but a quarter."* Despite this perception on her part, workers noted that there were other reasons to leave this facility. Wages were an intelligible reason for leaving, but in the interviews, wages were not the issue in attracting workers.

Wages could be a good reason to leave a bad job, however. One administrator at a high turnover, low quality home complained that the facility around the corner had just '*stolen away my 'medication nurse' for $26 an hour, for an LVN! She called in at 5 am and said she wasn't coming in one day and never returned, but word got back to me through the grapevine about what had happened. That's more than we pay our RNs, we pay LVNs $18 an hour."*

Facilities that raised wages over time were more likely to keep workers. This was true in the unionized facilities where annual percentage or flat increases were awarded by contract. This was also true in the low-turnover facilities where workers had earned regular increments over the years and now made more at their facility than they could at another new workplace. One worker at a high-turnover facility expressed her frustration when asked about the pay: *"It's not that great. We get 8.10 an hour, no shift differential. Then there's insurance, I pay part from my check, and then the co-pay too. And I've never taken a vacation in three years I've been here."* Why? *"I have nowhere to go. I never take no time off."* *What happens to your vacation pay?* *"They give me eight days of pay, sometime at the end of the year."* What would it take to bring more people into this kind of work? *"It would help bring more people in if they paid better. A lot of people leave because they find better paying jobs."* Is there any raise for seniority or experience? *"No, there is no kind of salary raises on any schedule. A brand new CNA gets the same 8.10 I get. And they can't do it as good."*

In California, the mandated wage pass-through legislation of the previous year seemed to have reduced complaints about insufficient funds to pay decent start rates, according to several administrators. In Wisconsin, one HR Director has 100 screened resumes to interview. Why? *"If I put up one poster in a bus stop, 300 people would come in. They just see the rate. It's 10.00 an hour, because we are union. That's the start rate. They all get the same raise, because we are union, too."* Yet workers still felt in every single state that they made too little money for the work they did. The entire industry was under-funded, in their view.

Some facilities offered shift differentials or weekend differentials. These had helped in the case of one HT facility to attract employees to those shifts, and to encourage others to work 'doubles' or extra weekend hours. *"Corporate sets pay scale. It's easier. We are very competitive with other facilities in the area. We start CNAs at 9.50 (an hour). This corporation began doing something, last year, that wasn't happening with the previous owners.... Shift differential and evening and night weekend bonus, all in nursing."* Some

facilities offered bonuses to workers who signed up other workers, and many offered bonuses to new workers, ranging from $200 for a CNA to $1,000 for a licensed nurse. The worker usually had to stay employed between six months and a year to collect the full bonus. There were no consistent patterns that differed between high and low turnover facilities on shift differentials, or on bonuses, though lower-turnover facilities had far less need to offer bonuses to recruit workers, and fewer did. Bonuses could also have a demoralizing effect on longer-term employees, who did not receive bonuses and saw others come and go as soon as they fulfilled the minimum requirement.

While wages are important, most agreed, they were not determinative. *"If they drop out of college they can get a job here. But fast food pays as much as we do. We used to pay low, but now we pay $9.87 an hour to start. With any experience you are over $10.00. And then with shift differential you can get up to $12.00 or $13.00. It is still better than it was wage wise. My family, in southeastern Kansas, would die for these wages,"* said one HR director.

One former Director of Nursing commented that wages are not a sufficient reason to do the work, or to do it well, as many CNAs also noted. *"The people who do this work want to care for people. It's their calling. They still have to be able to enjoy their coworkers. [Fifteen years ago] we had nine older and middle-aged women, who worked part time to help with family expenses, not to support their families. They could come in an extra day here and there, they were committed. Now... they are retired. To get people to work extra shifts we pay a $25 shift bonus to CNAs, $40 a shift to nurses, plus time and a half, if they work an extra shift in their pay period. But then they are tired, and they take short cuts."*

