Team Building in Memory Care Staff

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Abstract

Problem identification: Leaders at a local assisted living facility recognized disparities in the dementia caregiver staffs' job satisfaction and retention and sought an intervention to improve both. Purpose: Team building via a peer-led orientation process for new-hires was identified as an avenue to incorporate leadership support. The didactic content included information regarding dementia and dementia care, resident-centered care, cultural competence, professional relationships, and mindfulness in the workplace. Hands-on skills demonstration and practice were also included for new-hire caregivers to facilitate correct skill expectations before new staff provided care to the residents. The didactic orientation content was also presented to current dementia caregiver staff to enhance team building in the existing staff. Theoretical frameworks: Dr. Jean Watson's Theory of Human Caring provided guidance in the concepts of resident-centered care, cultural competence, professional relationship, and mindfulness in the workplace. Evaluation: The outcomes indicated that both the new-hire and existing staff gained new knowledge about the concepts covered. The participants also verbalized a greater level of interpersonal growth related to the interactive, discussion-focus of the training sessions. Finally, the development of peer-to-peer training presented an opportunity for professional development and career advancement within the organization.

Team Building in Memory Care Staff

Quality, person-centered care is beneficial for both the residents in memory care settings and their caregivers, with one study indicating that person-centered care promotes feelings of support and competence in caregivers (Willemse, De Jong, Smit, Visser, Depla, & Pot, 2014). Not surprisingly, memory care staff face challenges including frustration with resident behaviors (Zwijsen, Gerritsen, Eefsting, Smalbrugge, Hertogh, & Pot, 2015) and communication barriers; strained relationships with residents' families and with co-workers; feelings of inadequacy and conflict of conscience in attempting to meet residents' needs (Ericson-Lidman, Larsson, & Norberg, 2013); lack of support by supervisory personnel (Willemse, De Jong, Smit, Visser, Depla, & Pot, 2014); and personal, outside of work, daily life stressors. These caregivers are at risk for burnout, lack of committedness, and decreased job satisfaction, which leads to poor staff retention.

Leadership Imperatives

Leaders in the memory care environment must provide the support and tools for staff to enact person-centered care and maintain job satisfaction (Ericson-Lidman, Larsson, & Norberg, 2013). Team building is one tool leaders use to strengthen the care team by incorporating activities that reinforce common goal attainment within the work setting; there are multiple team building models available to guide team cohesiveness. Regardless of the model used, a team building program to improve job satisfaction in a memory care setting should include specific dementia-related information. Care strategies, including the management of behaviors; the development of professional relationships with residents and their families; and the concepts of person-centered care and mindfulness in the work environment comprise essential program content. Guidance on the recognition of stressors and identification of effective coping

techniques and the recognition of signs of burnout may also be included. The ultimate goal of the team building activities is the enhancement of job satisfaction and the promotion of staff committedness and retention.

Providing quality education and training for new employees is mentioned by multiple authors (Cook, Fay, & Rockwood, 2012; Manthrope, 2012; Squires, Hoben, Linklater, Carleton, Graham, & Estabrooks, 2015) as imperative to job satisfaction and retention. A peer-to-peer education orientation program can provide an ideal format for a team building venture. Providing and sustaining the program is the responsibility of facility and organization leadership and demonstrates leadership's engagement and investment in staff welfare. Di Benedetto and Swadling (2013) add that burnout is more likely to occur in newer employees; addressing employee commitment, staff satisfaction, and retention is a priority for new-hires in reducing staff turnover.

Problem, Purpose, Objectives, Question

Problem Statement

Facility leaders, both locally and at the organization level, indicated that memory care caregivers at the local assisted living care facility experienced work and non-work-related stressors and poor or decreased job satisfaction, which was evidenced by negative attitudes and poor retention (Residence and Marketing Coordinator & Residence Manager 2016, November 17). This lack of satisfaction was reflected in resident care; commitment of staff to residents, co-workers, and the organization; and, ultimately, the retention of staff.

Purpose Statement

Facility leaders indicated that caregivers must contend with patients, and their families who often experience guilt over admitting the family member to the care facility; strain and poor

communication between coworkers; and life stressors including transportation, child care, work schedule, and other family issues (Residence and Marketing Coordinator & Residence Manager 2016, November 17). The facility leaders expressed the wish to work with this DNP student to develop a team building strategy and an ongoing program to assist caregivers in addressing their barriers to providing quality care, improving organizational commitment, and achieving job satisfaction and retention at the facility.

Project Objectives

The DNP student worked collaboratively with facility leaders to develop a team building program and achieve the following outcomes:

- Create and implement a team building program that assesses and addresses barriers to effective teamwork and decreased job satisfaction and retention.
- Provide leadership through a teamwork-based, orientation education program for caregivers including the concepts of dementia care, person-centered care, resident and family relationship development, and mindfulness in the work setting; knowledge assessment will be measured through the use of a pre- and post-orientation evaluation with an expected positive knowledge base change of five percent or greater.
- Develop policy and procedure to include the team building program in initial orientation and annual training, with the potential to expand the program to other facilities within the organization.

Project Question

Do staff who work with memory care residents, and are supported by organizational leadership, experience greater job satisfaction, committedness to the organization, and an increased rate of retention after a two-month team building program?

Literature Review

An exhaustive search of databases including CINHAL, ProQuest, Ebsco, ProQuest psycARTICLE, and ERIC availed over 120 current articles related to some aspect of job satisfaction and retention in dementia care workers, building health care teams, leadership support of dementia care workers to sustain a positive work environment, and behavioral strategies studied in dementia care. Nineteen articles were chosen to base support of the introduction of team building into the orientation, and annual training for caregivers in the assisted living dementia care unit at the selected project facility.

