

# Leaders Without Portfolio

*The case for leadership training for licensed vocational nurses.*

by Alisha Sanders

Licensed vocational nurses (LVNs) play a critical role in nursing homes in motivating, teaching and improving the skills and performance of certified nursing assistants (CNAs) who deliver the bulk of hands-on care to residents. According to surveys by the National Council of State Boards of Nursing, more than 60 percent of LVNs act as charge nurses or team leaders with responsibility for supervising and directing the care provided by CNAs.

Too often, LVNs are put into de facto leadership roles without preparation for the special demands that supervising and teaching place on them. This is an account of a collaborative program designed to train LVNs for leadership roles, along with recommendations for providers on how to better support their nurses.

**P**ast research has demonstrated that most long-term care nurses are poorly prepared to assume supervisory and leadership responsibilities. It is little wonder that many are uncomfortable with taking on these roles.

Inadequate leadership and supervision is a major contributor to job dissatisfaction and high turnover among frontline nursing home staff. Many research studies have also linked high vacancy and turnover rates to poor quality nursing home care.

## **A Curriculum for Leadership**

With support from the California HealthCare Foundation, Aging Services of California teamed up with researchers from the Institute for the Future of Aging Services (IFAS) and the University of Wisconsin-Madison School of Nursing to create a training program that would help licensed vocational nurses (LVNs) in California nursing homes become more effective leaders and supervisors of frontline staff. The training program was piloted in four nursing homes in the Oakland, Calif., metropolitan area.

The project team developed a curriculum to help participants enhance critical thinking skills, improve coaching and supervisory skills, develop better conflict resolution techniques, strengthen communication proficiency and increase cultural competency. Incorporating adult learning theory, the training was designed to be highly interactive, with audience participation invited through discussion of several scenarios and case studies. These examples were based around the practical problems charge nurses confront in their daily routines to make the training as tangible as possible to the participants.

The program consisted of one full-day session followed by a half-day booster ses-

sion approximately six weeks later. The booster session was originally envisioned as an opportunity for participants to review the knowledge and skills learned during the first training, and to get further assistance in applying the new techniques.

While the initial training primarily addressed communication with CNAs, many participants noted they were more uncomfortable expressing concerns to their DONs and administrators. A component was therefore added to the booster session on how to “communicate up” to management so their voices would be heard and their issues addressed.

The rest of this article describes the lessons learned from this program—lessons that could help to solidify the gains made by the LVNs who participated, to the benefit of staff and resident care.

## **Affirmation of Program Goals**

The study found that most LVNs do not recognize themselves as managers or leaders of their units. They receive no formal training in this area and have no professional association that helps them define this role. Most see themselves as floor nurses who are primarily responsible for “passing meds” and helping to ensure resident safety.

Furthermore, the attitude among many registered nurses that LVNs are “lesser nurses” discourages the LVNs from assuming any leadership role. While the scope of practice in California does not identify management as an LVNs’ core responsibility, in reality, most of these nurses do become charge nurses on their units and are responsible for activities on the floor and the CNAs who provide most of the direct care.

One of the major successes of this pilot training program was the recognition by

many of the LVNs that they were leaders and that they had a responsibility to manage their units, to communicate with and mentor the CNAs and to develop a team approach to service delivery.

### Content of the Training

The scenarios highlighting why and how LVNs are leaders on their units provided the “a-ha moment” for a number of participants. Some recognized for the first time the potential to develop their leadership skills and found the training helpful in laying out steps for successful unit management.

One nurse told a story of how a CNA had once called the administrator in response to how she (the LVN) had handled a situation. The administrator told the LVN to be the supervisor and not let the CNAs push her around. “I didn’t know how to talk to the CNAs,” she says. She believes the training provided information she needed to be a more effective supervisor. “It helped to be more understanding, how to communicate with CNAs, how not to offend, how to listen and get their opinion,” she says.

Management at two of the pilot sites saw a subtle increase in assertiveness and confidence among the participating nurses. For example, at one facility management had expressed frustration that the nurses would suffer through problems on the floor rather than bring the problems and possible solutions to their attention. After the first training, a group of nurses

came to the director of nursing (DON) with concerns that they were giving so many patients stool softeners, yet they were not working. In response, the DON and nurses decided to have the pharmacist come in and do reviews of the patients’ medicines.

The coaching/mentoring module was found to be effective in showing the LVNs the difference between “command and control” supervising and a coaching approach. Through scenarios and interactive role playing, the participants learned how to use “teachable moments” on the floor with CNAs to help them improve their hands-on care and communication with residents.

Several nurses felt they were more cognizant of listening to and soliciting CNAs’ input on patient care needs and keeping CNAs in the loop regarding patient status. One nurse says “I listen to their ideas now and I didn’t before. Before, I said you need to do it this way. I didn’t realize that they could have some good ideas, because they deliver so much of the care.”

Some participants believe the CNAs have noticed the changes. One nurse says, “They used to be pretty quiet. They’re telling me more about the patients now. I think now they feel included. Before, they just finished their shift and left.”

Management also seemed to notice some differences. They believe nurses are approaching CNAs in a more respectful manner and are sharing more information with CNAs regarding patient conditions.

When asked whether the nurses benefited from the training, one director of staff development (DSD) said, “I think that they did, a few of them no, but the majority ... realized that they need to share more hands-on things with the CNAs, that they need to make the CNAs feel more important and not so menial.”

### Lack of a Facility-Level Implementation Plan

Prior to the development of the training program, the project team met with the upper management of each of the facilities to ask them to consider how they were going to help the LVNs implement what they had learned once they were back at the nursing home.

We learned how difficult it is for DONs and administrators to create an infrastructure and provide ongoing support that maximizes the potential for implementation, diffusion and sustainability. Several administrators did provide some acknowledgment of the training and support for the LVNs, but this occurred on an ad hoc basis rather than in any type of formal, consistent manner.