One CNA summed it up, explaining why he would not be a CNA long. *"It's hard to have a future in a CNA job. There are no benefits, no nothing. If there were retirement plans, or more unions. Every time you get a raise, PG and E shot up through the roof and gas got higher. Most have no medical benefits because family coverage is the full price. We really care about the patients. Seems like so much of a business now. Everybody helped out more in the past. Now they see it as a business instead of being more helpful."*

5.5.2 Benefits and Pay in Lieu of Benefits

One high turnover facility offered staff an additional 1.00 per hour in lieu of paid sick leave, vacation, or holidays. About 50 percent of the CNAs took it. The director of nursing explained that, '*I try to tell them when I hire them, they will have no vacation or sick time, they need to think about it, and be real good at budgeting.*' She noted that this was usually a problem for them. *"I worry that they do not understand the pay in lieu of benefits."*

Health insurance was a major benefits issue to workers, though very few of the paraprofessional workers could afford it, and very few of the facilities provided it at an affordable rate. One aide with 2 children, a single parent, said when asked if she had health

insurance, *"I'm not able to have that taken out right now. I'm the breadwinner. I gotta live for now."* In her high-turnover facility, single health insurance required a contribution of more than $70 a paycheck, or 20percent of her take home pay. Family insurance was out of sight. For licensed staff, facilities typically paid a higher proportion of the health insurance, but even their lower co-payments were felt as significant out of pocket costs to these higher-paid staff. Virtually no CNAs interviewed for this study had health insurance. What are the worries you have? "*Insurance. We can't afford it." "No, it's too much. even for just you."*

One CNA said, when asked what would make her stay a CNA,"*Wages, health insurance...I am not doing insurance through here. This is the lowest wage I ever had. In San Francisco it starts at 10.00, and you get 10 to 12.00 over time. But here, $8.10, that was the highest.*" When asked what a health insurance policy cost the employee, an administrator said, *"I don't know, but I do think the company contribution is $142.00 for a single person. I think for an employee and spouse they contribute $207."* But the important thing to workers is not what the facility contributes, but what it costs them. Hardly any non-licensed employee interviewed was covered by employer health insurance, or any insurance besides Medicaid.

The role of benefits was contested and confusing at times. Managers initially spoke of benefits as an important part of their recruitment and retention strategy, but some changed their mind when pressed for details. One administrator said, "*Benefits is a key thing. Our company offers excellent benefits, a good benefit program. It is a cafeteria* plan." How many of the CNAs actually are able to use it? "*Well, not many of them actually sign up. Most are on Medi-Cal, the CNAs (the California Medicaid). Many are single parents, and they are eligible for it."* And what about retirement? *"We are so far behind the industry on 401-Ks! I have been working in the industry for 30 years and I have no real retirement. [Corporation X] had no 401-K till two years before I left. . So your longevity just doesn't matter. Compare it to my girlfriend who just retired, at my age, from Pac Bell! And she was not licensed or managerial! And this one, you have to be here a year to even participate in the 401-K. I don't mind that they don't contribute, but why don't they let you put anything aside? I was told in an in-service that our facility was the only one where there was no one participating in the 401-K plan..."*

Company changes, or ownership changes, did also have a large effect on benefits. One facility was owned by a corporation that in turn was owned by a real estate corporation that owned the land on which the facility sat. Another had been bought and sold several times in the last five years. One administrator noted, "*Company B bought it in 2000, and the staff lost half their seniority. So they are very sensitive about that."*

For professional staff that might have been more able to save for retirement, the lack of a retirement plan or any deferred compensation seemed like a serious barrier to staying in the industry. One LPN said, "*There are no benefits here. No 401-K. No retirement. That was*

the reason I left earlier. I enjoy what I'm doing. I love behavioral disorders. I have been told I have a gift for them." But another LPN in the same facility, one of the few African-American charge nurses in the studied facilities, was leaving in two weeks to go to work for a corporation that had a minimal 401-K plan, because she had just turned 55, had raised six children, and had no retirement benefits after nearly 30 years of full time work. In both these cases, talented staff were lost because they did not have the most basic deferred compensation benefit, even one that cost the company almost nothing (a pre-tax contributory plan).