Article selection represented the closeness of the contextual setting to the application in assisted living dementia care. The project aim was to use existing research in implementing a leadership initiative. Articles rejected presented concepts in settings too unique for a logical translation; population did not involve dementia or a residential setting. Articles related to job satisfaction directly link to caring for persons with dementia in the residential setting. One article did expand to residential geriatric care in general, but dementia care does occur as a subset of geriatrics. An article studying Australian psychologists references mindfulness, which the DNP student felt was requisite in any patient care situation.

Literature addressing team building related to team building in the health care multidisciplinary arena, though concepts of team building originate from other, business setting contexts. The inclusion of the multidisciplinary team was central to team building where each team member has a particular function. Articles discussing specific behavioral treatment approaches were in direct relation to dementia care, as the approach to interactions with dementia residents differ from other mental illnesses, for example, refraining from reorienting the confused person with dementia because of anxiety provoking responses. One team building

article was not a study, but the information lent meaning to definitions and concepts within the other literature chosen. The policy article inclusion was appropriate because it demonstrated the importance of extending the policy making process to include the implementation stage.

Job Satisfaction

A number of authors addressed the topic of job satisfaction and working with the dementia population. Two studies highlighted the importance of person-centered care, supervisory and organizational support, and providing for staff decision-making to increase job satisfaction and quality of care for dementia caregivers (Erickson-Lidman, Larsson, & Norgerg, 2013; Willemse, De Jonge, Smit, Visser, Depla, & Pot, 2014). The first study, part of a larger study on stress in caring for the elderly, interviewed 12 direct care providers in a private, not-for-profit, residential dementia care setting in Sweden. The second study used questionnaires sent to 1093 direct care staff to determine the relationship between person-centered care and the work demands, feelings of control, and the supervisor support staff perceived in their work with individuals who have dementia. Person-centered care was defined as a focus on the person and his or her psychological needs to deliver care, not making the disease more relevant than the person (Willemse, et al., 2014). The latter study also addressed the need to build meaningful relationships between care staff and dementia care residents.

In their study of a group of 165 Australian mental health care psychologists' experience of burnout related to work-setting, self-care, and mindfulness, Di Benedetto and Swalding (2014) used surveys to determine that mindfulness, the ability to remain focused on the present moment without seeking explanation, to be of value in preventing burnout, thus increasing work satisfaction. Two meta-studies also provided insight into dementia care workers and job satisfaction. Cook, Fay, and Rockwood (2012) found five themes in their study of 34 articles

related to the job-related perspectives of paid workers: “approach to care, education and training, the emotional impact of work, organizational factors, and relationships on the job” (p. 127). Empowerment and autonomy were the two important factors identified for job satisfaction in non-professional dementia care workers through an analysis of 42 studies involving long-term care aides (Squires, Hoben, Linklater, Carleton, Graham, & Estabrooks, 2015). Though this study was not specific to dementia care, the long-term care population does often include residents with dementia.

Team Building

Team building is an important component of a successful work environment. Wienclaw (2016) made the distinction between a group and a team; specifically, that group members work in a parallel fashion, doing the same or similar work; team members each have specific functions and are mutually dependent on meeting a common goal. Hakanen and Soundunsaari (2012) discussed the importance of developing trust in team building, and that sharing information through effective communication and forming trust built upon each other. The authors supported their stance on trust in team building from a study in progress, which combined the use of research to form an ecosystem with health-related industries. Top-level managers’ interview results shed light on trust building within the business-healthcare relationship.

Following the need for trust, Leicher and Mulder (2016) introduced the concept of interpersonal risk taking in expressing ideas within the team. They included the need for reflection, knowledge sharing, and learning as a team. The study included 30 elder care teams to total 149 caregivers from 17 participating retirement homes. The authors expressed that psychological safety had a high impact on team learning activities. Kumar, Dehmukh, and Adhish (2014) indicated teams must be cohesive in a collective vision; teams should identify

motivators and realize the applicability of Maslow's Hierarchy of Needs. The article discussed two team building theories including Bruce Tuckman's Forming, Storming, Norming, Performing, and Adjourning model; and the Team Performance model by Allen Drexler and David Sibbet. The authors also highlighted job satisfaction as an outcome of positive team interaction along with better patient outcomes.

Job satisfaction as a result of effective teamwork was again mentioned by Banjnok, Puddester, MacDonald, Archibald, and Kuhl (2012) who acknowledge the need for a team agreement, a team action plan, and a team building process to enhance decision making and patient outcomes. Their project, Teams of Interprofessional Staff (TIPS) was initiated in Ontario, Canada by a registered nurse and a physician, both representing respective professional organizations, to introduce a healthy, collaborative workforce. Five healthcare teams worked for eight months to transform their practice settings into fully collaborative models. Conversely, Tibbs and Moss (2014) attempted to introduce Teams Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) into a busy, 24/7, military-run operating room (OR). They had partial success with one surgical sector, gynecology (GYN), but were unable to move the change throughout the entire OR. The authors noted that planning should also consider any barriers, including staffing preferences and work rules. Protocols and algorithms provided direction, but if the work environment was not supportive, the protocols and algorithms were not effective.

Behavioral Strategies

Additional strategies that reinforced teamwork lie in managing the behavior of residents with dementia. Saunders, Hale, and Harris (2016) studied the role of the Advanced Practice Nurse (APN) in identifying vulnerable populations, which include persons with dementia. The

authors indicated the APN role was to function within the interdisciplinary team to educate and support during care planning and function as a change agent. The study used data from the interview of 12 Clinical Nurse Specialist (CNS) participants by asking how they best advanced the practice to vulnerable populations, including persons with dementia, and how they best advanced the well-being of patients from these underserved populations.

Van de Ven, et al. (2012) described patient-centered care and retaining personhood in dementia care. The authors pointed out that a negative staff and a negative environment elicited negative behavior in persons with dementia. The study focused on introducing dementia-care mapping as a person-centered intervention in Dutch nursing homes, which included at least 250 residents from 11 nursing home organizations. A four–day training course prepared staff to be observed interacting with residents, receive feedback on responding to residents, and making changes in how they interacted with residents.

