Self-Managed Work Teams in Nursing Homes: Implementing and Empowering Nurse Aide Teams

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Purpose: This article describes the progress of our study to examine the advantages and costs of using self-managed nurse aide teams in nursing homes, steps that are being taken to implement such teams, and management strategies being used to manage the teams. Design and Methods: A quasi-experimental design is underway where certified nurse aide (CNA) teams are being established in five nursing homes (NHs) in the Dallas-Fort Worth metropolitan area, and five additional NHs are being treated as comparison NHs. Results: As of March 2004 CNA teams were established in five NHs, and baseline survey data were collected from the CNAs, nurses, residents, and family members in each of these NHs as well as from those in the five comparison homes. Implications: Qualitative analyses show positive effects of CNA teams. Quantitative analyses will not be complete until follow-up survey data are collected 12 months after team implementation. Steps for implementing teams include surveying management to be sure that they want nurse teams; orienting and training the managers, nurses, and nurse aides; and facilitating the teams. Management of the teams includes routine feedback from management to the teams and vice versa while using a give-and-take approach.

Key Words: Nursing homes, Certified nurse aides, Staff empowerment, Self-managed work teams, Long-term care

U.S. corporations have experienced intense international competition throughout the past several decades. The result has been a growing urgency to find new ways of reducing expenses while maintaining or increasing productivity and quality. This situation has led many executives to reexamine their organizations’ structures and processes and, in particular, their organizations’ use of human resources. In reexamining their human resources, a growing number of executives have concluded that their workforce can be better used by allowing non-management employees to participate in management decisions related to their work (Black & Gregersen, 1997; Donovan, 1988; Henricks, 1997; Lawler, 1986, 1992). This participative-management strategy has been accomplished in a variety of ways, ranging from having weekly meetings between employees and management in order to allow for employee input (e.g., quality circles) to organizing employees into work teams and allowing the team members to make a variety of management decisions about their work. These self-managed work teams (SMWTs, also referred to as autonomous work groups, self-directed work teams, and other names) typically consist of 3 to 15 employees who are responsible for managing many aspects of their work, including, for example, planning and scheduling who will do what,
monitoring the team’s performance, and disciplining team members. At the same time, the employees are still responsible for performing the technical aspects of their work such as assembling computer boards to be installed in “smart bombs” or assembling components to be placed in automobiles (Johnson & Johnson, 1994; Wellins, Byham, & Dixon, 1994; Yeatts & Hyten, 1998).

The theoretical basis for using participative management within SMWTs can be found in several different schools of thought. The “human relations” school argues that participation is effective because it leads to higher order employee needs, such as self-expression, respect, and independence, which in turn lead to increased morale, commitment, and reduced labor turnover and absenteeism (Bouckert, 1999; Cummings, 1978; Hackman & Oldham, 1976; Hyman & Mason, 1995; Lawler, 1986; Likert, 1967). “Cognitive models” suggest that participation in decision making increases performance because it enhances the flow and use of important information in organizations (Anthony, 1978; Frost, Wakely, & Ruh, 1974; Kren, 1992; Pasmore & Purser, 1993). “Contingency models” argue that no one theoretical explanation holds across a wide variety of individuals and situations. Instead, participation will affect satisfaction and performance in different ways for different people and different situations (Anderson, 1992; Kelly, 1991; Schuster et al., 1997; Singer, 1974; Yeatts & Hyten, 1998).

Scientific research on participative management and SMWTs has occurred almost exclusively within the manufacturing industry. These studies have found that, under the right circumstances, manufacturing employees who are allowed to participate in management decisions will (a) perform at a higher level, (b) have higher job satisfaction, and (c) have lower turnover and absenteeism than will employees managed in a more traditional manufacturing environment, where employee participation is not sought or allowed (Becker-Reems, 1994; Hitchcock & Willard, 1995; Ray & Bronstein, 1995; Shonk, 1992; Wellins et al., 1994; Yeatts & Hyten, 1998). Unfortunately, relatively little research has been done on the effects of SMWTs beyond manufacturing settings, even though the theoretical explanations suggest that the positive effects of SMWTs will occur in other environments such as nursing homes. Perhaps the nursing home research that comes the closest includes those studies that have focused on the systems within nursing homes that have the potential to improve the quality of resident care (e.g., Burgio & Stevens, 1998; Schnelle, Ouslander, Osterweil, & Blumenthal, 1993).

