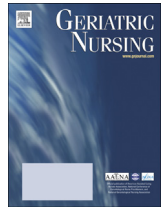Contents lists available at ScienceDirect

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Feature Article

The Responsive Leadership Intervention: Improving leadership and individualized care in long-term care

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ABSTRACT

The Responsive Leadership Intervention (RLI) is a multi-faceted intervention. We evaluated the influence of the RLI on i) responsive leadership practices by team leaders; ii) health care aides' (HCAs) self-determination; iii) HCAs' perceived ability to provide individualized care. A quasi-experimental repeated measures non-equivalent control group design was used to assess participant outcomes in four long-term care facilities (two control, two intervention) across four time periods. Change from baseline to 1-month post-intervention was greater in the intervention group than control group for Individualized Care (IC) ($p = 0.001$), but not for Self Determination ($p = 0.26$). Perceived levels of responsive leadership was greater following the intervention among participants with baseline measures that were less than the median ($p = 0.007$), but not if greater. At 3-months post-intervention, the intervention group retained 32% of the difference from control in IC, and 49% of the difference from control in responsive leadership; at 6-months post-intervention, 35% and 28%, respectively. The RLI is a feasible method for improving responsive leadership practices and individualized care.

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The provision of individualized, person-centered care is considered by many to be essential to both the quality of care and quality of life of people residing in long-term care (LTC) facilities (also referred to as nursing homes or residential care facilities).[1] Individualized care is an interdisciplinary approach to care that acknowledges residents in LTC settings as unique, autonomous persons and respects their preferences regarding care decisions and practices.[2] Interdisciplinary collaboration is defined as working across healthcare professions to cooperate, collaborate, communicate and integrate care in teams to ensure that care is continuous and reliable.[3] As such, interdisciplinary collaboration in healthcare work environments is recognized as a vital component to safe, high quality, individualized care.[4]

Health care aides (HCAs; their equivalent in the US are certified nurses' assistants) provide 80–90% of the direct care to LTC residents[5]; they play an essential role in the provision of high quality, individualized care because they are arguably the most knowledgeable team member with regards to daily resident care preferences and concerns. Reviews of the literature indicate the existence of pervasive low levels of interdisciplinary respect, communication, and collaboration among HCAs and regulated, professional care staff in LTC settings[6,7] Thus, HCAs' unique and important understanding of residents' care needs is often excluded from the residents' care plans, and they are unable to influence organizational decisions regarding care practices.[8] This results in low levels of empowerment and self-determination and ultimately influences the quality of individualized care residents receive in these environments.[5,9]

Incorporating team huddles into the daily care practices in LTC facilities may be one way to improve communication, information sharing, and collaboration among these essential care-team members, thereby increasing the provision of individualized care in these institutions. Team huddles are small group meetings during which each member has the opportunity to exchange information vital to the team's performance. The use of huddles can result in improved collaboration and information sharing in the workplace.[10] Establishing team huddles in health-care settings has been associated with significant improvement in two dimensions of patient safety culture: 1) frequency of event reporting, and 2) organizational learning, both of which are influenced by information sharing and collaboration.[11] However, successful initiatives designed to improve team communication and collaboration depends on supportive and responsive leadership.[12] For example,

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Caspar[5] found that team huddles in LTC facilities led by team leaders who were not responsive to the HCAs' needs and concerns resulted in HCAs feeling and expressing disempowerment and a lack of trust, which in turn caused the HCAs to be less inclined to share information during the huddles.

Supportive supervisors and team leaders in LTC settings positively impact HCAs' stress, job satisfaction, and turnover.[13] In addition, research has shown that supportive and positive leadership practices play a fundamental role in the transfer and sustained use of best practice guidelines in clinical decision making.[14] Despite these findings, there have been few training interventions in LTC facilities developed to enhance nursing supervisors' leadership and supervisory skills.[15] Furthermore, most registered nurses (RNs) in LTC report on-the-job training and life experiences as primary sources of learning about supervisory and leadership roles.[16]

These findings guided the development of the Responsive Leadership Intervention (RLI)—a multi-faceted intervention based on: 1) attendance by team leader RNs and licensed practical nurses (LPNs) at a workshop focused on responsive leadership strategies; 2) the implementation of care-team huddles (i.e., small care-staff group meetings to exchange resident-care information and improve inter-professional collaboration) into the daily care practice, and 3) a support system provided to the team leaders to reinforce the transfer of new skills into practice. The specific objectives of this study were to:

1. Examine the influence of the responsive leadership intervention on: i) responsive and supportive leadership practices by team leaders; ii) HCAs' self-determination; and iii) HCAs' perceived ability to provide individualized care.
2. Examine the acceptability of the RLI to care-staff members, including an examination of adherence rates as well as enablers and barriers to the implementation of the RLI.

