INQUIRY INTO REGISTERED NURSES IN NEW SOUTH WALES NURSING HOMES

Organisation: Australasian College of Care Leadership & Management

Date received: 23/07/2015

<u>**Parliamentary Enquiry into Registered Nurses in NSW Nursing Homes**</u>

To Ms Jan Barham MLC

Dear Ms Braham, I am very keen to add my professional advice in regards to the subject of the parliamentary enquiry. I have investigated this exact issue as a matter of evidence based best practice in my doctoral studies in my PhD.

This issue has raised itself at the most pertinent time for the change that is needed to develop a more modern and contemporary practice standard that meets the community needs, and allow nurses to gain the professional status they need in this specialised area of practice.

The removal of the RN from the aged care setting will be disastrous for the individual and for society. The ageing population is creating a new domain in care needs that are yet to be experienced by the total population as yet. When the numbers increase we will need the expert nurse there to support guide and lead the care that is essential to the quality of life and living along with the respect and dignity in dying and death.

Key issues:

There are a number of Key issues that sit with the establishment of Registered Nurses within residential aged care settings, to which I am sure you will receive considerable feedback through this inquiry. As a specialist in gerontology I would like to focus the light for the panel on the issues that are evidence based in the literature, and that being, but not limited to:

Clinical Leadership in aged care:

1. The role of the RN in the RACF (formally a nursing home);
2. The Clinical Governance of the frail and vulnerable that meets the personal needs of individuals and their loved ones;
3. The over regulation of the industry and its barriers to providing quality long term care; and
4. The need for **clinical leadership** in gerontic care of the growing ageing population.

Today it is time for Australia to evolve with its ageing population, and allow the nursing profession to undertake its role in society as it has done since the early ages. Nurses and nursing has held the hand of society and been the leaders of

change and the protectors of standards that society demands in quality health care for all. As the nursing home becomes the inevitable hospice for society, we need to have a focus on the role of the RN in aged Care, and NOT the removal of the most needed leader.

I would like to offer this evidence based submission that I am currently preparing for publication to support the need for clinical leadership in aged care as the issue is to build the capacity of registered nurses to manage the ageing population issues.

I hope you find the reading of interest and I look forward to being asked some questions in the future.

Evidence and literature review:

The role of the registered nurse (RN) in Residential Aged Care Facilities (RACF) is as complex as it is diverse, as nurses attempt to manage the individual impact of ageing and the expectations of clients and their representatives in regard to care and support needs[1]. Nurses are required to provide leadership and guidance in care planning and to delegate direct care activities to the team. As clinical leaders of multidisciplinary health teams, they provide learning and development to subordinate staff and other professional team members as well as assisting clients to make informed decisions, particularly on issues regarding treatment choices, palliative pathways and end-of-life issues[2, 3].

The complexity of the clinical leadership role of the nurse in aged care is, however, not well known or understood. Pearson et al (2006)[4] explain that the perception of 'Best Practice' in aged care is usually achieved through the internal management systems utilised within the structure of the aged care facility, that enhance compliance to regulation and benchmark the organisation's performance against industry standards using Continuous Quality Improvement (QCI). Consequently 'Evidence Based Healthcare' as a platform for achieving 'Best Practice' in patient care is being missed. The organisation generally assumes that the health professional is already skilled and educated in the field of clinical best practice, and the opportunity to action the nurse as a vital tool in clinical leadership and

transforming the care is underutilised. Nurses often report in the literature that they feel unprepared for the role as leader of the multidisciplinary care team and lack the skills necessary to meet the Key Performance Areas (KPA) of their job descriptions[5].

Registered nurses in aged care: A "Resistance and Resilience" towards policy implementation and change

Prior to 1950 Geriatric nursing had not been pre-dominantly identified within the medical or nursing literature, although the care of elderly has been part of practice since the 1800s through the development of alms-houses that were society's answer to institutionalising all marginalised peoples together in one house. Although many of the nursing specialities have been birthed from the ideas and concepts of medicine, geriatric nursing emerged from the USA and the UK with the acknowledgment that caring for the frail and vulnerable elderly was the role of the nurse.[6] Subsequently the nursing home was established to care for the specific needs of the older adult, and professional nurses focusing on providing a "good death" and end of life care emerged as forerunners in the new reforms of nursing and society.

Unlike the USA and the UK, geriatric and gerontic nursing is not yet formally recognised as a specialisation within Australia, as the general nurse is regarded as being suitable to work in a number of healthcare settings.

It is obvious when reading through the pages of qualitative research outcomes and published works, that senior nurses have found ground in their own career retirement strategy and take up leadership roles within the aged care setting, as they are presumed to have lifelong professional skills to offer the care organisation. Academic nurses are direct in their statements claiming that gerontic nursing is a specialised field, and the role of the specialised gerontic nurse requires establishment to enable pathways for nurses to become Gerontic nurse leaders or

Geriatric Nurse Practitioner (GPN) is regularly recommended, yet this knowledge has not been transformed into practice, as fewer graduates are focused on aged care as a career beginning, and education pathways are not established.

In an Australian context of successful population ageing, there are different care settings available to the elderly population to live with assistance, advice and support as society demands a blending of the 'medical model' with the 'social model' of healthcare to allow a holistic approach and choice driven by the consumer. Independence to remain living at home with supportive services directed by the consumer is the current government philosophy known as Consumer Directed Care (CDC)[7, 8].

The CDC model is well established in America and the UK and is slowly replacing the generic model of community care in Australia, where the registered nurses' roles can be specialised to provide direct clinical care and reporting, case management and care services deployment[8]. Other Australians may opt for residential retirement living (over 55s and retirement villages) and receive flexible support to remain independent within their own dwelling, at the same time utilising the CDC model. Although the philosophy for home care support is strong, the sick, frail, and vulnerable may find themselves living in a nursing home or Residential Aged Care Facility (RACF), where there is 24 hour per day assisted nursing care, with registered nurses in charge and supervising the services.

This tiered, flexible, blending of social and medical models for care settings or long term care environments is similar to that found in 1st world countries around the globe that are facing complex issues with supporting ageing populations. The role of the registered nurse in a long term care setting or Residential Aged Care Facility (formally a nursing home) is filled with complex scenarios and diversity within the delivery of service[1]. The contemporary registered nurse today is usually found in a

clinical leadership role within a healthcare team, or autonomously working in the community with interdisciplinary collaboration utilised through a social worker, case manager or a community care coordinator. In general, the RN is identified as the clinical leader of the care team on shift or the link nurse for specific case management and coordination and clinical directorship in care needs [9-11].

The literature has painted a global representation of nursing, much like a collage. Stories expound a broad range of experiences for nurses working in aged care settings and one that reflects practice in Australia clearly, almost in 3D, if books could allow it.

Colourful descriptions of diverse role delineations and job descriptions for nursing in geriatric or long term care tell the story of what it takes to provide quality care to the most frail and vulnerable in our society, keeping them independent and empowered and at the same time safe and secure with clinical governance in place. In residential care homes (formally nursing homes), the registered nurse is placed in the leader's role to manage the care team on different shifts over twenty four hours a day, seven days a week, and clinically leading a multidisciplinary team. This role has been established to transition the care recipients, who traditionally enter the care home at a 'low care' state of wellness and then care managed into a 'high care' or the palliative stage for end of life.

As society has changed and age care reform has taken hold of the industry, demand for services is being directed into the consumer's private home [12-14]. This reform change still requires the leadership of the registered nurse to conduct clinical and care assessment for collaborating the care service to the individual and at the same time providing quality auditing and case management. Care service providers offer services to recipients across all domains of living and utilise the registered nurse across the services in different ways.

Practicing here also are those nurses who are acting independently in the community and in remote rural areas, and are providing or coordinating multidisciplinary care services within recipients' homes, day respite centres, or assisted living for the disabled [15-17] . The lived experience of the nurses who have the role of team leader in these care settings is often described in negative terms with moments of paradoxical feeling appreciated by some and not others for the work they do, yet they remain stoic and loyal to nursing care for the elderly and vulnerable. This core value of nurses is understood by nurses to be the foundation to professional practice and nursing ethics, however not jointly recognised by the organisations they work for.

Being nursing's newest or youngest specialised area of practice, Schwab (1973, cited in Eborlsole & Touhy 2006) stated that care for the elderly demands the mix of the best skills that nursing can offer, yet it is considered the lowest rung of the professional nurse[6].

Nurses and the aged care organisations, "singing from different hymn books"

Much of the discourse published within the aged care domain is also representative of the organisational impacts and key performances such as timelines, budgets, culture, and the identified lack of leadership skills in general [1, 13, 18-20].