An examination of nursing homes suggests that they provide a particularly appropriate environment for SMWTs because of the need to reduce turnover and absenteeism, the need to improve customer (resident) satisfaction, and the lack of employee empowerment in nursing home work environments (Bowers, Faan, & Jacobson, 2003; Eaton, 2000; Noelker & Harel, 2001; Stone & Wiener, 2001; Yeatts & Seward, 2000). The purpose of this article is to describe the progress made so far in our study, which is funded by The Commonwealth Fund and designed to implement SMWTs within nursing homes and subsequently measure their impacts. The article focuses primarily on implementation and management issues, because impacts will not be known until all the SMWTs have been in operation for at least a year. Provided in the paragraphs that follow is first a brief discussion of the benefits and costs of certified nurse aide SMWTs within nursing homes. This is followed by a description of how certified nurse aide SMWTs can be implemented and managed.

The Benefits and Costs of Nurse Aide SMWTs

The rationale for using SMWTs in nursing homes has been previously discussed (Yeatts & Seward, 2000). There are at least two primary reasons. First, certified nurse aides (CNAs) are rarely given the opportunity to participate in decisions related to their work. SMWTs would give CNAs this opportunity. The resulting employee empowerment has been found to create several important benefits, including increased job satisfaction and reduced turnover and absenteeism (Binstock & Spector, 1997; Cohen-Mansfield, 1997; Halbur, 1986; Packer-Tursman, 1996; Versteeg, 1990). Second, nursing homes appear to be struggling as much as any type of U.S. service industry to achieve high-quality results (Lusky & Ingman, 1994). This includes the well-being of their residents and the general satisfaction of their residents and staff. SMWTs have been found to have positive effects on quality, because those who have the most firsthand knowledge are able to use this knowledge to improve quality. In the case of nursing homes, the firsthand knowledge of the CNAs would be more fully used in the care of the residents. In short, it appears that nurse aide SMWTs would be a benefit to nursing homes because the nursing home environment is a service industry that has not fully tapped the knowledge of its “frontline” workers (CNAs), has plenty of opportunity for quality improvements, and has done little to explore newer management strategies such as the empowerment of employees within SMWTs.

When the costs of nurse aide SMWTs are considered, they can be defined primarily in terms of time. Nursing home managers such as the Director of Nursing (DON), the Assistant DON, and supervisory nurses must take time to listen to input from the SMWTs, consider their suggestions, and provide feedback to the CNAs. Further, weekly CNA team meetings take time away from the direct care to residents unless the CNAs are paid to meet after regular working hours—and in this case the cost becomes one of extra pay to the CNAs. Still another cost can include financial rewards, such as a “Team Excellence Award,” to those CNA teams that are
found to be particularly effective at improving resident care.

**Implementing and Managing CNA SMWTs**

The manufacturing environment is very different from the service-oriented nursing home environment. The effects found from SMWTs in manufacturing may not be the same as those for SMWTs in nursing homes. In addition, the procedures for establishing SMWTs in nursing homes can be expected to be quite different.

The first step chosen to implement and measure the effects of SMWTs within nursing homes was to conduct a pilot study within a single nursing home. This included the creation of 12 CNA SMWTs. Further, four survey instruments were developed and administered to CNAs, nurses, residents, and family members to measure their attitudes and satisfaction before and after SMWT implementation. As the pilot study progressed, implementation problems were recognized and addressed, the survey instruments were refined, and qualitative data were collected on the SMWTs’ effects.

While lessons were being learned from the pilot study, a much larger and ongoing study was funded by The Commonwealth Fund. Its purpose is to implement what was being learned and to collect empirical data on any effects the SMWTs have. This is accomplished by establishing CNA SMWTs in five nursing homes and utilizing five additional nursing homes as comparisons. All CNA SMWTs will be implemented by March 2004. The effects of the SMWTs will be followed for at least 12 months.