Other behavioral approaches in dementia care are being studied and show promise. Goyder, Orrell, Wenborn, and Spector (2012) studied the use of the Staff Training in Assisted Living Residences (STAR) program to identify activators for dementia residents and help staff effectively modify their responses to the residents in two United Kingdom (UK) care homes. Positive results were identified in resident behaviors, and 22 out of 25 staff answered a post–implementation survey favorably for STAR in improved relationships with residents and a better understanding of dementia.

The STAR-VA study examined the use of the STAR behavioral interventions in 17 of the U. S. Department of Veterans Affairs (VA) Community Living Centers (CLCs) (Karlin, Visnic, McGee, & Teri, 2014). The CLCs are skilled nursing facilities that care for Veterans. Challenging dementia behaviors were identified and broken into six groups: agitation, care

resistance, vocalization, aggression/violence, wandering, or others that did not fit in the five categories. The study found the STAR program reduced the frequency of challenging dementia behaviors by 35% and the severity of said behaviors by 46%.

Zwijsen, Gerritsen, Eefsting, Smalbrugge, Hertogh, and Pot (2015) applied the Grip On Challenging Behavior Care Program (GRIP), an evidence-based behavioral program, in their study of burnout in caring for persons with dementia in 17 dementia care units in the Netherlands. The five-month study educated staff on the recognition of challenging behaviors and how to reflect on those behaviors. Plans of care were developed by the interdisciplinary team and carried out by the direct caregivers. The study concluded the program to be effective with care staff who had higher levels of education and thus experienced more caregiver strain and exhaustion.

A study involving the development of a tool to assess the evolution of communication behavior over the course of dementia progression shed light on the significance of non-verbal communication and well-being in persons with dementia. Kuemmel, Haberstroh, and Pantel (2014) discussed communication as having a content message and a relationship component. The authors noted that in dementia, the content might cease to exist, but the relationship or emotional component remains. Their tool assisted caregivers to assess the changes in communication demonstrated by persons as their dementia progressed to adjust communication techniques.

Policy and Procedure

Finally, no project is complete without a plan for sustainability, which can be implemented in the form of a policy or protocol. Strehlenert, Richter-Sundburg, Nystrom, and Hasson (2012) indicated the importance of policy formation. They described the evidence-

informed policy, which takes meaning from a balance of research and input from other sources: stakeholders, professional opinions, experts, tradition, values, and political lobbyists. The study compared the use of evidence-informed policy creation in two case studies. Their results indicated the tool was considered useful in data analysis and organization but required additional consideration for variables including policy makers, capacity for action, and working through the phases of policy development and implementation.

Conceptual Framework

The DNP student considered several conceptual frameworks before deciding on the Quality Implementation Framework (QIF). This framework, developed by Meyers, Durlak, and Wandersman (2012), is a more recent tool that focuses on successful innovation implementation in healthcare. The authors postulated that project implementation has a strong bearing on its success and sustainability and that the up-front assessments and planning are vital to an effective practice change with desired organizational impact.

The authors (Meyers, Durlak, & Wandersman, 2012) sought to develop an evidence-based framework by studying twenty-five previously used frameworks from 27 sources. The studies examined by the authors addressed health-related needs in community organizations and school settings for populations across the lifespan and represented themes including evidence-based practice, preventative health, disease management, mental health, physical health, veteran health, substance abuse, violence, management, and technology. Through the examination of these framework uses, the authors identified similarities that lead to a synthesis resulting in the QIF framework; they identified framework themes that translate to 14 steps in a four-phase process (Table 1).

The QIF answered the need to provide a framework for integrating evidence-based practice in healthcare interventions. All of the 27 studies' practice topics included areas where nurses impact people, families, and communities to provide education, preventative care, and treatment of wellness and illness. The authors indicated the tool accounted for similarity in any process of implementation and is broadly applicable "in many different fields" (Myers, Durlak, & Wandersman, 2012, p. 476). With its successful use in the medical realm, it was logically adaptable to the implementation of nursing innovations, especially a DNP leadership project.

The DNP student appreciated the QIF framework because of the care and thoroughness of pre-assessment and pre-planning. Phase one included eight steps, which considered the need for the innovation, how well the innovation identified with the organization's mission and vision, and the organization's readiness and ability to change. Other steps identified initiatives to bolster the organization in making ready for change, including obtaining buy-in, mobilizing key leaders, and training staff. Taking the time and effort to review the phase one information decreased late, unexpected discoveries and aided in precluding the need to make multiple adjustments moving through the process phases. The framework included a critical steps questionnaire (Table 2) that was initiated in phase one and followed through all four phases of the implementation process.

Phase two steps addressed creating the teams who implement the new practice and planning the actual implementation process. Phase three steps provided for an ongoing process that supported and would hopefully sustain the innovation; in phase four, evaluation and program adjustments, as required, occurred. The DNP student wished to remain thoughtful and deliberate in project implementation. The QIF framework provided a guide to meticulous attention and preparation focus and organizational alignment for attaining and sustaining a team building program.

Theoretical Framework

Jean Watson, the author of *The Philosophy and Science of Caring* (1979, 2008), developed the Theory of Human Caring for nursing. She indicated that nursing is a Caring Science with the intent of "bringing new meaning and dignity to the work and the world of nursing and patient care" (2008, p. 1). She expanded on her theory for over thirty-seven years, and it continues to hold relevance, especially in a world that embraces technology and a widening gap between humans and human interactions. Dr. Watson's theory uses ten carative factors, Caritas, to guide nursing practice. Her latest work with co-author Kathleen Sitzman, *Watson's Caring in the Digital World* (2017), addresses caring in a world challenged by cyberspace distractions and pitfalls, which readily occur in health care settings on a daily basis.