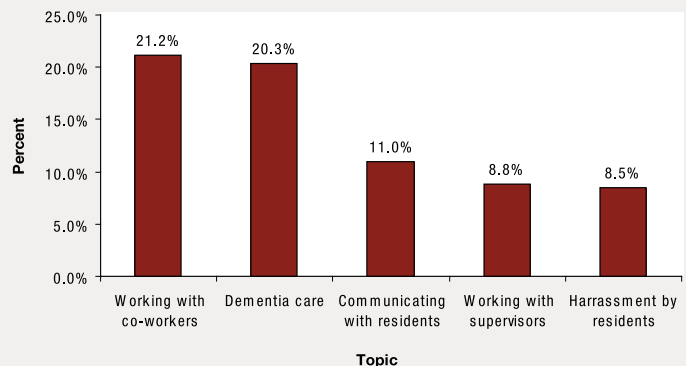
There seemed to be some cognitive dissonance between what upper management *felt* they were doing and what they actually *did* to support the program. That is, several administrators expressed enthusiasm for the program and believed they were helping staff to implement what they had learned. The administrators told the LVNs about the program prior to their attend-

## Number Crunch

### CNAs Want Training in Dementia Care, Improving Relationships

A national survey<sup>1</sup> taken in 2004 asked CNAs what topics they thought should be covered in education classes at their current job. While one-third (33.7 percent) of the CNAs interviewed did not identify a class topic, didn’t know what topics should be covered or didn’t answer the question, two-thirds (66.3 percent) identified at least one topic they would like to see covered. Among these CNAs, the top five class topics of interest were working with co-workers (21.2 percent), dementia care (20.3 percent), communicating with residents (11.0 percent), working with supervisors (8.8 percent) and harassment by residents (8.5 percent).

Topics CNAs Would Most Like to See Covered in Classes at Their Current Job



Compiled by the Institute for the Future of Aging Services (IFAS), AAHSA’s applied research arm.

To learn more about IFAS’ research into evidence-based models of care for older adults, visit [www.futureofaging.org](http://www.futureofaging.org).

<sup>1</sup> The 2004 National Nursing Assistant Survey was the first national probability sample survey of certified nursing assistants (CNAs) employed in U.S. nursing homes. The survey was performed as a supplement to the 2004 National Nursing Home Survey conducted by the National Center for Health Statistics. The CNAs interviewed represent 702,482 CNAs working in U.S. nursing homes in 2004.

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ing the sessions and afterwards asked how they liked it. For the most part, however, that was the extent of support.

It is clear from this pilot that a formal implementation plan with input from—and ownership by—all staff is a prerequisite for this type of training program. Upper management needs to work with the rest of the involved staff to develop policies and procedures that will support the charge nurse roles, including new job descriptions, criteria in performance evaluations, inclusion in orientation programs and in-services and other mechanisms for supporting the LVNs and holding them (and others such as the DONs) accountable.

In order to sustain this type of program, there must be opportunities for encouragement to provide “teachable moments” where LVNs can work with CNAs and others on their units to build teams and to help their staff perform efficiently and effectively. Incumbent and newly hired LVNs should be exposed to this program and the natural mentors who emerge should be used to help sustain the training and skills acquired.

### **The Essential Role of the Director of Staff Development**

Another lesson learned is the current and potential role that DSDs play in training LVNs to be better leaders and unit manag-

ers and in supporting them as they work with CNAs to build teams and create a healthy environment.

Despite the fact that California mandates the DSD position, these individuals appear to be underused, particularly in educating and supporting LVNs. The DSDs in the pilot sites had important relationships with both the CNAs and the LVNs and, in most cases, were respected and trusted by both levels of staff. DSDs, therefore, could be the glue that supports the LVN training program and that creates the pivotal link between the LVNs and upper management.

Unfortunately, DSDs are often tasked with additional duties and are spread thin. Their full-time role should be as staff educators, and they should cover leadership and supervisory topics in addition to the clinical and regulatory issues that are generally the focus of in-service activities.

### **Cultural Diversity**


While the CNAs in the focus groups described more examples of cultural conflicts than did the LVNs, the existence of ethnic and cultural differences and resulting problems and stresses began to surface when cultural competency was discussed in the training sessions.

The majority of the LVNs employed by the pilot facilities were from the Philippines. Through conversations with

management and observation of the nurses in the training, a number of cultural issues that may impede the ability of these charge nurses to assert themselves as leaders became evident.

For example, Filipino culture encourages deference to one’s elders and superiors. This, of course, could make it very difficult for a LVN to see herself or himself as a mentor to a seasoned CNA. The LVNs also expressed discomfort in approaching upper management with their concerns. A number of CNAs and LVNs from other backgrounds commented that the Filipino nurses often talked among themselves in their native tongue, a practice that created a sense of insecurity and discomfort among the rest of the staff. These examples underscore the importance of including cultural competence in any leadership training program, and of applying this knowledge daily on the unit.

### **Providers’ Responsibility to Charge Nurses**

Poor supervision by charge nurses is a major contributor to turnover among frontline caregivers, which in turn influences quality of care. Unfortunately, charge nurses often do not recognize themselves as leaders nor do they understand the impact they have on CNAs. Nursing homes must not only clearly spell out their expectations for charge nurses, but must also set up systems, policies and practices to support this supervisory role. Because LVNs receive little supervisory training in their formal education programs, trainings such as this one are crucial to help charge nurses develop their supervisory capabilities. This pilot study found that LVNs are in fact interested in learning the necessary skills and notice an improvement in their work relationships when they employ them. However, organizations must also have internal staff education components to help support and further the development of these nurses’ supervisory abilities. 

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