5.5.3 Recruitment and Hiring

Research shows that a high percentage of CNA turnover occurs within the first three to six months of hiring (Institute of Medicine 2001). This suggests a combination of potential problem issues involving recruitment and orientation. These might include difficulty recruiting and selecting the right employees, giving them a realistic job preview so they know what to expect, and difficulty orienting them properly to the difficult, demanding work they will be doing.

It was clear that greater selection in hiring would help, in these interviews. Each manager was asked what he or she looked for in hiring nursing staff. Many of them indicated they could not really afford to have too high standards, since there was a staff shortage. Very few gave any kind of written test or assessment, or did an English language assessment. They did not rely greatly on references, as they found these of little use. They did look for holes in people's work histories, or previous "misunderstandings" or other problems with other managers.

Even in a low turnover facility in Kansas, recruitment and retention was difficult, according to the DON: *"We are lucky if we can bring one person in a week... In four months I have hired 10 CNAs, and lost 7 of those CNAs."* How did you lose them? *"Some were experienced, and some were not. One is working in assisted living, she only lasted three days. She just didn't call and didn't come back. One was a man who had never worked in nursing homes, he just never came back. One was an older lady who had worked for many years. She had car trouble..."* Was the car trouble the problem? *"No, I think she found the work too physically demanding."*

In the lower turnover facilities, the directors of nursing were more likely to have a direct involvement in hiring CNAs. One DON said she did not test. *"No, no test. I interview them. I try to see how they respond to stress, to change, how flexible they are with reassignments, why they are interested, what they have done. I try to learn their attendance rate and punctuality at previous jobs, and how they dealt with work rules. Then I take them on the floor, and give them a tour. I learn a lot there on how they respond. If they are offended, I can tell."*

Recently nursing facilities in this sample had participated in a variety of welfare-to-work programs. This workforce was similar to people hired previously, but with even less work preparation and skill, and perhaps more problems with family and basic life issues. Few managers reported government programs were helpful to them. One said, *"There was some program, this place had signed up with to get CNAs, but they ended up with eight uncertified CNAs, and the facility was responsible for their supervision! That wasn't worth much. But that program was funded by the state."* But one CNA explained that her "GAIN" worker had been very helpful to her, in getting her the job and helping her keep it.

Most of the low-turnover facilities either taught a CNA class that was open to the community, or paid for employees to take it at a community college or adult education program nearby. This helped them get first access to potential new employees who could not fund their own two-week program. *"It is good to teach the CNA course in house, it increases retention. You can teach them the right way, and give them follow up support."* But teaching the CNA course and guaranteeing people a job afterwards was no guarantee of retaining people. One DON said, *"I did a study once, looked at all the people who had been through the CNA class. Even then, we had some agency. After six weeks, there were five of the 10 left, after 8 weeks, three, after one year, one. But we had still saved money over agency if you added it all up."*

5.5.4 Orientation and Training

> *"I didn't get an orientation, because the lady that does it was on sick leave. They hired me and I got to work with four different people."* – CNA in high turnover facility

Once employees were hired, striking contrasts were found between high and low turnover descriptions of orientation. High turnover facilities typically did orientation briefly, if at all. One manager acknowledged that, *"With new people, we throw them to the wolves."* She meant they are put out to work on the halls with little or no actual orientation, despite policies that call for orientation. This often happens because the facility is 'short staffed' and so requires the new staff members to work a full assignment, whether they are prepared or not.