The Caring Science theory highlighted the importance of thoughtful, purposeful, human presence in all nursing interactions with patients, colleagues, families, and communities through transpersonal caring. Watson's third Caritas addressed self-care and spiritual awareness, and the concept of self-knowledge appeared throughout the theory. With the greatest source of healing being love, the focus on caring transcends mere systems of health care delivery and draws from the spiritual source within each nurse (Watson, 2008). It is especially important that caregivers maintain a person-centered, caring focus in today's age of electronic presence. In their 2017 work, Sitzman and Watson addressed maintaining the transpersonal experience in the presence, be it necessary or distraction, of electronic communication and offered ways to express caring in a technology-compatible format.

Dementia care demands very personal and interpersonal interactions; these interactions can produce stress with internal and external manifestations in caregivers. Mindfulness in care increases satisfaction and well-being in caregiver work (Willemse, De Jonge, Smit, Visser,

Depla, & Pot, 2014). The Caring Science provides caregivers with mindfulness, presence, respectful, dignity-preserving perspective and direction for resident, colleague, and family care by drawing focus to transpersonal interactions, which provide greater meaning in caring and a sense of well-being from interactions.

Dementia care staff at the DNP project facility demonstrated the effects of strained interactions with residents, residents' families, and caregiving colleagues. Watson's Caring Science provided a framework for staff to refocus work perspectives and derive greater satisfaction from work interactions. Work satisfaction, in turn, has the potential to create an environment where caregivers choose to remain, instead of seeking other employment.

Project Design

Medeiros, Felix, and Nobrega (2016) described the use of Dr. Watson's Clinical Caritas Process in caregiver workshops for those working with institutionalized elders; the emphasis was on caring, valuing the caregiver, and valuing the recipient(s) of care. These concepts were well-suited to the practice in a memory care area. Incorporating Dr. Watson's concepts in this project design required collaboration with the local, project facility leaders to determine how the integration of Dr. Watson's concept of caring would enhance teamwork. Initial conversations with the Residence Manager and the Human Resources (HR) Manager, who indicated finding and keeping memory care caregivers was challenging, suggested that the orientation process for new employees was a logical place to start (Human Resources Manager at project facility site, personal communication, March 29, 2017).

Manthrope (2014) identified organizational empowerment as essential in the development of dedicated, long-term, memory care caregiver retention, citing initial training as a crucial component in determining job satisfaction. The Squires, Hoben, Linklater, Carleton, Graham,

and Estabrooks (2015) review of 42 articles regarding long-term care facility caregivers also supported the need for empowerment, autonomy, and training, indicating many direct caregivers in long-term care facilities were deficient in formal qualifications. Caregivers at the project facility were not required to hold nursing assistant certification as a contingency for employment.

The project facility had recently instituted a two-day, set-agenda orientation program for its memory care caregivers; though an improvement over past practices of little-to-no formalized orientation, there was still room for improvement in the onboarding process. The DNP project enabled facility leaders to bolster the current orientation process by incorporating current memory care caregivers in the orientation process as orientation mentors. Team building began in the orientation where the orientation mentors introduced themselves and lead discussions regarding need-to-know information from frontline workers about technical and interpersonal skills required on the job. This activity became part of the documented onboarding process and was logged in the employee orientation record. A skills lab experience was made available for hands-on guidance and practice facilitated by the mentoring peers.

Literature supports a project design incorporating hands-on experience and didactic concepts. Three articles discussed the need for more comprehensive training for memory care caregivers to include cultural competence (Davis & Smith, 2012); person-centered care, respect and acceptance of resident values and beliefs (Oeseburg, Hilberts, & Roodbol, 2015); and knowledge regarding dementia (memory care), geriatric illness, and life skills (Cui, Fan, Wang, Kaye, Kaye, Bueno, & Pei, 2014). Brown, Redfern, Bessler, Swicegood, and Molnar (2013) supported memory care caregiver education surrounding basic anatomy and physiology, infection control, and competency and quality standards in leading to better clinical outcomes for

care facility residents. Davis and Smith also encouraged the use of role-playing, vignettes, and critical thinking exercises in the education of memory care caregivers (2012).

Project Steps

Input from current caregivers regarding the top 10 need-to-know items for new caregivers was collected, and the two-day orientation program was revised to incorporate the day two, caregiver-focused learning. After data were analyzed, and the need-to-know information to be shared with new staff was determined, the facilitator and orientation mentors were selected from the pool of current memory care caregivers based upon the desire to participate and an outstanding work record. A facilitator and orientation mentor training took place over one-half day training sessions.

The first day of orientation remained unchanged and continued to be facilitated by the HR Manager, or her delegate, at the facility. Day one included a meeting with the Activities and Recreation Director to tour the recreation area with an overview of the resources available to residents and caregivers. The Activities and Recreation Director provided introductory training on the It's Never Too Late (iN2L) computer-based activity software available to promote interaction and cognitive stimulation with residents. The Dietary Manager greeted the new memory care staff and provided information regarding the available dietary services and assisted the caregivers in learning the communication process for residents' dietary requests and needs. The dietary presentation ended with a tour of the kitchen and dining room facilities.

On the second day, the team building project content was initiated with the orientation mentors introducing themselves to the new caregivers; the team-building activities were conducted for the remainder of this final orientation day. The new-hire caregivers discussed questions and concerns with the orientation mentors who shared tips for success as new memory

care caregivers. The aspects of dementia, dementia care (memory care), person-centered care, cultural competence, resident and family relationship development, and mindfulness in the workplace were reviewed. Policy and procedure regarding advanced directives, incident reports, and emergency situations were addressed; questions and discussion were encouraged.

