Peer Mentoring of Nursing Home CNAs: A Way to Create a Culture of Caring

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Abstract:

A carefully-crafted peer mentoring program for CNAs may be an appropriate component of any culture change movement in the long-term care setting. This paper contains a detailed description of the peer mentoring program developed by the Foundation for Long Term Care (FLTC) and how peer mentoring may affect culture, with or without a formal cultural change movement within the facility. In it, we suggest that peer mentoring is likely to (a) improve CNA retention rates; (b) improve orientation processes so that they reflect the values of the facility; (c) reinforce critical skills and behaviors; (d) teach the value of caring; (e) use exemplary aides to role-model exemplary care; (f) support new staff as they make the transition to being part of the facility team; and (g) provide recognition and a career ladder for experienced nurse aides. The nurse aide subculture is critical to a supportive nursing home environment and a culture of caring, and hence, must be considered in any culture change movement.

Key Words: peer mentoring; CNAs; culture change; long-term care; staff retention; staff orientation; role model.

Introduction

This article contains a discussion of why a carefully-crafted peer mentoring program for CNAs may be an appropriate component of any culture change movement in the long-term care setting. It also contains a detailed description of the peer mentoring program developed by the Foundation for Long Term Care (FLTC) and how peer mentoring may affect culture and cultural change, with or without a formal cultural change movement within the facility.

This FLTC peer mentoring program, entitled "Growing Strong Roots" in recognition of a powerful poem written by CNA Connie Trendel (see box) is designed to (a) improve CNA retention rates; (b) improve orientation processes so that they reflect the values of the facility; (c) reinforce critical skills and behaviors; (d) teach the value of caring; (e) use exemplary aides to role-model exemplary care; (f) support new staff as they make the transition to being part of the facility team; and (g) provide recognition and a career ladder for experienced nurse aides. It is a program in which experienced and excellent CNAs share values and their practice wisdom with new aides to help the new aides succeed in, and stay with, the facility. By being identified as an excellent worker and by being compensated for their peer mentoring, the experienced aides also benefit.

For the purposes of this project, (Madison, 1994, parentheses added).

The FLTC is a not-for-profit research entity affiliated with the New York Association of Homes and Services for the Aging (NYAHSA), an association of not-for-profit and governmental providers of elder-care services in New York state. The author hopes that the FLTC's enthusiasm for this concept will resonate throughout this paper.

Theoretical and research background

A FLTC survey of 345 nursing homes from three states (New York, Pennsylvania, and Illinois) in 1999 revealed that 69 percent of respondents have some form of self-defined mentoring or peer support program for their CNAs, but only 13 percent of respondents reported mentoring programs which focus not only on expediting initial training, but also on *supporting* new aides so that they remain with the facility (Hegeman, 2001). This expanded concept of peer mentoring is the one used in this article.

Based on information and concepts from these respondents, other extant models, a literature search and suggestions from our consultants and advisory board, the FLTC developed "Growing Strong Roots." At the time this article is being written, the FLTC is rigorously testing its impact in 15 New York state not-for-profit nursing homes.

There are three key ways by which a peer mentoring program relates to culture change: (1) it has the potential to improve retention of staff; (2) it is a cultural change movement of its own, focused on the CNA subculture; and (3) it supports other principles of culture change. Each of these responses is discussed below.

Improving retention: With turnover rates of nursing home CNAs cited as high as 105 percent (Wilner and Wyatt, 1998), it can be difficult to begin and support culture change. Historically, aides do not remain at a facility long enough for meaningful education, not only to the cultural change environment, but to the very basics of care. The revolving door of CNAs is

a self-perpetuating problem. Aides leave in frustration because staffing is short and staffing is short because aides are leaving.

Peer mentoring promises to be part of the solution to this disheartening downward spiral. Straker and Atchley (1999) report that in a survey they conducted "both nursing home and home health care agencies with low turnover rates were more likely to mention programs to *improve co-worker relationships* than their high turnover counterparts." Developing good co-worker relationships is, of course, at the core of peer mentoring. A study of one peer mentoring program found turnover was reduced from 53.7 percent to 17 percent once the program started (Shemansky, 1998).

Reducing costs: There is also a potential for considerable cost-saving. One study estimates the cost of turnover in a nursing home at $4,000 per position per year in 1992 dollars (Straker and Atchley, 1999). When translated to a facility level, just one facility with a high turnover rate could spend more than $240,000 on recruiting and replacing staff. This project may therefore result not only in improved care, but also in savings that can be used for direct care of residents.