Past studies of SMWTs have found that their positive effects are highly dependent on the teams being implemented and managed appropriately (Hitchcock & Willard, 1995; Ray & Bronstein, 1995; Shonk, 1992; Wellsins et al., 1994; Yeatts & Hyten, 1998). Provided in the paragraphs that follow are step-by-step procedures that have been used to implement CNA SMWTs. This is followed by a brief discussion of how SMWTs can be managed.

**Steps for Implementing CNA SMWTs in Nursing Homes**

These steps have been developed by initially clarifying the implementation procedures or steps used in manufacturing settings (Orsburn, Moran, Musselwhite, Zenger, & Perrin, 1990; Plunkett & Fournier, 1991; Wellsins, Byham, & Wilson, 1991; Wellsins et al., 1994). Once these were determined, the steps were modified to better fit the nursing home industry. These modifications were then applied in our pilot study that established 12 SMWTs in a nursing home. From this experience the steps were further modified and then used in our larger funded research project. We anticipate that these steps will be further modified as more experience is gained in the implementation of nurse aide teams in nursing homes. Although the steps described in the paragraphs that follow appear very prescriptive, it should be noted that the implementation procedures used may vary somewhat from one nursing home to the next, depending on factors such as the culture of the nursing home and attitudes of the managers and CNAs.

1. **Introduce the Concept of CNA SMWTs to the Management Staff**

   The first step is to introduce the idea of SMWTs to the management staff, including the Administrator, DON, Assistant Administrator and Assistant DON, Social Worker, Financial Officer, Department Heads, and any others in key management positions. This should be done by someone who has an understanding of SMWTs, including their benefits and costs and their implementation requirements. The nursing home management staff should be educated on what SMWTs are, how they might be organized within the nursing home, what their purpose would be, how management would interact with the teams, and their overall benefits and costs.

   It is recommended that the managers be the first nursing home staff oriented to SMWTs. Management support is crucial to the success of SMWTs but is often lacking (Cohen, 1994; Hitchcock & Willard, 1995; Tesluk, Vance, & Mathieu, 1999; Yeatts & Hyten, 1998). Further, managers are not likely to allow the CNAs to be oriented to the concept of self-management until they are in support of it themselves (Becker-Reems, 1994; Sims & Manz, 1994).

2. **Question the Nursing Home Management Staff to Determine Their Desire to Have CNA Teams**

   Once the management staff is familiar with the concept of SMWTs and their advantages and costs, assess the management staff’s interest in making CNA teams a reality. We have used a one-page survey instrument to assess management interest in having SMWTs implemented within their nursing homes (available from the authors). Managers were informed that their answers would be kept completely confidential and would not be seen by the administrator or anyone else.

   This step is crucial because CNA teams will not be successful unless nursing home managers want them to be successful. Managing SMWTs requires that managers work with the teams, provide them with information they may have never had in the past, and perhaps even allow the teams to try things that a manager would never recommend. What is most important is that managers must take time to work with the teams (this is the major cost of SMWTs). There is nothing more frustrating for an SMWT than to work hard at developing a solution and then never receive any feedback on it or approval to
implement it. Team members are soon heard saying something like this: “Why should we bother to work on this if it doesn’t matter what we come up with anyway?” Experience implementing SMWTs suggests that it would not be fruitful to go beyond this point unless the nursing home management staff believes CNA SMWTs are worth the effort.

3. Provide a More Detailed Orientation for the Management Regarding How SMWTs Work, Their Advantages, and Their Costs

This may take two or three 1-hr sessions and should include the same group of managers as in Steps 1 and 2. It should include more detailed information about how management must interact with the team, should review positive SMWT effects that have been found elsewhere, should review the importance of allowing the team time to develop solutions, and should note the importance of allowing teams to carry out their decisions even when their decisions do not appear to be the best available (as long as their solutions have no serious detrimental effects on the residents).

