ABC Dementia Home
ABC Long-Term Care Community

EVIDENCE BASED MANAGEMENT APPROACH TO BEST QUALITY OF CARE FOR PERSONS AFFLICTED WITH DEMENTIA REPORT

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Report Overview

Institutional Setting. ABC Long-Term Care Community consists of an assisted living complex, a nursing home and a dementia care facility: ABC Dementia Home. The goal of ABC Long-Term Care Community is to allow residents to enjoy an easier transition as their needs for care change throughout their senior years.

This report pertains to ABC Dementia Home. This facility’s physical environment is designed for the safety of our residents. Due to residents’ declining vision and mobility, our single-floorplan is simple; brightly lit; uses a high-contrasting color scheme between walls, floors and furniture; and solid-colored, slip-resistant flooring. One exception to our color-scheme is that our exit doors are the same color as the walls to make them less noticeable to residents attempting to wander.

Our facility offers a garden area and numerous tactile and sensory stimulation devices. Each resident has their own private room. In addition to family, most of our residents have many friendships from their time in our assisted living and nursing home facilities. For these reasons, we have created an inviting and comfortable common area to encourage frequent visits to our residents.

Residents’ daily schedules are kept as routine as possible in order to limit confusion. We consider several elements when designing this schedule and these activities such as what times of day the person functions best and each person’s likes, dislikes, abilities and interests. We also allow for ample time for meals and personal grooming. Planned activities focus on preventing
residents’ deterioration and their rehabilitation. These activities incorporate residents’ spiritual, social, physical and intellectual needs.

**Challenges.** While we have found that our physical environment has worked to improve the quality of life for our residents, we have also found that our care staff is suffering. Caring for people with dementia offers a new set of challenges and, therefore, requires a new set of skills. All care staff must learn stage-specific approaches in order to understand residents’ behavior and the best techniques to 1) minimize aggression; 2) to maximize understanding between the resident and the care provider; and 3) to promote the residents remaining abilities. Most new care staff enters this facility with a low expectation for our residents so our first goal is always to help these caregivers to realize the residents’ potential and full capabilities. Once care staff has worked in this facility for a short while, they have begun to show signs of burnout. Staff has reported feeling abandoned, isolated and discouraged. We are concerned that this will either result in an increased staff turnover rate or lead to decreased levels of care by the staff that remains and that these outcomes will hinder the residents’ quality of life.

**Interventions.** To address these challenges, our team has researched 1) the relationship between improving the staff’s working environment and residents’ quality of life; and 2) the relationship between the components of staff burnout and resident’s quality of life. These relationships are illustrated in the following chart:

Areas of interest are:
- Staff access to information;
- Flow of communication between management and front-line staff;
- Quick accessibility of patient history information for all staff members;
- Staff empowerment; and
- Causes of staff burnout and turnover.
**Research Results**

I. Professional Development and Communication

Research shows that several qualitative studies contain very good evidence that it is good communication from management to frontline staff that is most important to reducing turnover rates and quality of care for residents than any other intervention possibility.

Person – centered care is by definition an acknowledgement of ALL individuals involved in a long term care facility of any kind being able to maintain dignity and choices for themselves. From executives to the frontline staff to the resident with dementia all people involved in the facility need to be included in the person – centered care model for it to succeed.

Key words: Empower: educate and allow choices – Frontline staff: direct care nursing mainly – Structural: throughout facility – individual care or person-centered care: based on person’s and individual choices

**Patient History.** Life story work is a key to instilling empathy in care givers for their care recipients. Relationships, bonds, and respect are gained by acknowledging the care recipients life accomplishments. Having the knowledge to help someone in need of care remember the good along with assisting to maintain the individuals present capabilities while purposefully leaving out the shortcomings brought on by the disease. “Life Story Work seems to provide a vehicle for improved communication generally.” (McKeown, J., Clarke,A., & Repper, J., 2006, p 6)

There are numerous qualitative studies done with positive results for the use of life story’s (or narratives, biographical, patient history).One very good research source from Boothman (2007) has given us positive quantitative results represented in our structural model (with an r factor of +.55 for correlation from communication to patient history and an r factor of +.54 from patient history to staff relational coordination).