Here are some typical descriptions of orientation by high turnover facility managers:

"I try to make sure they are oriented to every hall. A different CNA would be assigned to every hall, so there is no mentoring, but they will learn the hall from a CNA who is familiar. I try to get them to work at least one shift per hall (there are 4) but don't always. It depends on the openings and number of staff. There are not enough CNAs." (Director of Nursing)

"Orientation would be nice if it were better, but for licensed staff, there is usually a 3 or 4 day orientation. From facility to facility, there is not a whole lot of difference. I like staff to be flexible, if there are a couple call-ins, they will need to move." Director of Nursing

"The orientation is two days. They work on the floor, learn to do paperwork, see videos, spend ½ day on the floor. After they go on the floor, I'll check on them, instruct them, tell them the policy. The charge nurse does not have a lot of management training." (Staff Developer)

"The people run the new people off the floors.... there is always a complaint about staff not helping. We are trying to eliminate back strains, to lower our workers' comp bill, and they won't help each other. There's this attitude of 'if I'm not your friend I will not help you.' There is always some type of a clique." (Staff Developer)

This was not only the case for CNAs. One RN in California who had just finished 4 years of school had been treated badly by longer-term nurses and a DON who did not help her "learn the ropes," as she put it, and she had decided to leave nursing after only one year of full time work.

In contrast, in low turnover facilities, more recruitment was accomplished through word of mouth, often with friends or relatives. In one facility, the researcher interviewed a brother and sister, niece and uncle, and other family members. This seemed to tie both employees more closely to the facility. One HR Director explained that orientation was a minimum of 30 days in their facility, and she thought that was not enough, before people had their own assignment. Managers in low turnover facilities also were more inclined to test or assess applicants, and to take their orientation to the facility and residents seriously.

"First, I use an assessment tool to see what their strengths and weaknesses are. It has 15 multiple-choice questions and 10 True/False statements. I tell them there are no right or wrong answers; this just helps me see where they need some review. But I also use it to go over their level of knowledge of the basics, such as how to take vital signs, what to report to a charge nurse, and how to assess residents."

A director of nursing said: "*In orientation I let them shadow for one week at least. I tell them they should only observe the first day, then help, the second day, and they can be on their own by the end of the week to do tasks independently. Then I ask them to come back in and tell me what they are not comfortable with. There is always something. Sometimes it will take three to four weeks. I do not rush them.*"

Another administrator who had reduced turnover dramatically at his facility, said: "*You can put aides on the floor immediately, they don't feel good, they don't know what to expect, they quit. Then you spend more money on training and keep on agency.*"

And CNAs themselves talk about making both training and orientation more useful to them. When asked what would make the job better, one trio in a high-turnover facility agreed unanimously, "*More CNAs.*" They talk about people who come and go. "*If they will just stay...you have to want to do it. Some of them, they find a dedication. The more help, it's easier. You have to not want to do it just for a paycheck.*" Another CNA said, "*Some of them, they are just here for the money, they are lazy.*" How would you recruit good CNAs to work here? "*Tell them the truth!*" They explain, tell them how hard the work will be, and what it will really be like. "*Tell them it's not easy. You have to be a strong person. You need a lot of patience. It has be something you want to do,*" said a CNA with thee years' experience.

Both employees and managers agreed that the required 75-hour minimum training does not adequately prepare employees for their work in the facility. One CNA explained, "*When you're in class, they prepare you for a certain kind of resident, and as soon as you get into a facility, it's so overwhelming. Two or three people expect something different than they actually get. Then they quit. They should be honest up front. In the classes and books, there are no bedsores and no malnutrition. There's been a big change in the last five years. Now Vietnam vets start to show up, in their 50s, their minds are not in the best shape. We are not prepared for these kinds of things.*"

Although it is not the focus of this report, the adequacy of training for nursing assistants, and the extent to which inadequate training contributes to high turnover, is a subject that deserves more attention and structured research. This is also true of management training for LPN/LVNs and for RNs, the paucity of which was discussed above.

5.5.5 Career Ladders and Opportunities to Advance

"*... A couple CNAs are going to school for their LVN or RN. But there is not enough education or retirement benefit in this company.*" This was the assessment of one high-turnover facility's administrator.