At this step, the managers should decide how many teams will be established and who should be in each. Managers also can identify issues that the SMWTs can take on (e.g., provide weekly reports on resident skin care, or determine how to reduce tardiness or how to improve the process for distributing food trays). It is important to stress the need for managers to provide information to the teams when they request it, encourage the teams as they learn how to make decisions, and reward the teams when they are successful.

4. Identify Several Managers to Take on the Role of “Team Contacts”

These will be managers to whom the CNAs can go for assistance when they are trying to solve a problem and need help, such as with obtaining additional information or encouraging a team member to attend the weekly meetings. These may also include managers to whom the teams make weekly reports. For example, the team may have a weekly meeting to review skin care, weight loss, and behavioral issues of residents and then report their findings to the appropriate team contact.

5. Provide a Detailed Orientation for the Nurses Regarding How SMWTs Work, Their Advantages, and Their Costs

To educate the nurses about SMWTs, several hour-long sessions may be provided. The sessions should cover the same materials as already noted for the senior managers. In some cases, nurses may take the role of team contact. This will typically happen when the issue being addressed by the team is directly related to the nurse. For example, if a particular nurse is responsible for making sure that all the residents receive baths on a regular basis, then she might ask the CNA teams to develop improved procedures or processes for giving residents baths.

6. Orient the CNAs to the Concept of SMWTs

At this stage, an all-staff meeting should be held to educate the CNAs about SMWTs. As in the case of management and nurses, the CNAs should be taught what SMWTs are, their purpose, their advantages and costs, and how they will work, including the process of working with management. It is important at this step that the CNAs not be given unrealistic expectations. In some cases in the past, managers have exaggerated the decision-making authority of SMWTs in order to gain team member support. When this happens, the team members eventually discover that their “decision-making authority” is not as broad as described, and they become disillusioned.

7. CNA Teams Begin Holding Weekly Meetings

CNA teams typically hold at least one 30-min sit-down meeting a week. The CNAs choose a day and time to meet that they feel is best for them (e.g., a relatively slow time during their work shift). Ideally, all CNAs on duty attend the meeting and, while they are meeting, the nurses assist with the CNA duties such as answering call lights (residents’ requests for assistance).

During or prior to the CNAs’ first meeting, the CNAs should choose a team coordinator and a backup team coordinator. These individuals are responsible for making sure that (a) the team meets each week, (b) the team meetings focus on what has to be covered, (c) everyone on the team has an opportunity to share their views during the meeting, and (d) notes are taken during the meeting and later shared with the Team Contact. The team may choose to rotate the coordinator position every 3 months or so. This prevents the coordinator from gradually acting as the new “supervisor” for the team. Typically, when it is time to rotate the team coordinator position, the backup coordinator becomes the new team coordinator and a different CNA is selected by the team to be the backup coordinator. In some cases, the CNAs will prefer not to rotate the coordinator position. This typically occurs when the coordinator has been effective in this role and has maintained an equal status (as opposed to supervisory status) with the other CNAs.

8. CNA Teams Receive Interpersonal Skills Training and Training on the Procedures to Follow for Making Good Decisions

During the CNAs’ first meeting, good interper-
sonal skills should be defined. This includes the importance of listening, the fact that no idea is a bad idea, the importance of not dominating discussion, and the importance of showing respect to all team members. With regard to decision making, the team is taught that helpful procedures include clearly defining the issue or problem being addressed, identifying all possible solutions, identifying the cost and benefits of each, and, subsequently, selecting the best solution (Brightman, 1988; Niederman & DeSanctis, 1995; Schuster et al., 1997). Teams are further informed of their new responsibilities, which may include identifying ways to improve particular work processes and providing clinical staff with weekly reports on resident health and well-being.

Training is typically provided by a team facilitator. This should be someone who is nonthreatening to the team and has the knowledge needed for the training. Experience from our pilot study suggests that interpersonal skills training is best provided as on-the-job training. That is, as the CNAs interact during their meeting, the facilitator may gently note when a lack of interpersonal skills is displayed (e.g., making fun of someone’s suggestion, not listening to others, verbally attacking another CNA), and when interpersonal skills are being used effectively (e.g., asking for others’ opinions, showing respect for others who have different opinions).