Peer Mentoring as Cultural Change for CNAs

Peer mentoring is also—in itself—a way to create a culture of caring among aides within a long-term care facility. When carefully-selected, experienced CNAs who embody the caring values of their facility become successful peer mentors, there are clear potential organizational changes:

- aides who demonstrate and embody a culture of caring are acknowledged and recognized. It is a program expectation that this acknowledgement will increase their own satisfaction and retain them within the facility. Therefore, we are rewarding the skills we most value;

- the behaviors and attitudes of staff that support a culture of caring are the behaviors and

attitudes the new CNA is exposed to, making it more likely they will be the traits which are learned and emulated; and,

- the facility establishes a formal process to develop a positive CNA subculture.

The nurse aide subculture is critical to a supportive nursing home environment. It interacts separately from and often in reaction to the corporate culture of the entire nursing home. Deal and Kennedy [in Ramirez (1990)] define the culture of a nursing service organization as just "the way we do things around here." If the "way we do things around here" is perceived as supportive, work redesign is more productive (McDaniel and Stumpf, 1993). If CNAs perceive "the way we do things around here" as supportive of both them and the residents they care for, there is likely to be a positive CNA culture.

By contrast, a negative perception of "the way we do things" can aid and abet a negative subculture of the nursing aide within the nursing home. A Web-site devoted to CNAs (http://www.nursingassistant.org/HorizV1.html) used the term "horizontal sabotage" for negative CNA-to-CNA behaviors which are in reaction to a facility culture that is seen as punitive. Examples included setting the next shift up for failure or blaming a previous shift for mistakes or omissions made by the current shift.

A negative CNA subculture can also occur by omission. In an observational study, Bowers and Becker (1992) noted that experienced CNAs were, while not hostile to the new CNAs, quite passive about making any effort to help them, commenting frequently on whether they believed a new employee would make it or not, but rarely offering any assistance to help the new hires be successful. This kind of studied indifference to the real challenges of starting work in a long-term care unit (which in some cases can also be seen in management staff) is what some advisory board members of "Growing Strong Roots" describe as a system in which nursing homes "eat their young." A peer mentoring program in which aides are empowered when they

support each other may well reduce the deleterious "horizontal sabotage" and "eating their young" effects on CNAs.

Another approach to the nursing home CNA subculture was developed by Tellis-Nayak and Tellis-Nayak (1989). It focuses on how the culture CNAs bring *to* the facility affects the culture *within* the facility, classifying inner-city aides into two types: (a) the determined "strivers" and (b) the disaffected "endurers." Needless to say, the "strivers" are hired more frequently, but tend not to stay.

The typical facility, Tellis-Nayak and Tellis-Nayak (1989) assert, with its middle-class management, often does not respond to the needs of this larger second group and reinforces their disaffection. The authors suggest that poor administrators ignore the affective needs of these aides, but excellent administrators foster a family spirit that compensates for the challenges of their personal world. Peer mentoring may be a way to create this family spirit.

Supporting Elements of Cultural Change

A third way peer mentoring can relate to cultural values and cultural change in the nursing home setting is by supporting other principles of culture change. Certainly, one cornerstone of cultural change in nursing homes is greater autonomy of both residents and staff. Bowers and Becker (1992) found that strategies developed by individual nurse aides to plan and implement the way they deliver care affected the quality of care they give. If, as would be logical, nursing home management selects mentors who embody *both* caring behaviors and excellent care planning/ time management skills, new CNAs will learn a critical, but often untaught "trick of the trade"-- effective management of their work load so that they work and respond to the collective needs of residents rather than work around a rigid task list.

The speed of the acquisition of knowledge will also be impaired. Instead of learning time and resident management by trial and error (or even worse, not learning it at all and quitting in frustration), new aides will learn important "tricks of the trade" faster. Peer mentoring is an ideal way to teach positive "practice wisdom" management not formally taught in the clinical skills component of the CNA certification program.

Description of the FLTC's Peer Mentoring Program

"Growing Strong Roots" is a project supported by funding from the Fan Fox and Leslie R. Samuels Foundation. The overall goal of the project, funded in March 2001, is to create an effective, replicable, and sustainable peer mentoring program for new nursing assistants which encourages their retention and commitment to explicit caring values of long-term care.

Measurable objectives are:

1. to develop a training intervention based on the "best of the best" of peer mentoring programs that have shown promise in nursing homes across the country;

2. to test this intervention in 15 nursing homes in New York state in terms of costs, feasibility and outcomes; and,

3. to disseminate findings through the World Wide Web, national conferences, specific trainings and through a Web and print-based "how-to" manual.

Consistent with the objective to build upon "the best of the best" of extent models, those models (Appendix A) were reviewed, analyzed, synthesized and broadened with input from the project's advisory board (Appendix B) and refined following experience at the pilot site.

The model that was ultimately developed has five core organizational components:

- training for facility coordinators;

- an orientation for the mentor and mentee's supervisor to assure their support;

- mentor training;

- follow-up booster training of mentors; and,

- a formal evaluation.