In contrast, in a low-turnover home in a rural area, the facility paid tuition and guaranteed work hours on a flexible schedule to employees seeking to further their education in nursing. One 30-year-old CNA interviewed had come to work in the nursing facility 10 years earlier, after she collapsed in the cauliflower fields because of an ectopic pregnancy and 'almost died.' She swore then to leave farm work and try to get inside work. Despite being born in Mexico and speaking little or no English, she took classes and passed her CNA class, and then had been an employee for eight years in the low-turnover facility. While raising two children, she had continued her education for her LVN license, and was waiting for test

results, concerned that her English skills were still too weak for her to have passed. The facility paid her tuition and encouraged her during her training. The second day the researcher visited the facility; she had received her results and passed the test. She was beaming. While the facility did not require employees to stay working there after their schooling, nearly all supported employees continued to work there and felt significant loyalty to the facility itself and to the managers and residents.

There can be other advantages of having a career advancement program at the facility. At one low turnover facility that offered support to CNAs who were just beginning their training, the retention of nursing staff was a positive contributor to retaining new CNA staff. An HR manager said, *"Here we have a number of charge nurses (LPNs) who went through the CNA training here, then became professional CMAs and completed their nursing training. The charge nurses hold it all together. They know what it is to be an aide, they are not afraid to work."*

One administrator talked about wanting things to change. "*We also have to put money into education. I want to hire a nurse aide trainer. We will hire a staff development RN to focus on nursing and class work. We have to do things that are learner centered, basic life skills, we put money into a distance-learning network so they can get constant in-services.*[5] *The staff has to want to make it change..."*

Different systems seemed to work. Even at higher-turnover facilities, some of the longest-term employees, especially LPNs or LVNs, had received their education with support from the facility. One charge nurse said, *"Going to school at that time, you got paid for four days and worked the fifth. At some point, I couldn't do that, it was too intense. It was a thirteen-month program, with no vacations. After the second semester, I came back here."*

Managers do not always seem to realize there are real barriers to continuing education. Many nursing facility staff also care for their own aging parents at home, or for children. One CNA in his 30s who had a real gift with the residents he cared for said, "*I was thinking of becoming an RN, I knew someone who went to the "Bridge Over" program in Kansas City at college. She really struggled... she was so poor one year while that was going on that I had to buy her toilet paper! And it was only $10,000 back then. I am not sure I want to go through all that."*

5.5.6 Why People Left Nursing Facilities

The investigator always asked why nursing staff did actually turn over, or leave. Most of the answers were consistent. "*They tell me, benefits, and staffing ratios*," said one HR director at a high-turnover facility. Many CNAs echoed this summary. An LPN reflected the terrible

[5] The Omnibus Budget Reconciliation Act (OBRA) of 1987 required that nurse aides have a minimum of 75 hours of initial training and 12 hours of in-service training per year (Hawes *et al* 1997).

choices to be made when she said, "*There are no benefits here. No 401-K. No retirement. That was the reason I left earlier. I enjoy what I'm doing. I love behavioral disorders. I have been told I have a gift for them.*" Wages also meant something to workers in nursing facilities. A charge nurses said, "*Then I worked at [Nursing Facility Y] for 8 years. I left there because of money. The money was short. I got a beautiful review, I mean fantastic, and they gave me a five-cent raise! I mean, that was ridiculous.*"

When another charge nurse explained why she left another nursing facility, the reasons directly related to the management.

"I was a team leader. It was good experience; I was a treatment nurse, and a med nurse. I left there because I was not able to communicate well with management...The real issue was management responsiveness. They would not take care of concerns, and there was a lack of follow up. If you brought concerns to them, they would blow you off. I understand there are a lot of things that can't be taken care of... but even if they called back and said 'x, y and z can't be done because...' But they didn't."