Although not difficult to find literature that adopts a negative view of the current philosophy of care to the elderly, it does exist more evidently in the context of role definition for the nurse and accountability for patient care outcomes as the multidisciplinary healthcare reform takes shape. In general the nurse is seeing the role in care leadership differently from that of the employing provider and policy maker. Feelings of 'a lack of appreciation' experienced by nurses are based on the lack of recognition for clinical nursing knowledge and feelings that utilising results

and tabulated data from multiple sources to create care management plans is not being valued as much as organisational compliance and management goals [5, 17, 21].

Aged care nurses express that they are overworked and underpaid, yet remain true to the call that is the foundation of nursing and resistant to the calls for change. Aroskar, Moldow, Good, (2004) [22] used a series of qualitative focus groups with registered nurses across mixed areas with the same age medium and length of service. This piece of work outlines the determination of some nurses who maintain stoic attitudes toward the traditions in the practice of nursing, and resistant to the changing roles being established in today's healthcare settings.

This underpinning culture is a cause of conflict for the registered nurses within aged care, who are increasingly under pressure to deliver services based on the heavy regulatory compliance overarching the industry including the individual client's particular healthcare needs and meeting the ethical and legal obligations as a nurse. Providing complex care correctly and to a standard that is evidence based and reflects best practice is adding pressure to follow the budgetary requirement or "meeting the bottom line" for the business of care delivery, and the two are in conflict and not singing from the same hymn book [22].

Overall, the general literature outlines a universal thread, where nurses' experiences seem to generate an abundance of negative themes while working in the aged care setting, however, the positive experiences were also well established in more balanced arguments of literature and systematic reviews. One key finding that was familiar throughout the literature is that nurses working with frail and elderly clients have a strong motivation to work in aged care and strive to improve things for each individual client [5, 18, 23, 24]. This positive finding resonates stongly in nurses who have the stoic traditional core values and fundamental priciples of nursing, depicted as a

service to the sick and needy. It is also the driver for organisational recruitment of nurses to work in aged care.

Nurses in aged care regularly experience feelings of being valued at different times by different people under their care, and also by other team members during practice in aged care settings [19], however, experience quite the opposite appreciation from senior management. This paradox is usually linked to a value conflict for the nurse, as the specialised role they hold is not considered known or appreciated by the senior managers in the organisation or by the direct care workers on the frontline under their supervision and delegation.

Much of the conflict described in the literature is focussed on the distinctness of values between nurses and the service organisations. There is a definite dissimilarity between how the nurse views their role as to that of how the management views their role. Venturato[25] identifies this as the nurse is looking for traditional value and recognition that would normally have been given by the recipient of direct care from the nurse. Today the nurse's role varies and nursing care is usually delegated by the nurse to team members within a complex and multidiscipline care environment, where the values of nursing and the values of care management are not shared or in sync.

The value of nursing for the organisation is seen as a commodity of need to the service compliance and care management and therefore devalues the skill and practice for the nurse [25].

The conflicting paradigms for nurse's roles in aged care

Organisational expectations in many aged care settings have a major impact on the experiences of nurses in leadership roles. Capezuti et al.[23] and Hasson et al. (2008) [18] found that the registered nurses in aged care who initiate clinical leadership programs for their teams are often disheartened when these programs are disrupted by staffing and time restrictions, working conditions and economic factors. The high demands of regulatory compliance and meeting government accreditation standards are experienced as a 'problem' and classed as a 'hindrance', creating numerous obstacles to care delivery for nurses leading the multidisciplinary care environment [17, 24-26]. Review of the literature indicates the disconnect between the values of nursing care and the values of organisations, and the individuals that manage them [24]. There is a strength of argument for adopting the clinical leadership models of Multi-Disciplinary Healthcare Management (MDCM), however, in contrast, the argument lacks the availability of evidence that provides answers or solutions to the open ended variables and a rationale for why the registered nurse is usually positioned as the team's clinical leader within these workplaces.

There is a strong recommendation raised from previous research for establishing the formal role of the registered nurse in the aged care setting in regards to benchmarking new standards of competency and Key Performance Indicators (KPI) for nurse leaders within the aged care framework. Weston, Falter, Werbylo, et al[27] outline their evidence that competencies in clinical leadership for nursing usually focus on the standards of evidence based clinical procedures and required outcomes for the specific client and health professional. Their research identifies a need for competencies to be set out for key nursing managers and leaders to be able to

manage healthcare teams and meet the organisational KPI holistically while still producing good care for the clients as nurses [27].

This research evidence in particular gives definite argument for the articulation of nurses as professional healthcare managers in long term care settings, confident to give clinical leadership and support to both the frontline staff, other colleagues and the organisation as a whole, and still meet the nursing duty of care requirements for the care recipient, resident, or client, however termed. This articulation with the literature was achieved by an educational model that developed competency in communication amongst allied health peer groups, critical thinking and calculated risk taking for both client outcomes and organisation performance measurement[27].

The literature of other authors [13, 15, 21, 27] has outlined specific skill sets needed in the role of nurse to achieve the delivery of care in a Multi-Disciplinary Healthcare Management (MDCM) approach.

This has opened up areas in need of future investigation and new research required in order to define parameters that integrate clinical and managerial skills needed by the RNs/Team Leaders in aged care settings and specifically Residential Aged Care Facilities (RACFs), and a major recommendation from experts such as Pearson et al [28].

The role of the RN and distress in aged care

The literature collage of nursing and nursing roles continues with a diverse mix of job and role descriptions for nurses within aged care organisations. Although named, each was presented without clarity or structured boundaries to its role.

This was a common finding and one that reflected the diverse working environments experienced in community home care and residential elder care settings, and one

that aligned with consumer expectation. Registered nurses experience a clouding of the professional boundaries [19] and nurse clinical leadership is often shared among tiered levels of nurses working in aged and long term care in Australia and globally [19, 29, 30]. This phenomenon, in conjunction with the care recipients' co-morbidities, increases the stressors that already exist in the aged care workplaces [17-19, 29]. Nurses experience a sense of doubt in their competency and have little, if any, professional nursing support in the clinical leadership context of their role [18, 19, 29]. This role confusion is viewd as a negative impact on care outcomes as nurses struggle to find autonomy in their role as clinical leaders in long term care settings and specifically geriatric and end of life care scenarios, when they are no longer the instrument of direct care and must delegate to others in the team and manage the resources. Although numerous institutes that support evidence based best practice with guidelines, education and resources available, it appears out of reach to the average aged care nurse.

There are examples in the literature that identify and highlight the troubled conscience experienced between nurses of different skill levels, ranks or roles, such as that presented by Juthberg and Sundin[29] as they face the ethical and professional dilemmas in aged care nursing. Nurses are regularly described as having a lived experience of paradoxical feelings because they feel challenged by the lack of support to develop specialised skills, overwhelmed with the level of autonomy and accountability, and feeling both valued and devalued at times in their work [19, 29]. Many nurses working in aged care settings feel overwhelming low self-esteem issues associated with other colleagues looking at those nurses working in the aged care or long term care sector as having poor competency and low skills in nursing [19]. In fact, this was reinforced on those occasions when critical clinical decision-making was needed in multidisciplinary practice settings [23, 29], and it identifies that clinical leadership skill is needed to transform the team, however no

pathway for education and learning is in existence for the registered nurse in aged care to achieve or master this skill.

Often there is a clear link within research findings to the nurses' education that explains the low self-esteem being experienced [18, 23, 26]. Common threads are presented in the literature which identify that operational and organisational barriers often hinder the availability for nurses to attend planned education sessions. Resources, and specifically time, were often limited in aged care settings and education sessions usually took second place to time and resources being used for matters of compliance and organisational capability needs [18, 23]. When given the opportunity to attend education or planning sessions, however, nurses often felt positive empowerment towards lifting the competency of the whole care team, as they were identified as the RN Team Leader and were expected to pass on their knowlege.

Venturato [24] provides a balance of negative and positive experiences of nurse leaders in aged care. The exploratory study was an extension of other qualitative work carried out by the author [25] on the impact of a changed care model inside a residential aged care nursing home. The model of care designated the role of clinical leadership to the registered nurse, incorporating focussed training to support the registered nurses to lead team-based care. The study demonstrated the positive impact of supporting the registered nurses' as the clinical leaders and empowering members of the team providing care to take delegation and strengthen communication and collaborative work with the clinical lead.

The study showed how clinical leadership changed the focus of care team members from 'reactive' to 'proactive' care, and the registered nurse moved to a focus of 'leading' rather than 'doing' the work as an individual in the team [24]. The stress

factors markedly decreased and the multidisciplinary leadership model was well supported by the organisation.