A 30-minute lunch break allowed the new-hires and the orientation mentors social time to continue getting acquainted. The afternoon session moved to the hands-on training area for demonstration, practice, and where applicable, check-off of skills. A mid-afternoon 10-minute break was given and the day concluded with a discussion, led by the orientation mentors, of the Top Ten Need-to-Know information caregivers wished they were told on their first day as a caregiver at the facility. The opportunity for the new-hire caregivers to return to the skills area on other days to practice caregiving skills with mentors, as personally required to gain confidence and competence in skill mastery was offered, time permitting. This project involved coaching and mentoring facility leaders and the orientation mentors; sustaining the orientation mentor process was the responsibility of the facility leaders at the conclusion of this project. The learning objectives for the new-hire memory care caregivers facilitated by the orientation mentors are detailed below.

At the end of the orientation, new-hire memory care caregivers will:

- Engage in team building and relationship building exercises. *Current caregiving staff (at least one, preferably two or more) and new-hire caregivers were introduced to provide familiarity with caregiver colleagues and team building experiences.*
- Understand the Top Ten need-to-know information for new memory care caregivers with the inclusion of work practices. *Discussion of the Top Ten need-to-know information for orientation of new caregivers and overview of work practices was provided.*

- Apply the concepts of dementia care (memory care), person-centered care, relationship development (with residents and residents' families), culturally sensitive care, and mindfulness in an orientation pre-test and post-test comparison. The post-test answers were reviewed with the new-hire caregivers at the conclusion of the orientation day. A pre-test was given prior to the introduction of the described concepts and comparison of pre- and post-test scores was done by the DNP student to assess previous knowledge and new learning of the new-hire caregivers. *Introduction and discussion of the concepts of dementia care (memory care), person-centered care, relationship development with residents and residents' families, cultural competence, and mindfulness were facilitated by the orientation mentors.*
- Demonstrate select required skills including but not limited to positioning, transferring, toileting, the use of gate belt and lifts, and the use of blood pressure equipment. Three to five of the most frequently performed and low volume-high risk skills were chosen based on the experience of the new-hire memory care caregivers. *Time was provided for return demonstration of select, required skills, i.e., positioning, transferring, toileting, use of gate belt and lifts, and blood pressure equipment, and others as needed. Principles of infection control were incorporated into the demonstrations.*

Population and Stakeholders

Memory care caregiver orientation that addresses the knowledge gaps of the caregivers and encourages team-building presented positive outcome potential for all stakeholders and the community where the facility is located.

Population

The assisted living project facility is located in a small town with an approximate population of 16,000 residents including families with children of all ages and retired

professionals and non-professionals. There are three other facilities for geriatric residents in the town; one provides assisted living services, the other two are skilled nursing facilities; all of the facilities provide care for persons with dementia. The project facility is a 74 unit assisted living facility with a 17 unit, locked, dementia care wing.

Stakeholders

The primary stakeholders included the new-hire and current memory care caregivers at the local, project facility. New caregivers were indoctrinated into the work setting with the potential to receive the education, skill set development, and facility acculturalization for successful onboarding and formation of work-life relationships with their existing peers. It was also essential that positive relationships form between caregivers and the residents for whom they care. Shenk (2012) discussed the importance of positive relationships between caregivers and those receiving care in her work to elicit meaningfulness in the caregiver role in memory care. She stressed the need to focus on person-centered care and not merely the tasks at hand, which aligned with Dr. Watson's caring in the moment.

Residents and their families were stakeholders in the impetus toward improved caregiver onboarding practices. Sharpp, Kayser-Jones, and Young (2012) discussed the importance of providing nursing leadership oversite and ensuring memory care caregivers have accurate knowledge of dementia and caring for those who have the disease. Other relevant knowledge included signs and symptoms of an acute illness; what and when to report changes in a resident; medication administration, especially inappropriate administration. Families rely on caregivers to provide the constant care and attention they cannot. The community as a whole benefit from the presence of the facility in providing memory care and presenting employment opportunities for the local and surrounding Las Vegas communities.

The local project facility leaders and ancillary staff benefit from retaining quality memory care caregivers; census drives the need for other departments including environmental management, facilities management, dietary, and recreational activities. The success of the local facility impacts the organization as a whole. An unprofitable facility drains organizational resources, a profitable one increases capital and provides shareable experiences resulting in practices that may be adapted to other facilities within the organization.

Recruitment Methods

All new-hire memory care caregivers initiating employment between July 1 and August 17 participated in the two-day orientation program as a requirement of employment. All current caregivers were approached by the DNP student and encouraged to participate by providing new-hire, Top Ten need-to know-information and by becoming orientation mentors. Mentorship was elective, as was input from all current memory care caregivers regarding the information they felt was essential for the new employees to have from day one.

The Top Ten Need-to-Know surveys were distributed to current, consented participants along with an explanation of the DNP project, on a face-to-face basis, either one-to-one or in groups of two to three individuals. Of the 27 current caregivers, 25 were available to discuss survey participation, 23 of those consented to participate and three persons returned surveys anonymously via a locked survey container in the nursing office. Two caregivers were on leave and unable to participate. The information from the Top Ten Need-to-Know survey responses was reviewed, and a list of 15 need-to-know items was created (Table 3). A total of five orientation mentors gave consent to participate and were trained in two separate, one-half day sessions; one was trained concurrently in a re-orientation session.

Participation as an orientation mentor was incentivized with the agreement that

orientation mentors were required to function as resources beyond their orientation responsibilities; this was accompanied by a promised wage increase and a promotion to shift a resource position. Brown, Redfern, Bessler, Swicegood, and Molnar (2013) described the use of mentors in peer education for caregivers to promote sustainability of a caregiver education program. All participants, current and the new-hire, were given participation consent forms to complete before the project activities commenced and had the choice to opt-out of providing pre-program information, acting as orientation mentor, or filling out the new-hire post-training evaluation. There was no penalty or retaliation toward those staff who chose not to participate.