In using past life experiences for each person needing dementia care and focusing on what the person can do today, an effective program can be developed to maintain a quality of life that helps the person “experience life and relationships, despite the progressive disease.” (Edvardsson, D., Winbald, B., & Sandman P., 2008)

Challenge found in the field was that it was necessary to have a staff member devoted to the project of collecting and writing out family histories to accomplish the task (Clarke, A., Hansen,E.J.,Ross, H., 2003)

**Current Topic Knowledge.** Current knowledge says moving toward a person-centered care program such as Eden Alternative and the Wellspring model have mixed results (Boothman, 2007).

Using the format for evidence based care which in short means using systems that are proven to fix a problem, the focus becomes finding a problem to fix that has broad positive results.
“Owing to the expected increase in the prevalence of Alzheimer’s Disease (AD), best-practice models that promote a good life for people with AD need to be developed and assessed.”
(Edvardsson, D., Winbald, B., & Sandman P., 2008)

Starting with direct care employees the known challenges are high turnover rates for individuals who handle 80% to 90% of direct care to a care recipient (Boothman, 2007, p.5) Certified Nursing Assistants (CNA’s) have a physically and emotionally demanding job that comes with low pay and little education. Yet the stress and strain of the job is not the reason for deciding to stay or leave. “Rather, it was in the way in which care aides were treated by their employers (i.e. feeling dismissed or insignificant due to organizational policy and practices). Where CNA’s advice was accepted or simply discussed in care plans, the turnover rate was 30% versus the standard turnover rates of between 40-75% in the industry. (Boothman, 2007, p.6)

CNA’s…opinion of support was supervisors helping with difficult behavior, participation with care plans, and flexibility to make decisions in approaches to attempt. (Cohen-Mansfield, J., Bester, A., 2006)

**Best Practices**

1. Focus of best practices needs to begin with positive communication from management to frontline staff. Finding a problem that when solved has a broad base positive influence for the facility as a whole. Making educational materials available to all staff is essential.

   “Access to structural empowerment had a statistically significant, positive effect…” (Boothman, 2007)

2. Life Story work first gives a care giver a tool to build respect for a care recipient and personalize the employees work making a foundation for an empathetic bond between them.

   A patient being aware of his care givers knowing who he/she is intimately makes the difference of affiliation one with another. When the patient believes that a care giver is with them and not a distant person making decisions for them without knowing who they are it eliminates the feeling of staff being a threat. Relationships can begin to be built with care, trust, and dignity as a good basis from a patient to a care giver. (Charon, R., 2005)

3. Training frontline staff would allow effective responses to the vulnerability of the elderly care recipient and would to validate the person individually.

   “recommendations: (1)short-term programs directed toward educating family caregivers about AD should be offered…(2) intensive long-term education and support services should be offered to caregivers of patients…(3)staff of long-term care facilities should receive education about AD…” (Doody, R.S., Stevens, J.C., Beck,C., Dubinsky, R.M., Kaye, J.A., Gwyther, L., Mohs, R.C., Thal, L.J., Whitehouse, P.J., DeKosky, S.T., & Cummings, J.L., 2001).
Implementation. A live model backing study of was done by Kerry Ann Sandsmark as an intern at North Woods Village in Mishawaka, Indiana. This study is an example of implementation of improved communication and the providing of educational materials to all staff. The goal is to inform all staff of resident needs before or the day of a resident moving into the facility with no delay. A brief explanation:

Family members of prospective residents moving into North Woods Village, assisted living for memory care in Mishawaka, Indiana, are given a 25 plus page questionnaire to answer about their loved one upon admission. These answers help the staff to better care for each resident and construct individual programming.