Examining both qualitative and quantitative research literature and taking the recommendations for practice on face value, it is recognisably important for the organisation and the nurse to work in collaboration and improve the health of the workplace in aged care environments. Recruitment of the best skilled nurse who is a clinical leader and manager of care services would be viewed as the best outcome for the business of care and a common theme in the literiture.

Recruitment and retention of the registered nurse in the aged care setting: "getting the balance right"

The literature review demonstrates that the aged care, long-term care (LTC) and geriatric care environments are characterised by turbulence, complexity and increasing frustration as a global increase in the older population places pressure on the healthcare system to provide choice in services of healthcare and end of life [2, 12]. However, there is a lack of recommendations that address the impacts of research on practice and more of a lean towards new research on healthy ageing, re-ablement and wellness for the ageing population. The gerontological associations that have been established globally as peak bodies and evidence based leaders, appear to have a collective voice on researching the aspects of active ageing, positive ageing and providing the evidence on improving the quality of life for older populations [31, 32]. In contrast, this direction befuddles the care organisations and industry workforce as they struggle to address the lived experience of caring for the negative aspects and impacts of ageing and frailty on the emerging client base.

Nurse retention and leadership fallout as a result of social change is another contentious topic in the healthcare sector, with rich examples of the correlation and relationship between nursing turnover, retention, nurse leadership, and the

autonomous role of nurses striving for the satisfaction of the patient [33]. Chenoweth et al.[34] conducted a systematic review on the recruitment and retention of nurses in aged care in order to identify and recommend the best strategy to deal with the current crisis being experienced in Australia.

The review described the culture and experiences of the nurses in the care working environment and identified leadership and policy as areas in need of improvement in organisational recruitment and retention. It recommended new policy frameworks be developed that reflect the same caring and nurturing values that nurses hold strongly to in order for nurses to evolve into nurse leaders in aged care. This review by Chenoweth et al. [58] demonstrates a need for a focus on the positive aspects of the geriatric specialty care area for nurses and a more positive change that is required to provide support and structure to improve recruitment and retention rates of nurses in these roles. The review, however, does not elaborate on the experiences of nurses being asked to clinically lead teams in daily care work or provide a guideline for contextualised programs that develop clinical leadership in nurses managing care teams.

Nurses in aged care settings are required to provide leadership and guidance in care directives and delegation. They provide learning and development to subordinate staff and team members, and they assist clients to make informed decisions, particularly on issues of treatment choices, palliative pathways and end of life issues[2, 9, 15]. Concerns are growing over the increasing numbers of nurses leaving the aged care sector as the ageing population rises and the need for clinical nursing expertise is on the increase[1, 35]. Another general theme the literature identifies is that registered nurses are considered to be the clinical leaders in aged care and that leadership is the hallmark of effective management and retention within the service. However, recruitment to this healthcare sector is low [35]. Numerous worldwide studies have identified the devalued image of working with elderly people, and this is

represented in the limited focus on teaching and implementation of geriatric nursing skills and clinical leadership in the undergraduate nursing curricula[13].

This paradox causes frustration and concern in the management of recruitment and retention strategies for aged care organisations and is also a barrier for nurses wanting to change career or acquire advanced skills in geriatric nursing practice yet have not identified with the leadership and management performance area of the role as designated by the healthcare organisation.

Over the past few decades, leadership issues and inquiries into recruitment and retention of clinical leaders in care organisations have been identified by researchers and attracted funding for research programs from the government. With changing workplace impacts and fluid movement within government reform, organisations that deliver funded care models are engaging in research to provide guidance with the aims of better practice and quality care through improved recruitment strategy [12]. Part of this movement is focused on how to best utilise the roles and skills of the registered nurse as effective clinical team leaders in care to address the social change that is being driven by the evidence of research lead by the peak gerontological associations.

The predominant methodology in much of the research undertaken in aged care and nursing is qualitative, where survey questions and focus groups were consistently used as methods to research and collect the data that was reviewed throughout the body of evidence. Anthony, Standing, Hertz [15] have used a self-evaluation model through the use of a skills assessment proforma. This method allowed the subjects in their research to utilise time in their workplace under set scenarios to be evaluated. The set scenario placed the subject in a position where there was a requirement to delegate and lead others in a particular situation for direct patient care. The analysis of findings discovered the registered nurse team leaders

demonstrated a lack of skills to lead and mentor others, delegate tasks and complete this performance area with confidence in one's own ability [15].

Dumas et al.[36] describes the current need for organisations to provide professional nursing entry points for registered nurses who are considering careers in geriatric care or long term care, and for unregulated care workers (that being the Assistant in Nursing (AIN) and the Personal Care Assistant (PCA)) to be formally trained in specific geriatric nursing skills, as these staff already have the underpinning culture and a positive attitude towards the industry and its objectives[36]. It is obvious in the literature that career pathways need to be developed to improve retention of registered and qualified workers already in the system before they leave due to frustration or attraction to higher paid curative settings.

Declining numbers of registered nurses and an increasing ageing population will require strategic and definite leadership to effectively deliver care services to the growing elder population. The literature identifies a need for more social sciences contribution to identify certain skills gaps and learning strategies to resolve emerging issues in implementing evidenced based healthcare and positive ageing in long term care environments [37]. An increasing approach to improving long term palliative care is currently underway in Australia, as care needs are increasing and consumer preference is voicing a need for care in the private home with assistive support for re-ablement and wellness. The feared result is that the residential care setting will become the hospices of the community and particularly for those that have not lived a healthy life consisting of active and healthy ageing.

A common theme for further research has appeared from the body of knowledge reviewed that has provided support for the direction of this particular research project. Exploration is needed to identify the skill sets that the RN/Team Leader

feels will satisfy the known KPI for this diverse and challenging new role within aged care settings.

The aged care nurse as 'clinical leader' or 'manager' or 'both'?

There is strong and clear recommendation and support for frontline nurse leadership in the readings and recommendations from numerous academics [38]. Noticeably, much of the literature integrates the language and interpretations for nurse leader, nurse manager, clinical leadership and management. Simultaneously there is a definite clouding of meaning and interpretations of the terms leadership, clinical leadership and management within the literature. The discourse appears to be that nurses identify themselves as trained expert clinicians, but not specifically as managers or leaders of people and resources, and the two are seen as distinctly different roles, adding more personal and professional frustration for individual nurses. On the other hand, the organisation as a whole views the nurse as a leader and manager of the care team, delivering the service and also holding the senior clinical skill as a registered nurse.

So whether they are nurses or managers is often the cloudy issue for nurses themselves or their supervising managers, as the values of the organisation and the values of the registered nurse are distinctly different at some point and power becomes positional within the organisation [5].

**Figure : Are they nurses or managers?**
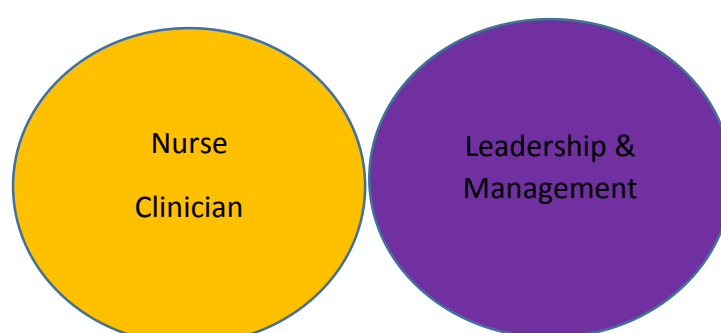
There are two distinct areas or skills sets being discussed within the literature that are used interchangeably throughout the discussions on findings and lack commonality or understanding between staff.

- Clinical scope and accountability, with
- Leadership and Management

A Nurse's clinical decisions in care assessment and planning is one skill set owned by the nurse. The other skill set, which is owned by the organisation, is aligned with leadership and management for delegation and compliance, which are expectations of the role in leading healthcare teams in aged care environs. There appears to be an overlapping of the skill sets within the role for the registered nurse in aged care settings and should be identified as a Key Performance Area (KPA) in Clinical Leadership, as seen in Figure

Figure: Clinical leadership

Nurse Clinician

Clinical Leadership

Leadership & Management
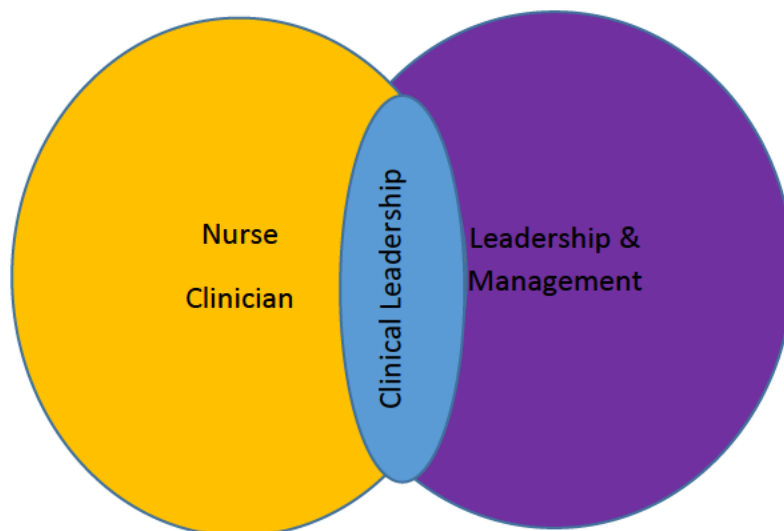
Leadership development is now considered critical for the sustainability of modern healthcare organisations that deliver aged and community care services, and nurses

now play a significant role in future recruitment and development of professional partnerships in care rather than being utilised as a mere workforce expense, which is regularly debated through much of the literature [5, 11, 21, 39]. Internally, organisations on the surface are doing much to educate and support leaders and managers of residential care through ongoing training. However, the number of published studies documenting the implementation and evaluation of leadership development programs for nursing professionals in aged care is limited to corporate or senior management and misses the clinical component and synergy with leading a care team in the frontline service.