9. Participation of Team Facilitator

Once the team has received training, the team facilitator should attend team meetings every other week and then slowly reduce visits as the team develops. This allows the teams to begin functioning independently. In our pilot study, we found that when the facilitator attends the CNA meeting every week, the teams can become dependent on the facilitator. In contrast, if the facilitator does not attend any meetings, the CNAs will not be fully trained and will sometimes lack focus. The goal is for the team facilitator’s presence at weekly meetings to be reduced over time, reflecting the team’s development and maturity.

Managing CNA SMW Ts in Nursing Homes

CNA teams are typically organized by shift and location. Like SMWTs in other environments, the CNAs who make up an SMWT are often those who work together on a daily basis and serve the same residents. This means that they typically work during the same shift and on the same floor(s) or wing(s) of the nursing home. Or they may work on two different shifts but serve the same residents.

During a sit-down meeting, the CNAs focus on issues identified by management (e.g., Administrator, DON, or Nurse) as well as on issues identified by team members. For example, the team may have learned from the nursing home’s DON that a number of residents and their family members have complained that when the resident is being fed breakfast the food is cold. The DON has asked the team to develop a more efficient process for passing out trays so that the residents will be fed hot food. The team follows problem-solving steps that include identifying possible solutions, obtaining information as needed, and weighing the strengths and weaknesses of each possible solution (Brightman, 1988; Niederman & DeSanctis, 1995; Schuster et al., 1997).

Once a potential solution is selected by a team, it can be presented by one of the team members to the appropriate management person. This is typically the manager who presented the issue to the team or, if the issue originated from the team, the manager who is most directly associated with the issue. The manager(s) then reviews the team’s potential solution and as soon as possible provides feedback to the team. The manager(s) may choose to accept the CNA team solution as is, may suggest some changes to it, or may point out serious shortcomings of the solution. In the latter case, the CNA team is typically lacking some crucial information, such as how early food can be delivered or how much the food service staff can be expected to do. When the CNA team is lacking information, the manager(s) must take responsibility for providing the CNA team members with the information they lack and then allowing the team to reassess its solution with this additional important information in hand. This process is known as “catch-ball” in manufacturing settings, because ideas and possible solutions are thrown back and forth between the team and a management staff person(s) until all agree on the solution to be adopted (Yeatts & Hyten, 1998).

It is crucial that the management person(s) always be supportive of the team during this catch-ball process. Even poor choices by the team are likely to have some merits that can be highlighted. Further, it is important that management not have a solution already in mind and force the team to continue reconsidering solutions until the solution matches that of management. In this situation, the team members soon recognize that it does not matter how seriously they take the problem or how hard they work to find a solution; whatever they propose will be rejected until it reflects what the manager wants. This quickly results in a team that stops problem solving. It is also valuable for managers to allow teams to try their solutions even when the solutions do not appear to be workable—as long as the solution will not harm a resident or otherwise have significant adverse effects. Teams can grow substantially by being allowed to make mistakes, recognize them, and make corrections.

Conclusions

The successful implementation and management of SMWTs in nursing homes will depend on having
the full support from the nursing home management, providing thorough training to management and CNA teams, providing teams with the information needed to make good decisions, allowing the teams time to meet regularly, and encouraging management to routinely interact with the teams in a catchball (feedback) style. Research in manufacturing settings has found that SMWTs can be an effective means of reducing turnover and absenteeism and of improving job satisfaction, decision making, and performance. However, it is not yet clear whether the same results can be obtained in the nursing home. Qualitative data from our pilot and current study have shown a number of positive outcomes, such as improved interpersonal relationships leading to better coordination of resident care, discussions of absenteeism and lateness leading to more awareness of these, and increased information sharing that has led to improved understanding of nursing home policies. The ongoing Commonwealth Fund study of five experimental nursing homes (using SMWTs) and five comparison nursing homes (using a traditional management approach) will help to further clarify the impacts of CNA teams on job satisfaction, absenteeism, turnover, and resident care as well as clarify implementation issues and factors important to SMWT success.

References