When faced with the problem that these answers were very much needed, but the process of getting it to the frontline staff was too lengthy which left communication gaps between those admitting residents and those directly caring for residents: a system was devised. First, the information concerning the kitchen and ADL (activities of daily living) care for nursing, needs to be condensed to a single page each within the initial questionnaire. One page for all direct care questions and one page for the dietary questions that then gets photo-copied and handed to that department instantly. This empowers the frontline staff to care for and safely feed a resident without hesitation and begins to build trust and comfort for the resident right away. Second, the rest of the questions get condensed into a brief ‘Life History Summary’ with resident interests, which are coordinated with a given patient level and appropriate suggestions for attending facility activities. This form takes approximately 30 minutes to fill out and because resident admission takes a minimum of a couple days to finalize the time to have it done upon admission is realistic with only the family’s timeliness of answering their questions as a factor.

It is worthy to note also that the kitchen staff can use their photo copied page of dietary needs to then fill out the readymade form, that includes picture (usually taken on arrival) and quickly add it to the form shown on the power point which then is distributed to all three dining rooms. Keeping a clear path of communication to all staff as to what needs to be done for a new resident. This particular form saves the kitchen head of department hours a week and hundreds of copies a month versus a nursing home facility ticket system. As each one of the department heads designed their own pages and have their own forms in their individual computer systems it increases empowerment within each department.

Lastly, the staff will be provided with three binders - one for each neighborhood - with printed information on different dementias, techniques of care (such as Montessori, Validation, etc), options for calm environments, copies of studies, and quick ideas for one-on-one care. This becomes necessary as dementia care has not been the schools priority for licensure and is dependent on the work place to provide. The ‘Life Story Summary’ has been met with a hundred percent approval which is beyond expectation. Other forms developed came as they were consequently asked for. It was very surprising how well this was received, but even more so how simple it is to make the information available for frontline staff to have ‘all the tools’ management can give them to do the good they want to do! This study supports the findings in Boothman (2007, p6) that communication and recognition from administration strengthens employees willingness to stay or leave.
II. Caregiver Burnout/Turnover
After examining different types of professional development and communication, it is clear that this impacts the stress and workload of caregivers in a dementia care setting. If the proper communication and professional growth tools are not available for the employees to utilize, stress and workload can become greater as caregivers work less efficiently. This heightened stress and workload correlates strongly with caregiver burnout and even turnover. However, our research did not suggest that the burnout of these caregivers has a strong impact on resident quality of life.

Workload is defined as the degree to which the amount of work required interferes with the ability to meet patient needs and deliver high quality care (Alexander et al., 1998). Stress is defined as a feeling of being overwhelmed or strained due to demanding circumstances.

Best Practices. The problem that I assessed was the staff development and the amount of burnout and turnover within a long term care dementia setting. To better understand the link between the two, I found the correlation between professional growth and communication with stress; professional growth and communication and workload; workload and burnout; and stress and burnout. Each had significant correlations to validate this connection.

1. Stress was significantly correlated with burnout by +.63 (Kennedy, 2005). This study suggests that when a caregiver is overwhelmed and strained due to being under educated or having a lack of resources, it is more likely that they will become burnt out.
2. Professional development and communication correlated to stress -.83 (Bakker, 2004). In this study, job resources were negatively correlated to stress induced disengagement. This suggests that lack of proper tools in the workplace cause the caregiver stress that leads them to have less interest in staying in their position.
3. Stress and turnover in the care giving workplace showed a +.63 correlation (Alexander et al., 1998). This study uses the term “work hazards” to define stress and fatigue in the workplace. It shows that this is the strongest correlation to turnover for RNs specifically.
4. Workload and turnover were correlated by +.79 (Alexander et al., 1998). Workload was the main reason for caregivers in this study to feel burnout and have the intent to quit their job.

Based on this information, my research suggests that giving the caregivers tools to make them feel empowered and enabled to do their job better, through tools such as patient history charts, care for the resident will be improved.