According to Kimball and O'Neil [40] building clinical leadership competency in the nursing profession begins with innovative educational programming that rethinks the way professional nurses are integrated into the healthcare system. As an example, the foundation and structure of the Arizona Nurse Leadership Model is based on the work of Longest (1998, cited in Weston, Falter, Werbylo, et al.[27] Longest describes six critical leadership competencies in healthcare today:

1. *Conceptual: knowledge and skill to envision one's place in the organization within larger society.*

2. *Technical: direct work performed in one's domain.*

3. *Interpersonal or collaborative: human interactions and relations through which one leads others in pursuit of common objectives.*

4. *Political: dual capacity to accurately assess the impact of public policies on the performance of one's domain of responsibility and the ability to influence public policy making at both state and federal levels.*

5. *Commercial: economic exchanges between buyers and sellers in which value is created.*

6. **Governance:** *establishment and enactment of a clear vision for the organization* [27].

This research in particular gives definite argument for the articulation of nurses as professional healthcare managers in long term care settings, confident to give clinical leadership and support to both the frontline staff, other colleagues and the organisation as a whole, and still meet the nursing duty of care requirements for the care recipient, resident, or client, however termed. This articulation described was achieved by an educational model that developed competency in communication amongst allied health peer groups, critical thinking and calculated risk taking for both client outcomes and organisation performances utilising integrated care and case conferencing[27]. Throughout the literature there are a number of systematic reviews and literature reviews that investigate the impact of leadership and management experiences of staff within the aged care sector [2, 28] and more specifically within the Residential Aged Care Facility (RACF) [38, 41].

These reviews explain the experiences of staff working within the sector, and their rationale for patterns of staff turnover, recruitment and retention issues and their direct impact on care outcomes. Some authors [12] claim that clinical leadership is generally context-specific and, given that nursing homes are heavily bureaucratic and over regulated, the workplace will change depending on the values of the leader in charge at the time who may not have a clinical skill set.

Aberdeen and Angus[2] validate that the clinical leadership within aged care settings is a well acknowledged principle, however poorly understood and implemented. In the past, managers in private aged care services were often experienced clinical nurses who have adopted dual roles in management positions such as Director of Nursing (DON) that eventually separate them from the direct care and move to the senior management focus of business operations.

This collective group of DONs is today underrepresented in management roles as the industry corporatises and organisations expand. Clinicians now hold few if any managerial skills which, in turn, renders them subservient to the regulations and compliance expectations of the organisation when recruited into the role of manger or leader. Clinicians who do have managerial roles quickly lose what has been learned and applied in their original professional skills base in nursing and also become subservient to organisational compliance as a benchmark in quality care [2]. This is the basis for a move towards change within aged care as the focus on clinical leadership becomes the 'bigger' issue. Aged care peak bodies are looking forward to the positive impacts that clinical leadership change brings to the industry and the effect it has on productivity in the business of providing care.

As an example, the work of Pearson et al. [42] points out the positive impact of effective clinical leadership and management on staff productivity and care quality in healthcare workplaces in general.

Nurses react well and perform at higher standards when the workplace environment is healthy and under strong clinical leadership. Leadership styles were identified as measurable in terms of staff positiveness and a sense of fulfilment derived from being in the workplace. Leadership is connected to positive experiences in collaboration and teamwork, and in turn improves the outcome for patients, which is well documented in his comprehensive systematic review.

Building on previous work, Pearson et al's.[42] further research in quality clinical leadership is well represented through extensive government funded systematic reviews. For clinical leadership and management to be effective, the collective authors' investigations are based around staff recruitment, retention and turnover, finding that they have a direct relationship to leadership and management [34, 38].

Five themes associated with the impact of leadership and management are clearly stated, namely:

    I.   staff job satisfaction and retention;

    II.   successful change and positive work place culture;

    III.   staff productivity and unit performance;

    IV.   care quality and resident outcomes; and

    V.   associated costs [38].

Throughout this body of knowledge is the discussion of nursing clinical leadership's impact on policy. Although discussed, much less is known about the systems and policies required to facilitate effective clinical leadership and management in the aged care area as a workplace, as resistance to change is a common barrier identified for research innovation. In addition, these reviews could not articulate in-depth intensive information or document the synthesised evidence on the 'personal meaning' of a particular clinical leadership and management role of the registered nurse in this well documented complex area of aged care.

It was noted that these reviews contained a broad focus and were more related to general healthcare environments or non-clinical leaders of multidisciplinary teams. Given that the registered nurse holds a team leader's role and is usually a supervisor of numerous multidisciplinary staff, there is argument for new research into supporting the role through policy improvement, education and skills development [5, 38]. The current reform in Australia is looking at the science and building a strategy for implementation. Consequently the work of Pearson et al has established the successful clinical fellows program within the Joanna Briggs Institute (JBI) in order to develop clinical leadership skills in health professionals through grounding the knowledge and utilisation of Evidence Based healthcare.

Building the future "Nurse Empowerment" through clinical leadership development: The way forward

It is evident that the leadership role of the registered nurse, nurse manager however it is interpreted, has become an emerging key driver in a healthy workforce culture [36, 38, 41]. Notwithstanding any interpretation, as previously discussed, in the past 10 years there has been a significant decrease in the retention of nurses as clinical leaders or managers of residential aged care, while the context for the role of the nurse in management and clinical leadership has grown extensively in relation to its responsibilities. Many registered nurses are poorly equipped with both managerial and clinical leadership skills and find themselves unprepared for the complex supervisory role they hold in aged care settings where delegation and huge accountability issues are at stake. This reflects their training preparedness and inadequate role description in the organisation [38].

There have been a number of important systematic reviews completed over the past 10 years that have made substantial recommendations to improve practice in aged care and for the role of the registered nurse. Of those reviews, and the review conducted by Dwyer [5], the following recommendations were developed based on the meta-syntheses carried out:

- Employers and policy-makers should be aware that nurses in aged care and geriatrics have a strong motivation to work in the aged care sector and want to be valued by the community. (Level I Evidence)
- Educational pathways and programs are needed to improve the professional practice and continuous development of nurses with clinical and leadership skills. (Level I Evidence)
- Aged care providers and healthcare policy-makers should understand that aged care and geriatrics is a specialised area of healthcare warranting its own recognition in professional practice. (Level I Evidence)

- Organisational barriers need to be reviewed and policy implementation improved in order to promote a healthy workplace environment, support continuous improvement, promote clinical governance and improve care outcomes. (Level I Evidence)

- Providing positive and healthy workplace environments that concentrate on skills development in clinical leadership and governance improves the workforce's productivity and holistic environment. (Level I Evidence)

From this review, it was suggested that further research be undertaken to validate the recommendations and take action to have a positive impact on the industry.

Case studies:

Case studies that validate the need for nurses and specifically registered nurses are plentiful throughout the industry, and many of which you have been reviewing in this parliamentary enquiry. My aim in this advice is to inform the panel that there is a better way to address the rising crisis in RACFs and aged care, and that the profession of nursing is well established to take the lead in this highly needed health domain. There is a great amount of literature and evidence based healthcare information available in the public domain and in the academic circles. I ask the panel to consider that there is a specific need to investigate the opportunities here.

Recommendations:

Perhaps the most obvious recommendation is **NOT** to remove the RN from the RACF (formally a Nursing Home). I have added the recommendations from my own doctoral studies in this area to inform the panel that there is a better way to establish the balance between quality nursing care for the elderly and the vulnerable and build the profession of nursing in aged care.