Tools

Manthrope (2014) noted the relationship between the ability for memory care caregivers to experience growth and possess a work-related decision-making ability and the impact on satisfaction in the caregiver role. An information-seeking tool was distributed to all current memory care caregivers asking them to describe ten things they wish they had been told when they initiated their caregiver role at the facility. It was hoped that the questionnaire findings would shed light on the gaps in caregiver knowledge that existed for new-hires; perceptions regarding the concept of caring were extrapolated during answer analysis. Additionally, memory care caregivers were asked to describe any situations they felt needed improvement related to their ability to provide care; they were also asked to include suggestions on how to accomplish the desired improvements. Provision of this information by caregivers was voluntary and anonymous.

A post-orientation survey (Appendix A) was administered to the new-hire memory care caregivers and to the current caregivers who attended a re-orientation session to determine the caregivers' perceptions of the orientation experience. A five-point Likert scale was used, and a

comments area was provided. Information obtained through the post-orientation survey was reviewed and analyzed by the DNP student; the information provided feedback to make improvements in the orientation mentor-facilitated portion of the orientation program.

Data Collection

Data collection for the information incorporated into orientation by current caregivers was solicited by the DNP student in written and informal interview formats. After providing written consent, each current memory care caregiver was given a questionnaire asking for their input regarding information they did not, but wished they had, received at the initiation of their employment as a memory care caregiver at the facility. An opportunity was provided to discuss any practice concerns they currently had and solutions they felt would help. A locked, secured, opaque receptacle for the Top Ten Need-to-Know questionnaire submission was made available in the nursing office to ensure participant anonymity.

The post-orientation survey tool (Appendix A) was administered to the previously consented participants at the end of the second day of orientation. A locked, opaque container was available for the survey collection, though participants chose to hand the forms, face-down to the DNP student. Respondents had the option of submitting a blank form if they preferred. All data collection was anonymous unless a respondent chose to disclose his or her identity. Responses were collected for analysis and stored in a locked drawer in the DNP student's home office; all forms were destroyed at the conclusion of the project.

Intervention and Timeline

The intervention took place over a seven-week time frame beginning on July 1st, 2017, after approval from Touro University, Nevada (TUN) was obtained. Beginning three months before the intervention initiation, the QIF (Table 1) conceptual framework pre-implementation

steps were reviewed with the facility Residence Manager and the Human Resources Manager. Steps 1 through 10, involving the first three phases of the QIF (Table 2) were completed by thirty days before the project was implemented. The QIF addressed the people-resources required for implementation; a skills area was prepared where the caregivers could learn and practice their physical caregiving skills to develop competence and confidence in caring out resident cares. This hands-on practice was in alignment with practices discussed by Sawyer and Campbell (2012) who described the benefit of combining demonstration, practice with feedback, and discussion in teaching caregiver techniques.

QIF Steps

Steps 1 through 3 were addressed by the local facility leaders' request to have this DNP student implement her project locally at the facility. Some uncertainty in completing step 3 was due to the lack a dedicated orientation facilitator to oversee the entire, two-day orientation process, including the team building program, through a consistent, organized onboarding process. Step 4, regarding the adaptation of the intervention, was not applicable because the intervention is designed specifically for the local facility. Steps 5 and 6 required further attention in recruiting a dedicated orientation facilitator; the duties were shared by facility leaders, primarily the HR Manager. Current caregivers from the day and evening shifts were selected to become orientation mentors. Steps 7 through 10 involved training the orientation facilitators, who were facility leaders, and the orientation mentors.

Rollout Timeline

With the approval of the TUN School of Nursing (SON), the Institutional Review Board (IRB) approval was not required, questionnaires were distributed to current dementia caregivers beginning July 1st, 2017. Final form collection occurred on July 7th, 2017; a locked, secured,

opaque collection container was made available during that time in the nursing office. The DNP student collected questionnaires from the container and compiled a list of need-to-know information for new-hires and a list of current caregiver concerns and proposed solutions. An invitation for ongoing suggestions for additions to the lists was presented to memory care caregivers through informal interviews. All written responses submitted via the questionnaires were kept anonymous, and collected forms were stored in a locked drawer in the DNP student's home office and destroyed after the project was completed. At the completion of the project, an executive summary was provided to the Residence Manager, and the HR Manager at the local facility, the anonymity of the participants was protected.

Training of the orientation facilitator and orientation mentors began on July 12th, 2017, with the first orientation cycle offering on July 12th and 13th. The first day of orientation provided facility-related information including the mission and vision of the organization, the building tour, and introductions from Human Resources and other facility departments including environmental management, facilities management, dietary, and recreation activities; all new-hire employees attended this day.

Orientation mentor training sessions occurred on July 12 and 19 with four mentors trained. On August 2, six facility leaders participated in the orientation mentor training to help them gain an understanding of the content and provide support for the new orientation mentors. A fifth orientation mentor was trained on August 14th concurrently with a re-orientation session. The re-orientation of current caregivers to provide the team-building component for existing caregivers was initiated on August 14th, 2017; eight training sessions took place between August 14th and 17th with a total of 11 current caregivers participating.

Day two of orientation was dedicated to the new-hire caregivers only and concentrated on

the required memory care caregiver skills; orientation mentors initiated the team building process through discussion accompanied by skills demonstration and practice. Multiple orientation cycles historically occurred on a weekly, bi-weekly, or monthly bases depending on the staffing requirements of the facility; this did not occur during the DNP project data collection timeframe. Staffing requirements remained stable during the data collection timeframe, and only one orientation was conducted during the seven weeks; data collection for the pre- and post-quiz and post-orientation surveys began on July 13th and continued through August 17th. Orientation evaluation surveys were distributed at the completion of the day two of orientation and the conclusion of each re-orientation session.

Ethics and Human Subjects Protection

The DNP project was conducted with local facility leaders to develop and provide a team-building, orientation program for new-hire memory care caregivers. The orientation process was part of the required onboarding process and involvement by current memory care caregivers as orientation mentors was voluntary. Permission to implement the project was obtained through the DNP student's SON at TUN. Consents were signed by current caregivers and new-hire caregivers before data collection, and by current caregivers upon agreement to participate as orientation mentors. No harm or retaliation was intended, nor did any occur, for the employee participants.