To build trust between the caregiver and the care recipient, the caregiver should have adequate information about their background. If the caregivers know more about the resident, they can build a bond which can create empathy for the caregiver. Once that empathy is built, the quality of care for the care recipient will increase and turnover for the caregiver is less likely to happen. A connection between caregiver and recipient is a major factor for the employee wanting to stay at their job. The longer that caregiver is around, the more trust and connection they will build between each other.

This can help build empathy between the care recipient with dementia and their family as well. The caregiver can work with the family to get their background and interests. Discussing these
things can remind the family that the person is still the same person that they love, just with dementia. If the caregiver is educated in dementia as they should be, they can also help the family understand what is going on in their brain that is causing them to act how they are. More understanding and communication between them will surely instill the empathy that should be happening for the care recipient that will last throughout their dementia journey.

**Current Topic Knowledge.** There have been many studies done on caregiver burnout and turnover on nurses. However, not as many have been done in a long-term care setting and on CNAs as well as nurses. These are other great resources to look for caregiver burnout and turnover that also explain the correlation between stress, workload, and other factors to burnout. These all suggest that stress and workload significantly impact the performance and satisfaction of caregivers.

1. In a job satisfaction study of nursing assistants, the findings were that Managers need to focus more on the stressful work environment than on job content to develop a more satisfied work force (Grieshaber et. al, 1995).
2. A longitudinal study of nurse job satisfaction in correctional facilities showed that were most dissatisfied with salary and benefits, followed by limited time to do their work. (Hinshaw, 1983).
3. This integrated model of staff nurses incorporates many aspects of a nurses characteristics to find what are predictors of turnover. felt stress, job satisfaction and organizational commitment, and intention to leave. Were the found variables to impact actual turnover. Actual turnover intention decreased as the amount of time increased between expressed intentions and actual turnover (Parasuraman, 1989).
4. The findings in this randomized control study indicate that perceptions of job and nursing unit attributes, particularly autonomy and task delegation, predict satisfaction most strongly (Weisman, 1980).
5. This randomized control trial tested restraint amongst elderly with dementia. The more educated the staff was, the less the staff felt like they should use restraint. These results suggest that educational programs can improve the quality of care of people with dementia (Testad et. al, 2005).

In each of these claims, they use turnover, job satisfaction, and stress. Turnover is the actual act of the caregiver quitting, not just the intent to quit. Job satisfaction is defined by the sense of accomplishment and comfort that the caregiver has in a position. Stress is defined as a feeling of being overwhelmed or strained due to demanding circumstances.

**Implementation.** Ensuring that the caregivers have the proper empowering tools to give the residents the care they need can reduce their stress and workload. This ultimately will reduce burnout and turnover. Tools such as patient history information and continuing education should be available to each caregiver. By getting to know the resident better, and being educated on how to do so, the employee will feel empowered to give the satisfying care that they desire to give.

1. This randomized control trial tested restraint amongst elderly with dementia. The more educated the staff was, the less the staff felt like they should use restraint. These results suggest that educational programs can improve the quality of care of people with dementia (Testad et. al, 2005).
2. A study was done on CNAs who had increased supervisory support by nursing staff. It showed that with more support from supervisors, stress was minimized and job satisfaction was higher among those CNAs.

**Unknown Research.** Institutionalized dementia care facilities are rapidly growing but unfortunately are fairly new. Because of this, there are not many studies done specifically in this type of setting. As the baby boom generation grows, and the discovery of dementia increases, more research will be done to better understand the relationship between caregiver and the care recipient. More research will also need to be done to find what education and tools are needed to properly care for the resident with dementia. When this is better understood, turnover and burnout can be better understood as well. These tools may be the key to keeping staff turnover rates low, however there is not enough evidence to suggest a strong answer.

With this, I would recommend taking the time to carefully evaluate the dementia training that the caregivers receive. New programs should be tested in different facilities, then the impact it has on quality of care for the resident and empowerment that the staff gets from the training should be evaluated.