The aged care industry and its sector support need to collaborate towards a strategy for the future needs of the ageing population and clinical leadership through nursing.

An ageing population is placing greater demand on the health services that is threefold. First and foremost is the demand on increased services for patients presenting with complex co morbidities within the ageing population and

demographic. The burden on resources is at a critical level. The philosophy for ageing in Australia is focused on mixing traditional medical models with contemporary social models that create a motivation for 'Healthy ageing, 'Active ageing' and to encourage the elderly to 'Live longer, Live better' as a government reform slogan meets the consumer voice in a growing demand for choices of care in the twilight years. Government is reacting through reform changes, in order to balance the impacts on home and long term care and assisted living for the elderly.

Second fold is the demand on the workforce. As discussed, an ageing population is also represented in the nursing workforce. As the nursing workforce is ageing, the global impact on the push and pull factors affecting the recruitment and retention strategies for nurses are major concerns of all healthcare industry stakeholders. Meeting the demand for increased services for the ageing population demands a strategy to meeting the workforce capacity to supply the needed expert nurses. Many of the nurses currently utilised in the aged care sector are demographically ageing as a cohort, and many of them will retire from the workforce and will need replacement.

Currently the multidisciplinary approach to aged care services is well practiced within Australia and overseas. This approach has found synergy with the increasing consumerism and person centred care philosophies that drive the reform as the population ages. Understanding that as humans we cannot live forever, the role of the nurse is becoming more important to the care needs of the elderly who can no longer live independently and require constant support, supervision or care in the activities of daily living. It is clear in the literature and established in practice that much of the care is provided by direct care workers under the supervision of a registered nurse. Immediately the nurse is placed in a positional clinical leadership role, required to lead a team and manage the care from numerous individuals, and

usually without the skills set or knowledge of the Key Performance Area in clinical leadership.

Now is the appropriate time for the industry peak bodies and nursing as a professional peak body to collaborate and design a strategy that develops the educational model for supporting the establishment of specialised gerontic/geriatric nurse and underpinning the skills for the role of team leader and including an ongoing pathway to Geriatric Nurse Practitioner as represented in the USA and UK.

The issue of role identity for nurses has been investigated extensively throughout the past. As far back as 1954, where Lyal Saunders [89] writes to inform us that the nurse's role is changing and will continue to change forever more. One hundred years ago the nurse operated as an autonomous individual applying the practice as an entrepreneur using a fee for service to an individual or family, working long hours and on a one to one direct care basis. Fifty years ago the nurse moved more into institutionalised care facilities offering their skills as a service for salary. Mixed into a team of other nurses and colleagues the work became impersonal, time allocation was decreased and patient numbers increased as the organisation took the control of funding and resource allocation away from the autonomy of the nurse.

Today, especially in aged care, the registered nurse has moved away from the bedside and the role of a registered nurse is heavily contextualised to the clinical and practical supervision of care through the team that they operate in and reflecting what is a 'collective expectation' to ensure the patient/resident is 'nursed' and the nurse will integrate care with others in a higher more complex multileveled team. In general the result we currently see is that the registered nurse is usually professionally and personally challenged as interpretation of the role is often seen differently by the registered nurse to that of the individuals in the collective. The art of nursing directly to the care recipient in the aged care setting has been appositionally

moved and this is grating at the core fundamentals of holistic direct patient care that nurses are still culturally trained in and hold strong value to. In order to develop the future of nursing in this emerging specialised field, undergraduate and post graduate education will be essential and will assist the recruitment of specialised nurses into aged care settings.

My research has identified that the intervention of clinical leadership training has a positive impact for the nurse even though there is a personal challenge to engage the learning program and develop new skills in order to meet the objectives in the role [90]. The finding here is that clinical leadership is a Key Performance Area (KPA) of the nurse who holds the position of team leader and is responsible for delegation of the care through subordinate staff and professional colleagues.

Through the clinical leadership training the nurse learns the skills that are needed to make the role laudable and maintain the integrity to nursing values over the continuum of care. The function of nurses in the past has been highly important, not only to the care outcome but also to nurses themselves. Identifying the registered nurse as a specialist and professional partner within an aged care organisation will build the capacity for future care services.

The emerging geriatric/gerontic nurse role will be more significant if, by combining the old values in nursing with the new clinical leadership techniques, a nurse can reach full potential as a clinical leader in a multidisciplinary team [91]. Nurses will need to be empowered to aim for those potentialities, during undergraduate training or identifying a move toward their collective future as health professionals with confidence in both their professional aspirations and their abilities to influence change[14]. I therefore make the following recommendation for industry and sector support as a strategy towards a tentative model for clinical leadership to improve outcomes in aged care:

Recommendation:

1. **Clinical leadership training is essential to the contemporary nurse role and should be grounded into the undergraduate nursing curricula and post-graduate nurse pathways; and**

2. **Leadership skills training should be incorporated into the key performance measurement for the role of the RN in the aged care setting to support the establishment of a specialist Gerontic Nurse role in Australia.**

Known in the literature [1] and validated in this research study is that people who work within aged care or geriatric care, have a passion to do so and are highly motivated for improved care outcomes. This is a key starting point for recruitment into the nursing workforce, and establishing common values between the aged care organisation and employee along with consumer of care services. One of those values has been established as 'clinical leadership' and leadership at all levels of the workforce. Transactional leadership is situational for care organisations, and the registered nurses role as clinical team leader is the key to transforming the team to meet the collective goal.

The values of nursing are a common thread for consumers and carers, and as such should be reflected in the educational development of nurses and the organisational structure and processes. The role of nurses has been specifically designed for them to be transformational leaders, in conducting their duties for clients, including the advocacy of values, education for informed choices, and planning care. Innovation is required by care organisations that blends nursing and nurses as a recruitment and retention strategy and empowers the service to continuously improve itself through nurse team leaders.

Registered nurses should be provided with a structured professional entry point including a clear role delineation when choosing to specialise in geriatric or long term care. The role of the nurse should also reflect their clinical leadership expectation as

valued by the organisation and positional to the nurse's role. Nurses in geriatric or long term residential care are best suited to be transformational team leaders and have a positive impact on care teams when trained well in clinical leadership.

Clinical leadership principles should be established as a key performance area (KPA) among all nurses and care service staff in order for them to transact and transform the best outcomes for clients and the organisation. I therefore make the following recommendation for workforce improvement:

Recommendations

1. **The establishment of the Registered Nurse Team Leader (RNTL) role** is recommended as the next nurse role in the tier of nursing within aged care, and includes both registered nurse (RN) and registered enrolled nurse (EN). This nurse requires skills in effective communication, counselling, competency assessment, conflict management, gerontic nursing skills to support clinical leadership and management of the care delivery through care workers. Preparing the quality data and care plan for collaboration in the case conference and under the direction of the GNP.

2. **The establishment of the Geriatric Nurse Practitioner (GNP) as clinical leaders of multidisciplinary teams within residential geriatric care is recommended.** This nurse has leadership skills sets in leading other nurses in clinical practice, and provides nurse practitioner directives and care treatments in complex clinical issues for multidisciplinary teams.
   Having the authority to diagnose and prescribe, the GNP is the leader of clinical decisions and a professional partner of the organisation.

Figure: Suggested pathway and tiers of specialised nurses in aged care:
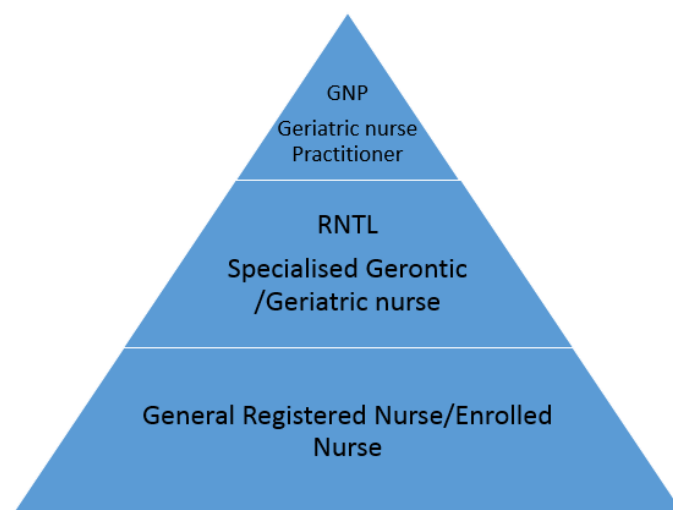
Organisational Implementation strategy (transforming the current workforce

Discussion: Leadership training should be a core principle for the organisation and valued as a key performance area

Notwithstanding the need for the aged care industry and its sector support, such as the university and college education of nurses, the organisations that deliver care to the frail and vulnerable elderly are in need of transforming the current workforce to be better equipped for reform. As it stands, the phenomenon of leadership is already underway in the aged and long term care (LTC), despite the limited interpretation that exist within the literature [13, 16, 17, 51]. Leadership is explained in numerous ways depending on the type of organisation and the value they give leadership itself, either as a quality in all staff, or a quality that is positional and status obtained such as in senior management.