Theoretical framework

The RLI leadership workshop was developed based on the self-determination theory by Deci and Ryan.[17] We selected self-determination theory because it provides an approach to motivation that uses traditional empirical methods to investigate how social conditions (e.g., workplace climate or a manager's motivating style) facilitate versus undermine people's motivation, functioning, and well-being.[18] According to Ryan and Deci,[18] basic psychological need satisfaction is assumed to represent the underlying motivational mechanism that galvanizes and directs people's behavior. In self-determination theory, three basic needs are distinguished—the need for: 1) autonomy—people's inherent desire to feel volitional; 2) competence—people's inherent desire to feel effective in their ability to adapt to complex and changing environments; and 3) relatedness—people's inherent propensity to feel connected to others.[18] Self-determination theory considers each of these basic psychological needs to be innate, fundamental propensities, much like biological needs.[18]

Central to self-determination theory is the concept of autonomous motivation—acting with a sense of volition.[19] Autonomous motivation is conducive to the satisfaction of the three needs and has been found to correlate positively with work-related well-being, optimal performance, persistence, maintained behavior change, job satisfaction, positive work-related attitudes, and organizational citizenship.[20]

Deci et al[21] contended that managerial autonomy support (i.e., leadership behavior that helps to cultivate autonomous motivation) is critical to positive work outcomes and employee well-being. Managerial autonomy support is defined by the following leadership behaviors, which were actively cultivated during the RLI leadership workshop: (1) acknowledging subordinates' perspectives, (2) providing relevant information in a non-controlling way, (3) offering choices, and (3) encouraging self-initiation rather than pressuring subordinates to behave in specific ways.

Design and methods

Design

A quasi-experimental repeated measures non-equivalent control group design was used to address the specific objectives. Team leader and HCA outcomes were assessed prior to the intervention and at 1, 3, and 6 months post intervention. Adherence to the intervention was assessed by observing Team leader–HCA interactions during the care-team huddles and monitoring the number of responsive leadership strategies team leaders used at the same post intervention time periods. Interviews were also conducted with HCAs to examine their perceptions and to ascertain the benefits of the intervention.

Setting

This study was conducted in four sites from two LTC providers located in Western Canada. Convenience sampling, based on partner engagement and needs, was employed for site selection. Two LTC facilities from each of the providers were assigned as a control site (resident-care information exchange as per usual daily care practices and routines) and an intervention site within which the RLI was implemented. Following the final data collection, the RLI was implemented in the two control sites.

All four sites employed care staff with a comparable skill mix (i.e., HCAs provided the majority of direct care to residents and were supervised by a combination of RNs and LPNs). The size of the intervention sites ranged between 78 and 179 beds and the control sites ranged between 60 and 111 beds. Specific units or floors were selected to participate by the managers of the facilities based on the consistency of the assignments of the team-leaders to HCAs (e.g., the same team leaders supervised the same group of HCAs as opposed to rotating throughout the facility). Ethics approval was granted by the University of Alberta ethics review board. The study period was from September 2014 to July 2015.

Sample and response

Following ethics approval, the research assistant (RA) and the principal investigator (PI) enrolled the study participants over a 2-month period. HCAs were eligible to participate if they: a) were directly involved in providing care, b) worked full or part-time, c) consented to participate in the study. Team leaders were eligible if they were assigned as a team leader to the HCAs who were study participants. Staff members at the four facilities who agreed to participate provided written consent.

In total, 131 HCAs (intervention group $n = 58$, control group $n = 73$) consented to participate. HCAs who declined to participate did not feel that participation would result in any improvements to their work conditions or did not share their reasons for not participating. The final sample of HCAs was 93 (intervention group $n = 39$, control group $n = 54$) (see Fig. 1). The decrease in numbers from baseline to final data collection was primarily due to most HCAs being unwilling or unable to fill out the measurement questionnaires unless they filled them out while at work while being replaced by a casual staff member. Thus, data collection was significantly impacted by two factors: 1) flu outbreaks, which resulted in many staff being off sick during our scheduled data collection days, and 2) winter holidays, which resulted in many