**III. Relational Coordination**

Because burnout and turnover did not result in having a large impact on resident quality of life (QOL) as was originally expected, and because relational coordination (RC) does have a substantial impact on their QOL, this facility should concentrate on promoting RC rather than on reducing turnover.

RC is defined as a method of staff interaction that incorporates communication and relationship ties into a reciprocally reinforcing process with the purpose of forming task integration (Gittell *et al.* 2008). The four specific communication dimensions and the three specific relationship dimensions can be seen in the following chart:

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**Figure 1**
Dimensions of relational coordination.
RC can be used to foster “relational competence…the ability to see the perspective of others, to empathize with their situation and to respect the work they do” (Gittell et al. 2008).

**Best Practices.** As RC is a relatively new area of study, there is no obtainable evidence suggesting how to implement RC between care providers and residents. Therefore, a broader scope into utilizing the positive effects of RC was necessary. Gittell noted that her findings “are also consistent with the client-centered approach” (Gittell et al. 2008) so, at present, client-centered, or patient-centered, care offers the best practices for communicating with and for building relationships with the residents themselves. Patient-centered care is defined as care that involves patients in their healthcare discussions and decisions by emphasizing the patient’s values, needs and desires (Constand et al. 2014). Consistent with RC, achieving patient-centered care requires “shared values and goals within teams” (Downs, 2013). There are numerous ways to apply this definition to the actual care of patients, none of which have been established as preferable over others. Thus, the best method to apply should be one that best suits this institution’s patient’s needs and that includes the three core components of all models: communication, partnership, and health promotion (Constand et al. 2014).

Specific to assessing, validating and effectively responding to the vulnerability of elders with dementia, it is recommended to create a center-wide dementia-friendly community similar to the communities currently being established in the U.K., Germany and Japan (Downs, 2013). Stigma and discrimination against dementia works to intensify the cognitive and functional impairments already being experienced by people suffering with dementia, hence causing social isolation and increasing their vulnerability (Downs, 2013). Instituting a community atmosphere that nurtures an understanding of what it is like to live with dementia and that supports people to live well with dementia will reduce this stigma and discrimination thereby reducing patient’s vulnerability and will allow for well-working patient-centered approaches to assess, validate and respond to all remaining vulnerability.

Specific to building trust and sustaining ties between the caregiver and the care recipient, good communication, which is facilitated by RC and a component of person-centered care, is essential. Care providers that “are mindful, empathetic, and flexible in their approach toward patients are better at facilitating disclosure of feelings from the patients” (Tay et al. 2011). Genuine care and concern, good eye contact, empathy, engaging dialogue, and appropriate tone and touch are all features of good communication (Tay et al. 2011). Staff possessing this good communication in combination with knowledge and competence, “increased patient’s confidence and trust in them” (Tay et al. 2011).

Specific to developing and maintaining empathy towards those with dementia and their families, the Dementia Initiative states that it is critical to remember that dementia is only one part of the whole person and that all of the parts of a person living with dementia must be embraced (Love et al. 2013). “It is important to focus on the strengths of the person living with dementia rather than on diminished or lost abilities and capabilities…it is important to ‘enter the world’ of the person living with dementia” (Love et al. 2013). Entering their world enables care providers to appreciate them, to best communicate with them, and interpret their behaviors from their
viewpoint (Love et al. 2013). It is in this understanding that true empathy can be developed and maintained.

**Current Topic Knowledge.** In addition to the studies included in this report, the following empirical studies have evaluated the best practices claims of RC or patient-centered care:

1. *Input Uncertainty and Organizational Coordination in Hospital Emergency Units* (Argote, 1982): found that coordination had a more significant effect on institutional effectiveness in institutions with high uncertainty, such as exists in long-term care facilities with dementia patients.

2. *Relational Coordination Among Nurses and Other Providers: Impact on the Quality of Patient Care* (Havens et al. 2010): relational coordination has been related to enhanced resident-reported QOL in long-term care facilities.

3. *Dementia Care and Quality of Life in Assisted Living and Nursing Homes* (Zimmerman, Sheryl et al. 2005): residents identified a better quality of life when staff had more participation in care planning and their outlooks were more favorable.