Boldy et al (2006)[45] has provided a great insight to how aged care organisations can and should structure a model of leadership within their services, by looking at the leadership behaviours they wish to model. Clinical leadership is achieved

through stages and applications of the characteristics of leadership principles and implemented through structured training for the registered nurse in charge of the healthcare team.

The first stage of leadership is driven by the organisation through first reviewing and disassembling the vision, mission and value statements of the organisation in partnership with the engagement, communication and feedback from all stakeholders in the team. This process is the beginning of **'values leadership'** and the principle of what it is that the team members value, and does it match the organisational ethos. This process builds the value in trust and the value of shared communication in regards to the understood and shared values across the organisation and is known as 'values leadership'.

Person centred care is one of the strong and most valued philosophy that is used to build a common goal in the aged care team. The philosophy is one of presenting "culture change" as a movement within the aged care sector, and one that creates a fundamental shift in thinking about how nursing homes should be and how care should be delivered to an individual [92]. Residential facilities are now vigorously marketing to the industry and community to be viewed not as institutions, but as person-centered homes offering long-term care services to the specific needs of an individual. Principles and practices are being shaped by shared concerns among consumer groups, policy makers, and providers regarding the value and quality of care offered in traditional nursing homes. Critical and comparative reviews on measuring person centered care outcomes using clinical tools [93] shows promise in improving quality of life as well as quality of care, and simultaneously addressing issues on high staff turnover. It is the issue of high staff turnover that is of concern to all stakeholders, as continuity in designated carers and relationships in care are key issues that form care partnerships. Management can capitalise on the transformational power through nurse leaders to meet the key performance areas of

regulation, reimbursement, public reporting, and other mechanisms that impact on the organisation.

Nurse leaders need to find ways to build open and transparent communications in which the team members' voices are heard and valued as a means of achieving continuous improvement as outlined by senior management. The registered nurse holds the critical and pivotal position that requires transformational leadership skills to interpret the direction of management, apply the nursing process, invoke cohesion in the team for person-centred care, and to lead change when antithesis is identified with the management goal [94].

This skill is perhaps the biggest barrier in clinical leadership, as nurses are challenged when the conflict of interest is driven by compliance or organisational need, and the true value of care and best practice outcomes have been ignored. The true characteristics we value in providing care are lost when an organisation applies no person centeredness to the people that culturally lead the care team to provide person centred care, as it is a true contradiction in practice. I therefore make the following recommendation for organisational implementation and transforming the current workforce towards a tentative model for clinical leadership to improve outcomes in aged care:

Recommendation:

1. **Organisations should develop roles that demonstrate a person centred approach to staff and their careers, if they are to achieve the goals of person centred care.**

2. **Transformational leadership is an essential model for goal accomplishment in the philosophy of person centred care, utilising the role development of the registered nurse team leaders to transform both policy and practice.**

Figure: Recommendation for organisational implementation strategy step 1:
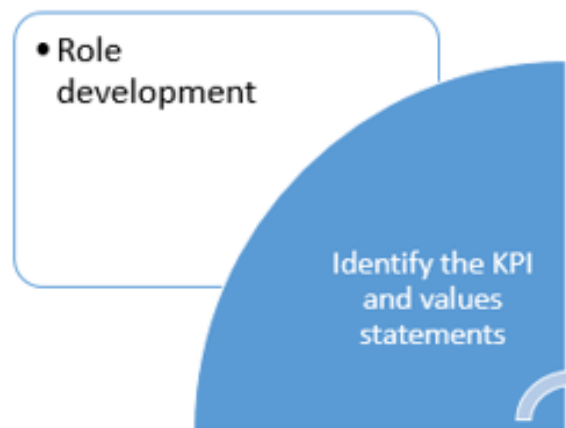
The second stage in the leadership development strategy is then identifying the facilitation approach and model they wish to apply to assist with change. Transformational leadership models are attractive and regularly validated options for nurse led teams, as the clinical leadership and clinical expertise is a driving force in meeting regulation and compliance and also establishing a valued input from numerous members of the team. Bass [95] explains "Transformational leadership occurs when leaders and followers raise one another to higher levels of shared values and motivations that result in a transforming effect on both leaders and followers".

'Transformational leadership' requires honed skills to motivate others through mentoring, communicating and challenging ideas including applications through learning opportunities or an imparting of knowledge from the leader to the team, or, from the team members to the leader. Hand in hand with transformational leadership is the **'transactional leadership'** approach. Transactional leadership encompasses the leader and the follower communicating and sharing their own self-interests, and setting goals of achievement for incentive or reward. Performance management is the tool currently used by leaders to identify weakness, or failure to reach goal or standards achievement, and allows the leader to engage and motivate

or support towards reaching goal obtainment and getting the reward for the job well done [95].

Academics writing about leadership capability frameworks discuss and recommend the **'Full range of leadership'** that includes leadership styles, behaviours, attitudes and management roles for organisational development and change as the transactional and transformational rubric can be applied to individuals within teams, teams as a whole and to organisations as a whole. Members of transformational teams learn to care about each other, they are mentored and encouraged to intellectually stimulate each other. Skills in 'transactional leadership' assist team leaders to inspire each member of the team, and to identify with the team's goals and construct pathways to higher performance. In general, transformational teams are high-performing and self-improving which is reflective of the national standards of nursing competency.

Senior management should have a core focus for the development of leadership and specifically clinical leadership through organisational policies and procedures that support and promote employee empowerment, creativity, and innovation and provide a sense of belonging to the same values and esprit de corps.

The organisational framework should include leadership training appropriate for the divergent levels of employee, meeting different skills sets for applying leadership that can be transformational at all levels within the organisation, and simultaneously working together, even in times of separation. This research has identified that clinical leadership training for the registered nurse in the role of team leader has a positive impact in empowering the nurse to motivate themselves to look for opportunity to share values and transform care as leaders.

Numerous authors have recommended that the industry would benefit from exploring the value of engaging with education providers for support to develop programs of

learning that pay particular attention to clinical leadership knowledge and skills needed in aged care. My research has effectively undertaken such a task with positive and conclusive results that have empowered and transformed the registered nurse. I therefore make the following recommendation for organisational implementation and transforming the current workforce towards a tentative model for clinical leadership to improve outcomes in aged care:

Recommendation:

1. **Clinical leadership principles should be adopted into the role of the RN team leader as a targeted recruitment.**
2. **Leadership principles should be adopted into the role of employees in aged care at multi-levels as a targeted recruitment.**

Figure: Recommendation for organisational implementation strategy step 2:

Discussion: Clinical leadership training is a positive change agent for transforming nurses and getting the evidence into practice.

Understanding that leadership is about the transformation of 'doing' what is necessary to lead and encourage others to 'get the job done', the nurse has a task at hand and numerous avenues to achieve the result. Those avenues are usually found in the sub-professionals or direct care workers in the team that are not as highly qualified as the registered nurse however, have the competency to learn new skills,

apply autonomy and have input into the delivery of care as a team member. Through clinical leadership training the registered nurse learns the improved skills in communication, mentoring, and time management, then realising that these tools are key to empowering the team to apply quality to an individual's person centred care. Leadership is seen by nurses as 'visionary' and 'relationship based' [96] and the evidence in the literature has provided a strong theoretical description of the impact of leadership on care outcomes [43], this suggests that leaders with relationship orientated values will utilise practice to improve communication flow, facilitate the interpersonal connections in the team, and provide a diverse cognitive perspective for care which in return will facilitate a positive patient outcome.

One of the major struggles experienced by nurses who work in residential aged care is to become complacent with holding a supervisory role and not be the direct care mechanism in every situation [1, 97].

Perhaps it is the lack of understanding that they themselves are the vehicle of change and the relationships they build within their teams is essential for achieving, as a whole, what would have been usually achieved by only one. Nurses in residential or community aged care then have the organisation's cultural barriers to meander through in order to get productivity at an acceptable level. Through clinical leadership skills training the RN had established that the control and power to change the organisational culture also sat in their hands through understanding the evidence based practice of clinical leadership and transforming the care.

Mentoring and supporting the needs of the team members is a positive way to develop cohesion within the team, and to achieve a mutual goal requires numerous skills and a confidence to transform the qualities that are known by the registered nurse as a professional into the other team members. During the qualitative interviews of this study, the registered nurse participants were eager to discuss that

they themselves were empowered to see the changes in productivity and performance within the team, even though having to engage in conflict, manage performance and applying a discipline to the workplace was a challenge both personally and professionally.