Some simply burned out or were stuck. "*I've been in it too long to go anyplace else... there is nowhere to go. I don't like paperwork, computers, or typing,*" said one LVN. A registered nurse got tired of having total responsibility for every resident. "*I left for four months, I got burned out and left. I was the only RN on staff for 17 months and I had been on call 7 days a week, 24 hours a day, for all that time. I wouldn't come back until they agreed to hire two assistant directors of nursing.*"

Then there were all those who left without leaving an official reason. In one facility eight people were "terminated" in April, two of them for 'no call no show.' In this particular company employees could be "no call no show" three times before they were terminated, so these were repeat offenders. Two left for 'personal reasons," one found 'another job" and two were terminated by the company. Similarly there were 8 CNA hires during April 2001, one RN and one laundry worker. Seven CNAs were hired in March, 8 in February, and 11 in January 2001. In March 2001, 2 self terminated, 1 terminated, 1 no call no show. Diane was hired 3/1, and self terminated one day later, on 3/2. Joan B was hired 1/9, and "self terminated 3/10." In Feb 2001, five CNAs were terminated. This facility was truly like the revolving door described in the introduction to this section. What this section documented is that there were a series of coherent reasons for this pattern.

5.5.7 Summary

In sum, a significant number of human resource (HR) practices contributed to either high or low turnover patterns in the nursing facilities studied for this report. First and foremost according to most administrators was compensation (among the HR issues), and several spent most of their interviews complaining about a lack of funds. But nursing staff agreed

that while wages were important, they were not determinative in turnover rates. Many other factors contributed to making a good workplace, especially in labor markets where competition for workers had virtually equalized the wages in the two homes that were studied for this chapter. The lack of health benefits was nearly as important, though very few facilities offered really accessible benefits to paraprofessional staff. Retirement plans were extremely important to the more senior nurses, especially those who had worked for many years without one, and the average age of nurses interviewed and observed was in their 40s or early 50s. For the aides, retirement plans were simply unavailable. In fact, some 50% chose to work without any paid time off or benefits in order to make another $1.00 an hour, or $40.00 a week. However, this caused more trouble than intended by management, when they had no sick days or holidays or vacation as a reason to stay, or to pay their bills if they were ill.

In addition to economic benefits, non-economic benefits such as longer orientation, more training, flexibility in scheduling, career ladders or educational opportunities, and having good feedback or good supervision seemed important to a number of nursing staff interviewed here. A longer orientation in and of itself seemed to help with retention of new staff, as did a more stringent selection process. Nursing facilities often did not have a human resources manager or coordinator, and this was apparent in a somewhat haphazard approach to benefits and other practices that are often designed to retain employees. Rather, most HR issues observed seemed to be about not being paid overtime, or for that extra shift one had worked. HR directors, if they existed in high turnover facilities, spent the vast majority of their time recruiting and screening staff, and processing their exit paperwork.

5.6 Motivational Work Organization and Care Practices

A series of well-known principles of motivational work organization are violated routinely in structuring certified nursing assistant's work, and also in other nursing jobs in long-term care facilities (see Eaton 2000, Hackman and Lawler 1980, Herzenberg *et al* 2000). For instances, CNAs are rarely given a "whole job" to do, but rather are instructed to take care of some portions of their residents' needs, without knowledge of the larger context of their diagnosis and treatment or care plan. Rarely are they given feedback about the results of their efforts and the consequences of any problems. They are autonomous in the sense of not being well supervised, but not autonomous in the sense of having a larger recognized responsibility than an unskilled worker usually has. And most typically, they are assigned to different residents each day, week, or month, as if the warm and mutual human relationships that are at the core of good care giving did not exist.

In low-turnover nursing facilities, a variety of care practices and different patterns of work organization emerged; many gave more credit to the relationships and to the workers' opinions and observations than in the high-turnover facilities. In high-turnover facilities, workers and residents alike were treated more as 'puzzle parts' that had to be matched up in

certain ratios, and any resistance to constant movement and flexibility was treated as a problem. However, no single successful set of care practices emerged from the study, as no such single set probably exists. Still, among the care practices that were observed to vary in the course of this study in the nine facilities were the following:

- consistent vs. irregular assignment
- generating feelings of responsibility, ownership, and accountability
- building on intrinsic motivation
- attachments to residents honored or dishonored
- floating staff
- use of agency staff
- dementia care
- extent of individualized vs. institutionalized care
- meal time etiquette
- shower and bath practices
- activities – extent and type, aides' involvement
- dealing with death and dying

The following section gives concrete examples of the most dramatic positive care practices, as well as some that promoted poorer care and less retention.