Analysis of Results and Evaluation

The first new-hire caregiver orientation participants consisted of two experienced caregivers. Neither were certified as nursing assistants or caregivers; both were informed of the DNP team building project and consented to participate in the pre- and post-orientation quizzes and post-orientation survey. The pre- and post-orientation quizzes were administered

anonymously; each caregiver placed an identification symbol on their quizzes to make it possible to determine changes in quiz scores after the educational intervention. At the completion of the orientation program, the post-orientation survey (Appendix A) was administered to both participants.

There were no new-hire caregiver orientations in the following weeks and the facility leaders, with the encouragement of the student, decided to bring current caregivers, excluding the previously oriented two new-hire caregivers, through the team building portion of the orientation day two. The re-orientation of the current caregivers was not initially included in the project plan; the student and facility leaders felt that the inclusion of current caregivers would enhance the cohesion of the didactic training element and result in greater team-building with the caregiver staff. Concerns that data collection from the current caregivers would vary greatly and skew the results were unfounded. Eight of the eleven current caregivers demonstrated an increase in their post-intervention quiz scores, as the two new hires had, though the increase in scores was not as significant for all eight current caregivers; there was a range of one to six points, most frequently one or two points (Figure 1).

These re-orientation sessions addressed the concepts of dementia, dementia care (memory care), person-centered care, cultural competence, resident and family relationship development, and mindfulness in the workplace. The Top Ten Need-to-Know list items were also covered in all but one session where the orientation mentor failed to remember to review the list; data for the post-orientation survey question relating to this information was excluded for the two respondents in that session. The hands-on training portion was also omitted in the re-orientation sessions due to time constraints; the post-orientation survey question number three

answers relating to the hands-on portion of the training were only considered for the two new-hire caregivers.

A total of 11 current caregivers participated in the didactic portion of the orientation. Participation occurred only after informing them regarding the DNP team building project, signing consents to participate, and confirming the understanding that the project participation criteria included the pre- and post-orientation quizzes and the post-orientation survey. All data collection was conducted anonymously with caregivers placing matching symbols to track the pre- and post-quiz scores. Data gathered from the re-orientation was combined with that of the initial two new-hire caregivers for analysis excluding the question three data and the two respondents for the question two, Top Ten Need-to-Know list data. No statistical analysis comparison was made between the new-hire and current caregiver groups due to the small size of the new-hire group, $n = 2$.

Discussions during the re-orientation sessions revealed that current caregivers did acquire new information regarding dementia and dementia care strategies. Also, the discussions revealed that current caregivers did not possess greater knowledge of the concepts of person-centered care, cultural competence, professional relationships, or mindfulness in the workplace; these were all relatively new concepts to both the new-hire and the current caregivers. The current caregivers expressed that they enjoyed the group interactions during the sessions and commented that they became better acquainted with their peers. Comments like “I didn’t know that about you” and “oh, me too” were verbalized on several occasions by the participants during the team-building discussions.

The post-orientation quiz consisted of 15 questions. Scores increased between one and six points for 10 of the participants (Figure 1) potentially indicating they had an enhanced

awareness of the concepts of dementia, dementia care (memory care), person-centered care, cultural competence, professional relationship development, and mindfulness in the work place. One participant's quiz scores remained the same, though some of the questions answered incorrectly changed, and two participants' scores dropped by one point, again, with some differing incorrect answers. Several respondents expressed concern indicating they had difficulty taking written tests, which could account for the decrease in the two respondents' scores. Though the scores increased for 10 participants, as Schoen, Gausia, Glance, and Thompson (2016) point out, the application of the new knowledge cannot be determined by assessing the quiz scores alone. The actual outcome of the knowledge application occurs when observing caregivers as they care for residents.

The pre- and post-quiz data were tested for normality and reliability by the student using IBM SPSS 24 software. Because of the small sample size, $n = 13$, the student performed the nonparametric, Wilcoxon Signed Rank Test for the pre- and post-quiz data. Statistics were generated to compare the caregivers' initial quiz answers to the post-orientation quiz results. Though no quiz scores exceeded 12 out of 15, a Wilcoxon Signed Ranked Test revealed a statistically significant increase in quiz scores following participation in the caregiver team-building orientation, $z = -2.756$, p .006, with a large effect size ($r = .54$). The median score on the quiz increased from pre-orientation ($Md = 8.0$) to post-orientation ($Md = 10.0$).

The post-orientation survey analysis was performed by the student using IBM SPSS 24 to elicit descriptive statistics for the ordinal, Likert scale variables; all variables were expressed with positive wording. The five-point Likert scale was expressed as 1 = strongly disagree, 2 = disagree, 3 = neither disagree of agree, 4 = agree, 5 = strongly agree. The survey results for the

caregiver respondents are found in table 4. The respondents answered favorably regarding the orientation experience with most questions receiving a strongly agree response.

The responses ranged from nine scores of five for question eight to twelve scores of five for questions five and ten from the respondent group of 13 caregivers (Figures 2 through 11). Question two asked about the caregivers' familiarity with the Top Ten Need-to-Know information which the orientation mentor neglected to include in one reorientation session; survey answers from the two respondents who were not given that information were omitted from data collection to avoid skewing the analysis. Question three related to the hands-on experience that was only availed to the two new-hire caregivers, both respondents indicated they strongly agreed that the hands-on experience was beneficial. Question number seven "I have more knowledge about maintaining mindfulness in caring for residents," was inadvertently omitted from the survey form and no data was collected for that question.

