Sigma Final Grant Report

Summary of Project Aims

Purpose: The purpose of this study was to understand nurse leaders' (Directors of Care, unit managers, facility administrators) experiences with, and responses to, resident-to-resident aggression (RRA) in long-term care (LTC) homes in Ontario, Canada. This knowledge aimed to fill a gap in the current RRA literature as it examines RRA from a nurse leader perspective.

Aims/Goals: *The short-term goal* of this research was to gain an understanding of nurse leaders' experiences with RRA, and the strategies employed to prevent, identify, manage, and report incidences of RRA. *The long-term goals* were to 1) improve the quality of life for older adults living with dementia in LTC, 2) provide critical knowledge necessary to design, implement, and evaluate interventions to improve nurse leaders' knowledge and skills related to RRA in LTC, and 3) to develop innovative, transformative models of care, best practices for healthcare leaders in LTC, and positive organizational change.

Theoretical/Conceptual Framework

Conceptual Framework: The proposed research was guided by the LEADS in a Caring Environment framework (Dickson, & Tholl, 2014). This framework was developed in response to the growing need for a concerted, coherent and sustainable strategy for strengthening Canada's health leadership capacity. The LEADS in a Caring Environment framework is intended to take good managers and build organizational capacity for excellence in leadership and has been adopted by organizations nationally (Canadian Health Leadership Network, Canadian College of Health Leaders) and internationally as countries seek to respond to the challenge of making good health systems better. Advantages associated with this model of leadership are that it is based on the act of 'caring' and recognizes that leadership is situational. It also recognizes the complexity of the Canadian health care system and that leadership strategies are highly dependent on culture. The LEADS in a Caring Environment framework defines three components of effective leadership: 1) Being (who the leader is); 2) Caring (the 'why' of doing leadership in health); 3) Doing (how). These three components are expressed as five domains of effective leadership; 1) leads self, 2) engages others, 3) achieves results, 4) develops coalitions, 5) system transformation. Each domain consists of four core, measurable capabilities.

1) **L**eads Self- This domain requires that leaders are self-motivated, manage themselves, develop themselves and demonstrate character by modeling honesty, integrity, resilience and confidence.
2) **E**ngages Others- This domain describes how leaders must foster the development of others, communicate effectively, build teams and contribute to the creation of healthy work environments
3) **A**chieves Results- This domain describes leaders as being 'goal oriented' and in order to achieve results, they set direction, strategically align decision with vision, values and evidence, take action to implement decisions and then assess and evaluate whether or not they have achieved their goals.
4) **D**evelops coalition. This domain describes collaborative leaders, ones who are purposeful in the partnerships and networks they create in order to achieve results. They also mobilize their knowledge and demonstrate a commitment to customers and service. They also navigate socio-political environments.

5) **S**ystem Transformation- This domain describes successful leaders as ones that demonstrate systems/critical thinking. They encourage and support innovation and they orient themselves strategically to the future. Finally, successful leaders champion and orchestrate change in order to improve health service delivery.

The LEADS in a Caring Environment framework was chosen because the leadership capabilities embedded in each of the domains (described above) apply to all leaders regardless of their role or position in the healthcare system (Dickson & Tholl, 2014). Using this framework consistently with formal leaders in this study and informal leaders in future studies allows for a thorough examination of the issue and a consistency in terms of examining leadership as it relates to RRA issues in LTC. The LEADS in a Caring Environment framework informed the interview questions and guided data analysis.

Methods, Procedures, and Sampling

Research Questions

1) How do nurse leaders, working in LTC, describe their experiences with RRA?
2) How do nurse leaders describe their role related to the prevention, identification, management and reporting of RRA?
3) What formal and/or informal leadership and/or management training have nurse leaders received to prepare them to address RRA in LTC?
4) What barriers do nurse leaders face when attempting to prevent, identify, manage and/or report RRA?
5) What resources (human and non-human) do nurse leaders require to effectively prevent, identify, manage and report RRA?

Research Design**:** A qualitative descriptive design (Sandelowski, 2010) was used to answer the research questions. Qualitative descriptive research methods are "appropriate for research questions focused on discovering the who, what and where of events or experiences and gaining insights from informants regarding a poorly understood phenomenon" (Kim, Sefcik, & Bradway, 2017, p. 24).

Subjects and Setting: Using a purposive, criterion sampling strategy, 14 formal nurse leaders were recruited to ensure a rich and thick description of the phenomenon of RRA was captured. The sample included 12 females and 2 males, 13 registered nurses, 2 registered practical nurses, and 1 nurse practitioner. The selection criteria included: being employed full-time in a LTC home in Ontario, English speaking, employed in current position for a minimum of 6 months.