Factors that once seemed too difficult and too hard to achieve due to confrontation and conflict of interests and values, were now seen as tools to improve and support the needs of the team members in reaching their own benchmarks at work. Improved attitudes to communication strategies using case conference frameworks was a measure of demarcation for the nurse leaders that brought the team together and provided continuity in care goals and enhanced the person centred approach that was mastered by the registered nurse as the clinical team leader and now shared as a valued philosophy amongst the team members.

The advice I have provided addressed the contemporaneous issues within the literature that 'leadership' and 'management' although different in context, are usually intertwined and understood to be espoused. This domain of thinking is guided by the regulatory frameworks that provide accreditation, compliance and funding to the organisation. Accreditation is understood to be the bailiwick of the registered nurse's performance as quality and continuous improvement are known to be foundational to the nursing process[98]. It is paramount for both the organisation and the registered nurse to build and perfect a professional partnership in clinical leadership of the aged care team through structured education and pathways for the specialised role. I therefore make the following recommendation for organisational implementation and transforming the current workforce towards a tentative model for clinical leadership to improve outcomes in aged care:

Recommendation:

1. **Transformational clinical leadership should training be undertaken as a structured and supported learning pathway in aged care for the registered nurse.**

Figure: Organisational implementation strategy step 3: Clinical leadership training
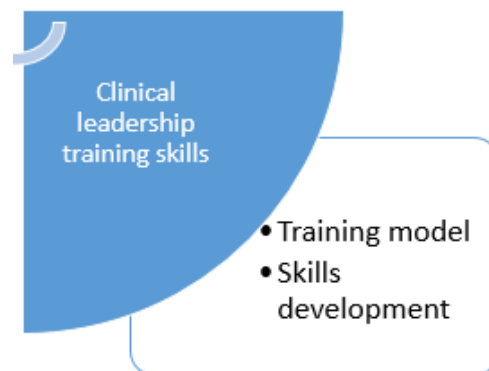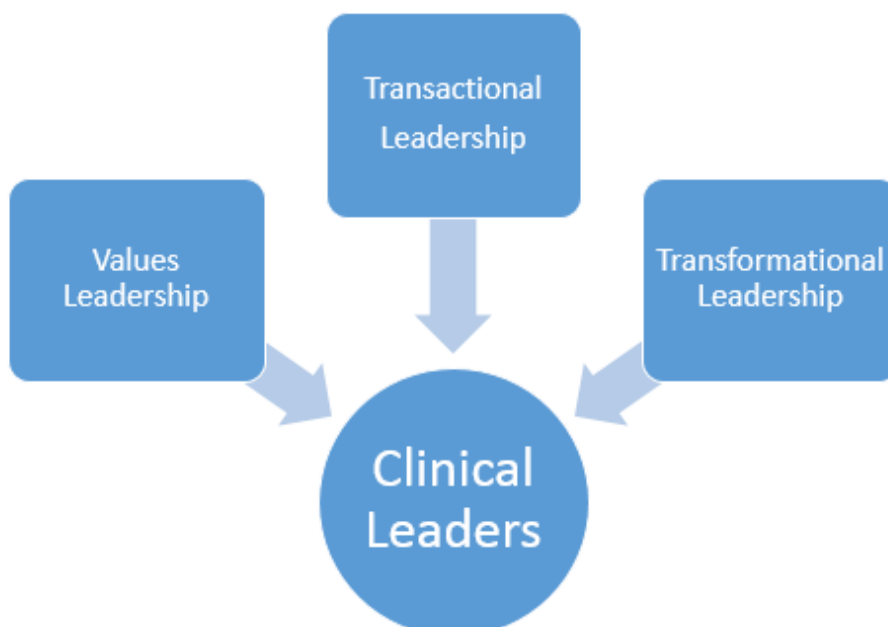

Figure: Organisational implementation strategy step 3.1: Clinical leadership training overview

More research is needed in the specialised development of IPE courses in the future and should be considered as a priority within the aged care sector.

Discussion: Clinical leadership training is essential for successful retention and building healthy workplace environs.

Recruitment and retention strategies that are collaborated between industry and nursing peak bodies and their support networks should provide opportunities for the general nurse or graduate nurse to also be contextually trained in leadership and management skills as a career pathway from General RN to specialised Gerontic/Geriatric RNTL to GNP in gerontic care. This process identifies gerontic nursing as a specialised skill and, with supported education and career advancements, it would improve the choices for nurses wishing to transition careers or move into management.

Organisations would be well prepared for improved retention through valuing the registered nurse as a clinical leader and professional partner in the business, providing avenues for transformational and transactional leadership with support to the role through continuous improvement plans. It is recommended that structured learning and skills training is continuously undertaken by organisations to support transformational leadership and to provide and improve on a healthy workplace environment for establishing professional partnerships with the registered nurse in delivering quality aged care. Below is the recommended organisational strategy for implementation step 4, and the whole strategy for organisational implementation

Figure: Recommended organisational implementation strategy step 4: Retention & continuous improvement

Figure: Recommendation towards a tentative model for clinical leadership in aged care: Developing clinical leaders in aged care.
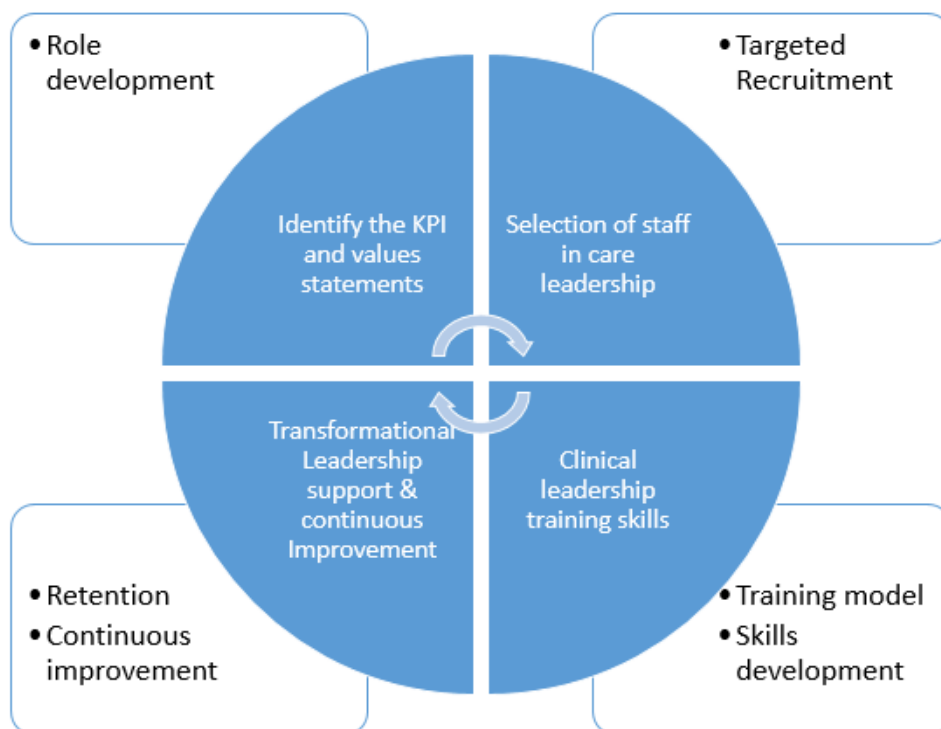
Summary

Aged care nursing is a specialised field of nursing work. Given that it may not be the most preferred work sector for many, there are those that have the passion and skills to devote their professional lives to the care of the sick, frail, and most vulnerable, and usually in very complex scenarios. As the population ages and the demands on healthcare change, so too will the impact on society. Nurses have played a role in a history that is well documented and filled with stories of leadership and change, as

they have held the hand of society in partnership as it has evolved. As society continues to transform, so too does the healthcare industry. Looking from the outside in and the inside out from the aged care perspective, we currently have one of the best equipped professionals on the planet that should be utilised more effectively in transforming the care through clinical leadership, and that is the registered nurse. Nurses are instrumental in transformational leadership within the aged care sector. Clinical leadership is a missing ingredient that will transform nursing and nurses to be the change agent they want to see both for the nursing profession and improvement in the delivery of care to the elderly population. The strength of the recommendations in this research should be well investigated as positive options for improvement to the industry, its services and the care organisations.

My own doctoral study has confirmed the hypothesis that clinical leadership training has a positive impact on registered nurses that work in residential aged care, and that targeted recruitment, training and retention assist with this process. Establishing clinical leadership is a transformational process for care teams and the nurse is well placed to be the transactional leader that transforms the individuals within the team and drives improvement for the organisation. Care service organisations can learn to value the importance of nurse clinical leaders, and support the role of the RN team leader and GNP with clear position descriptions, outlines of responsibility, and reflective pay parity to other nurse leaders and industry professionals. Nurses can learn that gerontic care is a specialised field and requires a skills set that is diverse and abstract from traditional nursing roles.