It is important to note that two of these components (facility coordinator and supervisor training and orientation) provide an essential facility-wide context for the peer mentoring training. It is, in the view of the advisory board and project staff, naïve and counterproductive to try to fix a system-wide problem by targeting resources solely on training of CNAs, who are often the victims of larger management problems (short staffing, scheduling, case mix) rather than its cause. A peer mentoring program is designed for aides, but it is also a statement that the entire facility has core values it wishes to impart to the new aides and is willing to reward experienced aides who embody these core values through a special program. Therefore, it is a project that should be "owned" by the entire facility. This facility-wide ownership, of course, is a prerequisite of any culture change endeavor.

The training for facility coordinators, called "facility liaisons" in this project, focuses on assuring facility "buy-in," an overview of project training content and a checklist of the myriad of logistical issues inherent in a project of this size. These logistical issues include: a process for recruiting and selecting mentors; union involvement; project oversight; training logistics; and evaluation.

The training program for the mentors requires a full six-hour day; it is recommended that the selected aides receive this training off-site, in the same way nurse supervisors and administrations attend workshops. This "away from work" training accomplishes two things:

(1) it sets this training apart from the familiar in-services; and

(2) avoids the CNA being called back onto the unit.

The educational goals of the peer mentoring training are to:

1. identify the four main roles of a mentor (role model, social support, tutor, peer resource);

2. describe how a positive attitude sets the tone for the social and professional integration of mentees into the facility;

3. demonstrate the use of effective communication skills;

4. describe ways to use leadership skills to recognize and manage potential conflicts and solve problems;

5. recognize situations when information or guidance is needed from other sources and be able to access the appropriate resources and references (a critical component here is that the mentor **does not** teach clinical skills);

6. describe how to use reinforcement strategies to assist the in-service coordinator and mentee to identify, plan, and reinforce learning experiences; and

7. apply mentoring skills to real-life situations.

The supervisor training is a one-hour overview which is intended to build support for the project. Without such an orientation, supervisors may resent or block mentors and mentees from spending extra time together because it is perceived as a disruption of work or as a diminution of their authority. The training content includes a review of the rationale and goals of the project and allows time for supervisors to make suggestions on the project implementation, therefore assuring increased support.

The booster session is an additional one-half day of training for the mentors scheduled after they have been working with their mentees for approximately four weeks. With a trained facilitator, the challenges, joys and frustrations of working in the program are shared. Several typical challenges are shared and joint solutions found. In addition, there is a review of important skills introduced in the training program.

The evaluation is described in a subsequent section of this paper.

Time-frame and Process

"Growing Strong Roots" is organized so that:

- The person assigned to coordinate the project within the nursing home receives five hours of focused orientation, using the facility liaison manual designed for this purpose.

- Each nursing home selects from 5-15 mentors to provide mentoring to at least 10 but no more than 30 "mentees" (The number range is large to reflect the different sizes of facilities and different sizes of new CNA cohorts).

- Mentoring takes place *after* the CNA certification is complete. This mentoring is intended to supplement, not replace or duplicate, the usual training of new CNAs.

- Each mentee-mentor has an active relationship for eight weeks (more if needed). The intensity of the relationship will be highest in the beginning, then reduces incrementally.

  The mentor is working on four areas with the mentee: role model; social support; tutor; peer resource. In the first week, the mentee and mentor work together on the same shift, with the mentee initially observing care and gradually taking on a more significant role in care. In weeks two to four, both mentor and mentee have a full complement of residents, but about two hours a week is devoted to mentee support by the mentor. In weeks four to eight, only one week of direct contact is involved.

- Mentor training makes clear that the mentor does not teach or re-teach clinical skills. Formal education remains the responsibility of the in-service educator and the mentor is encouraged to notify training staff when re-training seems indicated.

  At each stage, all four roles (detailed in training) are covered. The mentor is modeling correct clinical skills and attitudes, time management, reinforcing formal policies and procedures, explaining the far more subtle and informal policies of breaks, lunches, telephone usage, encouraging the new CNA to use the facility resources to make the job easier and more understandable, and being a good friend and advocate.

- The FLTC suggests that the mentor and the mentee(s) be on the same shift and on the same unit, as all other options will complicate logistics. If this option is not possible, however, each facility will have to decide who moves: the mentee or mentor.

- Each facility provides a 10-20 percent salary increase for the extra work the mentors will have. For some models, the extra work of the mentors simply cannot be accomplished in the usual shift. In that case, the facility must decide whether to change the honorarium to an overtime payment or to reduce the workload of the liaison.

This specific structure will not work for every nursing home. Therefore, one of the many responsibilities for the facility liaison is to determine which operational changes, if any, need to be made in this model so that it will work well. Even in a demonstration project, nursing home structures and needs may differ and nursing homes may operationalize the project differently.