The following case studies may be helpful in further assessing the best practices claims of RC or patient-centered care:

1. *A Relational Approach to Providing Care for a Person Suffering from Dementia* (Greenwood et al. 2001): environments conducive to educating people to the importance of relationships will be more likely to alleviate symptoms of people suffering from Alzheimer’s disease.

2. *A Patient-Centered Pharmacy Services Model of HIV Patient Care in Community Pharmacy Settings: A Theoretical and Empirical Framework* (Kibicho et al. 2012): found that patient-provider relationships containing caring attitude, responsiveness, access, and respect may lead to patient trust.


As previously stated, RC is a relatively new way of approaching nursing home management and, as such, more research is needed regarding human resource development of RC in order to establish a proper framework for implementation and to identify and remove any obstacles to this implementation (Gittell et al. 2008). Similarly, there is need for empirical testing of the effects of patient-centered care when used in different types of settings and care (Constand et al. 2014).

**Implementation.** With what is currently known, it is clear that RC and patient-centered care encourage improved QOL for long-term care residents living with dementia. Unfortunately, while we have sound theories of these practices and some evidence of their positive outcomes, we do not currently have a specific framework that has been proven to bring about enhanced
resident QOL. Waiting for this framework to be designed by others, however, would result in
continued inadequate care for our residents. Within the research currently available to us, we
believe that an article written by Dr. Brian F. Hofland, titled *When Capacity Fades and
Autonomy is Constricted: A Client-Centered Approach to Residential Care*, provides a sound
foundation in which to build our own framework for these methods. In his article, Dr. Hofland
tackles how to translate “a client-centered approach into practice and policy” (1994). He covers
many of the beliefs and procedures that should be addressed, with his primary focus being on
residents’ autonomy, including: activities; decision-making; care; communication; perspective;
environment; use of advance directives; and the relationships between patients and care-givers.

**Research Conclusions**

**Significant Findings.** Our team expected to find a higher correlation between staff burnout and
turnover to resident quality of life. Instead, we discovered that improvements in this area need to
be secondary to improvements in staff relationships and communication. Key findings were:

1. A high level of staff burnout does not lead to a high level of staff turnover;
2. Staff turnover does not have a substantial impact on resident quality of life;
3. Staff communication is more important that staff training;
4. Having the proper tools to treat residents both relieves staff distress and reduces the
   impact of staff burnout and turnover on residents’ quality of life;
5. Implementing a patient history pathway between each department is a much more
   complex and difficult process than expected, but can be made almost effortless;
6. Specific methods for implementing relational coordination and patient-centered care have
   not been empirically studied and established as sound practices; and
7. Our research has brought us almost full circle: utilizing patient histories will not only
   reduce staff distress, but also requires the communication and relationship ties found with
   relational coordination and, in turn, relational coordination will improve the utilization of
   patient history charts and this will reduce staff burnout.

**Recommendations for Improved Resident Care.** Our care staff desires to give a high level of
both physical and emotional care to our residents. We need to design a system that allows our
care givers to reach their potential and, once we do, our residents’ quality of life will be
enhanced by our care staff’s improved abilities.

Care staff needs to be given the tools to provide individualized, or patient-centered, care to each
of our residents. Because a better understanding of a resident's background aids in tailored
interactions, the first tool in the staff’s toolboxes should be our patient history charts. These
charts will enable care staff to quickly understand each resident and to provide resident-specific
communication, care and activities which will result in resident-tailored-care. This tailored care
will not only enhance the resident’s life, it will also build the levels of trust and empathy between
care staff and each resident. Furthermore, use of the patient history chart should result in
improved communication between care staff and residents which will also build trust. This
improved communication should result in a higher level of care staffs’ understanding of each
resident which will increase their empathy for each resident.