5.6.1 Consistent Assignment and Individualized Care

"I don't try to match CNAs with LVNs or residents. They are assigned all over the facility. Some residents like certain nurses. Some rotate, some are permanent." -- A staff developer at a high turnover facility.

"Mostly I try to keep them on the same halls, I have been rotating the CNAs the last few weeks, so they will get to know the other halls, so they can be flexible. After a while, you can get to burnout on some halls, and need a break, different acuity.... They need to know the whole building, if there are a couple call-ins, they will need to move." – Director of Nursing, high turnover facility

"The Alzheimer's' unit is the most enjoyable place to work here, because it is smaller. It is more like a ... neighborhood. The staff have a consistent work assignment. And after a while, I noticed that the residents started to look better, their hair would look better, their clothes neater and cleaner... the aides would bring in barrettes for their hair, or tomatoes from their garden for them. They would act more like a family visit as opposed to coming in for a job. They do the extra things-- that are absent unless you go back to a social setting." – Director of Nursing in a low-turnover facility, where smaller neighborhoods are being considered for all residents

While most recent research and practice innovation (Eaton 2000, Fagan *et al* 1997) points toward the advantages of consistent assignment of residents to staff for just the reasons that emerge in the example above, most administrators and nursing directors, and some staff members, resisted the idea and the reality. The most typical explanation given in this study was, "They have to know everyone in the facility so they can work everywhere if they are pulled or if someone calls in." This assumed that people would not come in to cover their assignment, so others would have to do it, which then in some sites became a self-fulfilling prophecy. The other reason given for rotating or floating staff was to 'even out' the care assignments so that no one will have the 'difficult' residents all the time. However, this reasoning assumed that all residents were either difficult or not, when that was clearly not the case to workers--- some aides got along famously with a particular individual while others could not deal with the person successfully at all. In fact, aides regularly kidded each other about special relationships with particular residents. This may be because no one else had figured out the real reason for the 'difficulty,' or just because of a special connection that was made between a resident and a worker. Note this example, told to the researcher by a CNA:

"There was one gentleman, they told me to be careful, he's rough. But we get along well. I'm the only one who can put him down. I don't put him to bed until he's good and ready. When a man is 70-something years old, you don't tell him when to go to bed. If eight o'clock and nine o'clock pass by, I let him wander around. I have no problems with him. It was hard to find out what he wanted. Sometimes you don't have to talk a lot to be heard ... They can refuse meds too, which makes it a little more of a challenge especially if they really need them. But there's ways to work around everything."

In this case, the gentleman was "difficult" or physically resistant because someone was putting him to bed at 7 pm, and he did not want to go—but apparently either he could not communicate it, or the person did not listen. So this CNA simply figured out, from his own innate sense of what was appropriate for someone this resident's age, that he should be able to go to bed when he was 'good and ready.' It does not sound like a radical intervention, but in most nursing facilities, it was.

In contrast, note one administrator's response to a question about individualized care, do people get to decide when they get up, what they eat, what they will do? "*No, it is more of a schedule. They have set scheduled meal times for the dining room. We try to be flexible but you have to be careful. A few people like to get up after 9, and breakfast is at 8, so they are offered toast or cereal, something that isn't too hard to prepare.*" Whatever she was being careful of, it was not the residents' ability to eat when they wanted to, or to get up when they preferred. And this may have directly led to higher turnover of nursing staff because of the difficulty of getting everyone to eat at the same time (despite the institutional advantages of having everyone eating simultaneously) as well as, hypothetically, poorer nutrition, hydration, and even more depression.