As the need for nursing care staff increases in our ageing population, we have the clear opportunity to build tomorrow's leaders today. Removing the RN from the nursing home setting is a disastrous recommendation and improving the role of the RN would be the gold standard of future care. We have the ability to change the way the RN is utilised in aged Care. The issue will be time and I feel it's nearly too late.

Respectfully

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References:

1.   Nay R. RECRUITMENT AND RETENTION OF NURSES IN AGED CARE. Australian Nursing Journal. [Article]. 1998;5(8):30-.
2.   Aberdeen S, Angus J. A Systematic Approach to Curricula Development for Aged-Care Leadership. Educational Gerontology. 2005;31(6):481-97.
3.   Caruana E. Comprehensive systematic review of evidence on developing and sustaining nursing leadership that fosters a healthy work environment in health care. Journal of Advanced Nursing. [Article]. 2008;62(6):653-4.
4.   Pearson A, Schultz T, Conroy-Hiller T. Developing clinical leaders in Australian aged care homes. International Journal of Evidence-Based Healthcare (Wiley-Blackwell). 2006;4(1):42-5.
5.   Dwyer D. Experiences of registered nurses as managers and leaders in residential aged care facilities: a systematic review. International Journal of Evidence-Based Healthcare. 2011;9(4):388-402.
6.   Ebersole P, Touhy T. Geriatric Nursing : Growth of a Specialty. New York, NY, USA: Springer Publishing Company; 2006.
7.   Buntin MB, Damberg C, Haviland A, Kapur K, Lurie N, McDevitt R, et al. Consumer-directed health care: early evidence about effects on cost and quality. Health Affairs. 2006;25(6):w516-w30.
8.   Low L-F, Yap M, Brodaty H. A systematic review of different models of home and community care services for older persons. BMC health services research. 2011;11(1):93.
9.   Anderson RA, Issel LM, McDaniel Jr RR. Nursing homes as complex adaptive systems: relationship between management practice and resident outcomes. Nursing Research. 2003;52(1):12.
10.   Baldwin KM. Elder case management by registered nurses. Prof Case Manag. 2013;18(1):15-22.
11.   Boldy D, Horner B. Leadership in aged care. Geriaction. 2006;24(4):23.
12.   Moiden N. Leadership in the elderly care home sector. Nursing Management - UK. 2002;9(8):24-8.
13.   Nay RG, S. Koch, M. Challenges for Australian Nursing in the International Year of the older person. Geriatric Nursing. [journal]. 1999 1999;20(1):14-7.
14.   Weiner JM, Tilly J, Alecxih LMB. Home and Community-Based Services in Seven States. Health Care Financing Review. [Article]. 2002 Spring2002;23(3):89.
15.   Anthony MK, Standing TS. Changing Mdels of Care. The Journal of Continuing Education in Nursing. 2001;32:5.
16.   Cheek J, Ballantyne A, Jones J, Roder-Allen G, Kitto S. Ensuring excellence: an investigation of the issues that impact on the registered nurse providing residential care to older Australians. International Journal of Nursing Practice. 2003;9(2):103-11.
17.   Cherry B, Ashcraft A, Owen D. Perceptions of Job Satisfaction and the Regulatory Environment Among Nurse Aides and Charge Nurses in Long-Term Care. Geriatric Nursing. 2007;28(3):183-92.
18.   Hasson F, Kernohan WG, Waldron M, Whittaker E, mclaughlin D. The palliative care link nurse role in nursing homes: barriers and facilitators. Journal of Advanced Nursing. 2008;64(3):233-42.
19.   Karlsson I, Ekman SL, Fagerberg I. A difficult mission to work as a nurse in a residential care home - some registered nurses' experiences of their work situation. Scandinavian Journal of Caring Sciences. 2009;23(2):265-73.
20.   Pearson A NR, Koch S, Ward C, Andrews C, & Tucker A. . Australian aged care nursing: A critical review of education, training, recruitment and retention in residential and community settings. . Canberra: Department of Education, Science and Training. 2001;.

21.   Chenoweth L, Jeon YH, Merlyn T, Brodaty H. A systematic review of what factors attract and retain nurses in aged and dementia care. Journal of Clinical Nursing. 2010;19(1-2):156-67.

22.   Aroskar MA, Moldow DG, Good CM. Nurses' voices: policy, practice and ethics. Nursing Ethics. 2004;11(3):266-76.

23.   Capezuti E, Taylor J, Brown H, Strothersiii H, Ouslander J. Challenges to implementing an APN-facilitated falls management program in long-term care☆. Applied Nursing Research. 2007;20(1):2-9.

24.   Venturato L DL. Beyond Doing: Supporting clinical leadership and nursing practice in aged care through innovative models of care. Contemporary Nurse. [Journal]. 2010 2010;35(2):157-70.

25.   Venturato L KU, Windsor C. Nurses experience of practice and reform in long term aged care in Australia: Implications for the retention of nursing personnel. Journal of Nursing Management. [journal]. 2007 2007;2007(15):4-11.

26.   Carryer J OHC, Blakely J. Experiences of nursing in older care facilities in New Zearland. Australian Healty Review. [journal]. 2010 2010;34(34):11-7.

27.   Weston MJ, Falter B, Lamb GS, Mahon G, Malloch K, Provan KG, et al. Health care leadership academy: a statewide collaboration to enhance nursing leadership competencies. Journal of Continuing Education in Nursing. 2008;39(10):468-72.

28.   Pearson A, Laschinger H, Porritt K, Jordan Z, Tucker D, Long L. Comprehensive systematic review of evidence on developing and sustaining nursing leadership that fosters a healthy work environment in healthcare. International Journal of Evidence-Based Healthcare. 2007;5(2):208-53.

29.   Juthberg C, Sundin K. Registered nurses' and nurse assistants' lived experience of troubled conscience in their work in elderly care—A phenomenological hermeneutic study. International Journal of Nursing Studies. 2010;47(1):20-9.

30.   <20060200_Nat_NP_DP7DocPallCareDem.pdf>.

31.   Peel N, Bartlett H, McClure R. Healthy ageing: How is it defined and measured? Australasian Journal on Ageing. 2004;23(3):115-9.

32.   Andrews G, Clark M, Luszcz M. Successful aging in the Australian longitudinal study of aging: applying the MacArthur model cross–nationally. Journal of Social Issues. 2002;58(4):749-65.

33.   Kowalski K, Bradley K, Pappas S. Nurse retention, leadership, and the Toyota System Model: Building leaders and problem solvers for better patient care. Nurse Leader. 2006;4(6):46-51.

34.   Chenoweth L, Jeon Y-H, Merlyn T, Brodaty H. A systematic review of what factors attract and retain nurses in aged and dementia care. Journal of Clinical Nursing. 2010;19(1-2):156-67.

35.   Fussell B, McInerney F, Patterson E. Experiences of graduate registered nurses in aged care: a case study. Contemporary Nurse: A Journal for the Australian Nursing Profession. 2009;33(2):210-23.

36.   Dumas LG, Blanks C, Palmer-Erbs V, Portnoy FL. Leadership in Nursing Homes--2009: Challenges for Change in Difficult Times. Nursing Clinics of North America. 2009;44(2):169-78.

37.   Wilkinson JE, Nutley SM, Davies HTO. An Exploration of the Roles of Nurse Managers in Evidence-Based Practice Implementation. Worldviews on Evidence-Based Nursing. 2011;8(4):236-46.

38.   Jeon Y-HM, Teri Chenoweth, Lynn. Leadership and management in the aged care sector: A narrative synthesis. Australasian Journal on Ageing. 2010;29(2):54-60.

39.   Brown B, Crawford P, Darongkamas J. Blurred roles and permeable boundaries: the experience of multidisciplinary working in community mental health. Health & Social Care in the Community. 2000;8(6):425-35.

40.   Kimball B, O'Neil E. The Evolution of a Crisis: Nursing in America. Policy, Politics, & Nursing Practice. 2001 August 1, 2001;2(3):180-6.

41.   Jeong SY-S, Keatinge D. Innovative leadership and management in a nursing home. Journal of Nursing Management. [Article]. 2004;12(6):445-51.

42.   Pearson AL, H. Porritt. K. Jordan, Z. Tucker, D. Long, L. . Comprehensive systematic review of evidence on developing and sustaining nursing leadership that fosters a healthy work environment in healthcare. Int J Evid Based Healthc. 2007; 5:45.