We envision that this eight-week cycle will be repeated each time a new class of CNAs enters the facility. This time frame excludes the initial planning time as well as the preliminary work the facility will have to do to develop its own protocol for recruitment and selection of mentors. Timing for these activities will be at minimum a few months, and probably more for most facilities, especially those which involve a union.

Costs

Grant funding is being used to develop and refine the training materials, orient and train the participating sites across New York, and conduct the evaluation. It does not support costs at each site, and in fact, each site is required to contribute matching funds toward the cost of the project. Each site is also monitoring costs as one of the evaluation activities.

Because, at the time this article is being written, we are in the early stages of the project, formal cost information for participating nursing homes is not yet available. However, some costs are predictable: management staff time in planning and implementation; training (an outside trainer is recommended); extra payment for mentors (either in the form of a temporary salary increase or honorarium); extra staffing costs when the mentors are being trained to cover their units; and depending on how the mentor-mentee relationship is designed, extra staff costs during the eight-week mentoring program.

Outcomes

Outcome data is not yet available.   However, a comprehensive project evaluation has

been implemented. The 15 New York state nursing homes in this project are divided into one

pilot site (which received the training first and provided feedback so that the training material

could be refined); seven intervention sites at which the program will first be implemented; and

seven "wait-comparison" sites which will implement the program after the first intervention sites

are completed.   For evaluation purposes, however, data at the wait-comparison sites will be

collected at the same time the intervention groups are completing the peer mentoring program.

The evaluation design consists of:

- Comparison of retention rates of new CNAs being mentored with CNAs in wait-comparison
  group at (1) baseline, (2) post-test, and (3) post-post-test intervals; and,

- Comparison of attitudinal scores of mentees at (1) baseline, (2) post-test, and (3) post-post-
  test intervals.

 At the end of the three-year intervention, we intend to answer such important process

questions such as:

1. What barriers (organizational, administrative, fiscal, etc.) assist or impede effective
    implementation of the intervention?
2. What staffing and deployment strategies assist or impede effective implementation of the
    intervention? and,
3. What are the cost benefits of this intervention as compared to the hidden costs of doing
    nothing about high turnover?

The heart of this project evaluation, however, is to determine its impact on the new CNAs,

since their longevity and nature of the care they give is critical to quality. This part of the

evaluation will answer the following questions:

1. When implemented in a sample of New York state nursing homes, does the FLTC's
    model of peer mentoring have a positive impact on the retention of participating nurse
    aides?

2. When implemented in a sample of New York state nursing homes, do the "peer-mentored" aides demonstrate more knowledge of the importance of their role, their resident-staff relationship, and more effective caring behavior than comparable aides who were not mentored?

Relevance to Social Work Practice and Values

There is a natural potential affinity between social work and a peer mentoring program in nursing homes. In terms of conceptual affinities, both look for and build upon the strengths of a target population. Mentors' strengths are acknowledged and used to develop new aides. Both value empowerment. Peer mentoring of aides empowers the mentors to supplement their caring nature to extend from residents to peers. It empowers the new aide by providing a locus of support.

On a more practical level, participating in the design and training of a CNA peer mentoring program may present an expanded role for the long-term care social worker. Social workers are always relied upon to enhance the residents' integration into the facility. It seems a logical extension for the long-term care social worker to be called up to enhance the integration of new staff into the facility as well. The interpersonal skills of the professional social worker can be well used in this manner, and foster interdepartmental cooperation in pursuit of a common goal.

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The Caring Tree

Nursing facilities are like trees...
The residents are the leaves...
growing, changing and falling away from the tree.
The branches are the homes,
giving the leaves a safe, nurturing environment to do their growing,
the other staff are the limbs,
they keep the branches sturdy,
the administration is the trunk of the tree,
supporting the limbs and branches.
I'm sure you are
wondering where nursing assistants' fit into this analogy...
they are the roots.
Leaves fall, branches and limbs may break in a strong wind,
you can even cut into the trunk of a tree but if the roots are strong,
growth will continue.
Have you ever seen a tree that has a root disease?
The leaves will die without the nourishment the roots provide.
The limbs, branches and trunk will remain for a while but they too
eventually die.
They are the roots of every facility.
In the past, they've been called the 'lowman'.
I guess they are, after all, roots are the lowest part of the tree...
also one of the most
vital.

By Connie Trendel, CNA

Connie Trendal lives in Michigan where she has been a Certified Nursing Assistant in long-term care for over 20 years. She is a Certified Eden Associate and serves as her facility's NAGNA (National Association of Geriatric Nursing Assistants) Chapter Chairperson. Connie has taken advantage of many opportunities to write about, and teach others, her powerful message – that a CNA is not "just an CNA", but a professional caregiver.

Appendix A

**Other Resources for Peer Mentoring of Nursing Home CNAs
Used in the Development of "Growing Strong Roots"**

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Appendix B

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