The patient history chart should also prove to allow residents a greater level of autonomy since
this tool will enable care staff to better access the capabilities of each resident. It is important that
each resident be able to do stage-appropriate activities and not be treated as less capable than they are. Equally important to their quality of life, is their ability to make some of their own decisions. The improved communication, relationships of trust and empathy and ability to see things through the resident’s perspective listed in the above paragraph will all work to reinforce the resident’s autonomy.

While secondary to relationships and communication, staff distress and possible burnout does also somewhat impact the care given to our residents. Our research shows that by empowering our care staff with this patient history chart tool, as well as with improved relationships and communication, this staff distress will be reduced, enabling each staff member to feel that they are able to give a better level of care. Reducing staff distress will also have a limited impact on staff retention, which will allow residents to enjoy long-lasting relationships with care staff. These long-lasting relationships with familiar faces will allow dementia residents to feel more comfortable and secure.

As this tool is provided and utilized, we should become more aware of the next tool(s) to introduce to the care staff so that they may provide even better care to our residents.

**Recommendations for Changes to Care Management.** As with all training and programs, the effectiveness and proper utilization of these patient history charts will need to be assessed. After assessment, management will be able to address any improvements that can be made in how the care staff are using this tool. Since this tool requires the cooperation of every department in this facility, management will also be able to access how well this cooperation process is working and then initiate any improvements needed to this process. These findings should also improve the implementation and outcomes of each additional tool introduced to the care staff.

In addition to the patient history chart, relational coordination needs to be effected into our facility. Relational Coordination will create a feeling of interconnectedness among our care staff which will improve the quality of life of our residents. These improvements will also result in better process flows and communication between departments. In order to establish relational coordination, and strengthen the care staff’s communication and relationship ties, another team needs to be established to research possible implementation methods. In the meantime, this team believes that using the patient history charts and involving each department in this process, are essential and important first steps in this direction. We recommend that this team use the following explanation provided by Gittell when designing this facility’s relational coordination method:

“the effectiveness of coordination is determined by the quality of communication among participants in a work process…Frequent and timely communication can generate rapid responses to new information as it emerges, resulting in minimising delays and maximizing responsiveness to customer needs. Accurate communication reduces the potential for errors, and problem-solving communication avoids the negative cycle of blaming and information hiding, keeping the focus instead on continuous improvement and learning. High-quality relationships reinforce high-quality communication, encouraging participants to listen to each other and to take account of the impact of their own actions or inactions on those who are engaged in a different part of the process, therefore helping them to react to new information in a coordinated way, further contributing to performance of the work process.”
We suggest that in order to implement a successful relational coordination system, management should recognize and foster one of the underlying themes of this process: mutual respect for all co-workers, regardless of which department they work in. We further suggest that in order to foster this respect, management should hold a staff meeting that shows each staff member the tasks of each department and the importance of those tasks on every other department and on the quality of care of the residents. We believe that this will provide a foundation on which to build a well-working coordinated environment that will nurture staff communication and, thus, help staff to realize their shared goals and be more willing to share their knowledge with each other.

**Personal Research Application**

**Kerry Ann Sandmark:** The research will be used in my future career as it will help to create and develop programs that begin with improving a management’s ability to get information to front line staff and add a responsibility to educate their employees. When the people at a facility can communicate well with each other and about their residents then the concentration of energy at work can be directed to the resident’s quality of life.

**Raven Popoloski:** Ensure staff has access to proper tools and training to care for the residents. If the staff feels more empowered to properly care for them, their stress level and overall workload will decrease leading to less caregiver burnout. In the long run, a better cared for staff will lead to better cared for residents.

**Jennafer Kelly:** Regardless of which area of health care administration that I decide to work in, I plan to remember the importance of relational coordination and how each dimension works together and promotes the other dimensions. These relationships build on what I have already learned in my leadership courses and past work experiences. Eventually, I hope that I can learn to develop these principles and theories into realized ways of operating in my work environment, whether I am in an entry-level or a management position. If I can work in a healthy work environment, the chances are far greater that I will be able to do work that makes some sort of difference in peoples lives.
Research Cited