Recruitment: Participants were recruited using a variety of methods. Pre-existing partnerships with LTC homes in Ontario were contacted and sent an electronic copy of the recruitment poster. An electronic recruitment poster was also distributed through the Alzheimer Society of Ontario, Registered Practical Nurses of Ontario (RPNAO), and Mount Nemo Christian Nursing Home. At the end of each interview, participants were asked to notify colleagues about the study and to ask them to contact the principal investigator if they would like to participate.

Data Collection and Analysis: Data was gathered using semi-structured telephone interviews. An interview guide was used to allow the research team to capture the perspectives of the

participants. Each semi-structured interview lasted for 45-60 minutes, and all interviews were conducted by the principal investigator. All interviews were audio-recorded and transcribed verbatim. Data collection and analysis occurred concurrently in an iterative process (Streubert-Speziale & Carpenter, 2010). Two researchers independently coded transcripts and, once a code template was finalized, all transcripts were coded a second time, following which categories and themes were identified.

Summary of Findings

Leaders in long-term care (LTC) described resident-to-resident aggression (RRA) as a daily occurrence in their homes, often related to dementia and are often unintentional, and not predictable. Leaders described resident-to-resident aggression being physical, verbal, or sexual and were adamant about not using labels such as 'aggression' or 'aggressive', rather a responsive behavior with an unmet need. When RRA occurred in their homes leaders identified exploring the triggers behind the behavior and why the behavior occurred. Leaders identified getting staff involved and following up with staff. When engaging with staff, leaders describe working limited staff and working with those who have basic knowledge about the causes of RRA and the strategies to address responsive behaviors and those who lack knowledge and experience with RRA. Leaders noted how incidences of RRA require a significant amount of time to address the needs of the residents, staff, family, organization, and the reporting requirements of the Ministry of LTC. Leaders worried for the safety of the resident, other residents, and staff.

Leaders described their role as complex, demanding, and time-consuming. Leaders described making decisions about the resident's eligibility for their LTC home, developing plans of care, engaging in crisis management, and developing strategies to prevent and manage and address RRA. Within their role, they managed with limited human and non-human resources. Leaders described navigating the healthcare system including admissions from the community, transfers to the hospital, and transfers to other LTC homes. A significant amount of the leader's time was spent observing and assessing residents to determine the risk of RRA, reporting RRA, and attending care conferences and updating resident care plans. Leaders collaborated with the interprofessional team to identify appropriate interventions and described reaching out to additional community resources when the demands of the situation were greater than the local resources available. The leader also described being responsible to determine the appropriateness of a resident for their LTC home and being involved with the family to discuss incidents of RRA prior to admission to identify any early potential risk to themselves or others. Leaders described several roles within their leadership position in terms of identifying, managing, preventing, and reporting RRA.

One challenge faced by leaders was determining what "was" and "wasn't" a reportable incident of RRA. The decision to report an incident was influenced by that fact that submitting a report of RRA to the Ministry of LTC would trigger an inspection of the LTC home, creating additional work for the leader. One significant facilitator to address the challenge of RRA was interprofessional collaboration with the extended healthcare team including police and security to prevent, identify, and manage incidents of RRA. However, external collaboration was often inadequate in response to acute care needs following an incident of RRA.

Recommendations

Findings from this study have implications for LTC homes, nursing education and health policies. First, LTC home leaders must have the knowledge and skills to adequately prepare them for a leadership position to promote the prevention, identification, management and reporting of RRA. This will require cooperation from post-secondary institutions that offer undergraduate and graduate degrees in nursing. More time is required educating future registered nurses to assume leadership roles in LTC. Second, more educated front-line staff trained in dementia and RRA is necessary if RRA is to be prevented, accurately identified, and reported. Third, policies within and beyond the institution need to be developed to guide LTC leaders to support their decision making related to reporting RRA. Fourth, LTC leaders must be supported through the provision of adequate time and resources (human and non-human) to prevent, manage and report RRA. Finally, the Ministry of LTC in Ontario, Canada must examine its policies related to LTC home inspections and to use these inspections as an opportunity to provide support to LTC homes and work together to develop strategies to avoid future incidences of RRA rather than take a punitive approach.

Testimonials consisting of three to five sentences about how receiving the grant assisted you in completing your research

The funding provided by Sigma Theta Tau allowed us to explore a new area of research, one not typically a priority for funding agencies. Examining leaders in LTC and their experiences with RRA has allowed us to consider future interventions to support leaders. The funding received has also enabled us to identify a gap in nursing education- leadership. Without knowledge of leadership principles and strategies, leaders in LTC are ill-equipped to respond to RRA related challenges. This research represents the first step in a long path towards addressing RRA in LTC. Without this funding, leaders' voices would have remained silent.

References

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