5.6.2 Quality of Care: Potential Implications of Individualized Care for Management Practices and Nursing Staff

While this study was strictly cross-sectional and did not use patient care records to assess quality, some indicators of general quality of care at a facility were evident from observation. For instance, at a facility with no individualized care plans and no consistent assignment, the researcher sat in the lobby for 45 minutes waiting for a meeting with the administrator. The following field notes were taken:

Having nurses rotating and taking care of lots of residents means that, for instance, someone gave a wheelchair-bound resident a glass of water and a paper carton of a serving of ice cream. Then, someone else came by and picked it up, not knowing it has been spilled (water was) or not eaten because the person couldn't get the top off (ice cream) or that it took this resident a very long time to eat it because of a serious tremor (in the end her ice cream was taken away half eaten, when she seemed that she really wanted to keep it and tried to indicate that but the nurse did not appear to be paying attention). Few employees seemed to be in any personal relationship with them, they just come and go, give out meds, give and take a serving of food or water, but don't talk or really engage....One other resident tried to explain that the first resident wanted her ice cream back, but no one on the nursing home staff listened to her either. (Field notes, Lobby of a high turnover facility, also observing nurses' station)

Some facilities studied, usually the lower-turnover ones, were in the process of thinking about how to increase individualized care. For example, the researcher asked, 'What are you doing, if anything, to increase resident choice?' "*We are looking at it. Ideally, we want them to eat when they want. We encourage them to tell us what care they want, a shower or bath, or to get up when they want. We try to... when they come they have a meeting with the dietary manager, and she makes up a preference list for foods. And we try to learn what kinds of activities they like.*" (DON) But most had not made it very far. One nursing assistant reported a positive story from her past work experience in another state. Note how this story illustrated a deeper understanding of who the resident is, as well as helping the CNAs do their jobs better. "*In Washington, we let them help, cook their own breakfast. One lady, we gave her a basket of baby clothes to fold. She would fold that basket over and over all day long. She was a farm girl and she slept from 7 pm to 4 am, and then she was up. You couldn't get her to sleep late, but she loved folding that laundry.*" *(Certified Nursing Assistant)*

Importance of Relationships in cases of Dementia:

One aide in a low-turnover facility explained that she chose not to work as an agency staff person because of the relationships she had developed with residents. "*I like the direct care. We're all they really got. But last year I worked 125 hours in two weeks! Course, I was quitting smoking at the time, too. But really, they need to hire more people!!*" What do they do if someone calls in, call someone else to come in? "*There's nobody to call in. People don't use the agency staff because it's too expensive. I thought about doing agency work, because you get paid more. But I realized you don't know the people. You've got to know how they are, some of them can't communicate. You have to go by gestures and blinks and points.*"

It seemed that it might take more staff to implement individualized care, at least at first. At the one facility where individualized care had gone the furthest, a manager noted, "*They created seven aides positions, on evenings, last year. They needed them to implement more of a philosophy of choice.*"

5.6.3 Neighborhood Concept

Several low-turnover facilities were discussing converting their hallways to smaller neighborhood units that would have more consistent assignment and perhaps more individualized care. "*We want to go back to the neighborhood concept, get rid of the nurses' station. We believe we will retain staff in the future because of this.*" (Administrator/ CEO) It is important to realize that any change in care practices also has effects on the nursing and care giving staff. "*I think a maximum of 20 residents is needed to function as a neighborhood. I am hoping for more ownership, along with the physical changes in structure. We will remove the nurses' station so it is less institutional and has a more home like look. We are hoping that there will be space for people to sit and visit. We have to think outside the box, there are tons of ideas!*" (Administrator)

Some facilities had created nursing units that functioned something like neighborhoods. Staff tended to get very attached to 'their' unit, and the people on it. For instance, one aide said, "*This is my home, C____. It's rare you find a whole entire staff that's family-like.*" 'What do you mean by 'family-like?' "*We can go to each other's houses after work and have fun. On other floors, no one does that.*"

5.6.4 Meaningful and Varied Work

One of the basic precepts of work process research is that people need and require and welcome meaningful work (Hackman and Oldham 1980). In its way, nursing work was intrinsically meaningful in terms of its effects on the lives of others. Some workers realized that, no matter how troubling other aspects of their employment are. A 33-year old male