Three write-in questions at the end of the survey yielded several themes. The first question, "What was the best part of the orientation?" related answers included: an increased knowledge about the caregiver role, dementia, and dementia care; the interactive nature of the orientation sessions; and the learning and sharing of resident behavior strategies. Twelve of the 13 respondents answered the first write-in response question. The second write-in response question was answered by five respondents; it asked what respondents wished they had learned about/learned more about during the orientation. The respondents indicated they were satisfied with the content; one current caregiver expressed a regret that the content had not been provided at the start of that caregiver's employment. The final question, answered by four respondents, asked for other comments; the comments expressed appreciation for the didactic and interactive content and that the information would be helpful in the caregiver setting. The overall response

to the team-building orientation and re-orientation sessions was highly favorable. Some respondents expressed concerns regarding management's support for the caregivers and the intent to sustain the new orientation team building content (top ten surveys, 2017, July 1, 2, 3, 5; group and personal conversations, 2017, August 15, 16, 17).

The concerns regarding current facility leadership support and caregiver practices discovered through the Top Ten Need-to-Know questionnaires and group and personal discussions in the re-orientation sessions were addressed in an executive summary presented to the local facility leaders at the completion of the DNP project. An opportunity to share the project outcome and follow up with the caregivers was arranged through the HR Manager. Though turnover rates from the previous years may shed light on the current retention status at the facility, reviewing for changes after the intervention may not prove meaningful until some months after the team building program is in place and sustained. The facility is responsible for sustaining the intervention practices and performing longer-term monitoring of caregiver staff turnover.

Significance for Nursing

Comparing the data analysis to the intended outcomes and the project question provides insights into the value of the team building project in addressing the lack of team work and job satisfaction experienced by the facility's dementia caregivers. The intended DNP program outcomes of developing and implementing a team-building program were met; the program included the desired components recognized through the literature search as essential for dementia care. Manthrope (2014) reinforces that training is an important factor in job satisfaction among the dementia caregiver group. Based on the post-implementation of the project findings, the participants agreed with this Manthrope research indicating the added

benefit of providing meaningful and applicable content was beneficial.

The concepts of dementia, dementia care (memory care), person-centered care, cultural competence, professional relationships, and mindfulness in the work setting were presented to all 13 caregiver participants. Ten of the 13 participants increased their post-orientation quiz scores by 6.7% to 40.2 %, meeting the desired increase of at least 5%. Three caregiver participants did not reach that intent, several related they were poor test-takers and expressed concerns they would not do well on the quiz. The goal of affecting policy and procedure changes to incorporate the new orientation format was not met thus far. The facility leaders expressed the desire to sustain the program indefinitely and to provide monetary incentives for the orientation mentors with an expectation that they serve as resources for their peers beyond their orientation mentor duties (personal conversation with HR Manager, 2017, August 17).

The DNP project question sought to learn if dementia caregiver job satisfaction and retention would be positively impacted by a team-building program along with facility leadership support. It was hoped that the endorsement and provision of the team-building orientation component was seen as supportive by the new-hire caregivers. It is believed this was the case based upon the comments of the two new dementia caregivers who expressed they felt the team-building orientation process with the didactic and hands-on skills practice was valuable. One commented “I have never experienced this type of orientation before. It’s different, it’s great!” The other new caregiver verbalized agreement with her peer (personal conversation, 2017, July 13).

The orientation mentors expressed that they felt the team-building orientation presented a new potential for improvements in caregiver teamwork and resident care; they also acknowledged the accompanying increase in the responsibility associated with being an

orientation mentor and peer resource and a pay raise as being desirable and positive. They all expressed wanting to perform in the orientation mentor capacity. A change in the number of orientation mentors occurred before the orientation sessions initiated; the facility leaders realized they had over-selected the number of persons required for the role necessitating them to decrease the number of orientation mentors to only one or two per shift (days and evenings only).

The current caregivers who attended the re-orientation training did overwhelmingly indicate they felt they had gained knowledge and increased comradery with their peers, though there were comments indicating doubt in facility leaders sustaining the new orientation process. According to Isik, Timuroglu, and Aliyev (2015), a significant and positive relationship between teamwork and trust exists. From this relational perspective, the enhancement of caregiver comradery and teamwork itself may contribute to greater trust in collegiality and leadership at the project facility. Baillie, Sills, and Thomas (2016) point out that presenting materials to an entire work group vs. several individuals, with the provision that training is mandatory, reinforces the intent of organizational leadership support. The facility did decide to provide the team-building program to the current day and evening shift caregivers and not limit the program to new-hire caregivers.

This DNP project was only able to consider the introduction of new behaviors to caregivers over a short time frame; more time was required to reinforce the team-building behaviors and increase organizational trust. Reassessment of the lasting effects of the orientation and re-orientation sessions should be performed over the next six to twelve months before determining the full impact of the team-building interventions. The DNP student returned to present the leaders with an executive summary of the project; at that time, leadership indicated

that they planned to continue providing the team-building orientation component for new-hire caregivers.

According to Bowman and Rogers (2016), dementia is in the top ten chronic health conditions experienced by persons in assisted living, and 70% to 80% of the hands-on care by paid caregivers in this venue is provided by non-nurse caregivers. Considering that the cost of care is high and rising, non-nurse caregivers will continue to be used as the primary, frontline workers in the dementia care (memory care) setting. The results of this project may provide the impetus and support for other organizations to provide team-building orientation and recurrent training activities for caregiver staff, especially those who work in dementia care.

Limitations, Dissemination, and Sustainability

Further scrutiny of the DNP project outcomes included a discussion of the limitations experienced in the project design and data collection and analysis. Opportunities to share the knowledge gained and encourage the development of similar team building models for memory care, or related caregiving staff at other facilities or organization were considered. Finally, the requirements for the sustainability of the team building component in new-hire caregiver orientation were addressed.

Limitations

Size. The original design of this DNP project addressed new-hire dementia caregivers only. The project facility incurred a large new-hire caregiver group the month before the DNP project was implemented and only two new-hire caregivers were on-boarded during the implementation period. Because of the small orientation group, the facility leaders agreed to a re-orientation program for the current caregivers with 11 additional staff from the day and evening shifts receiving the didactic team-building content.

The number of participants in both the orientation and the re-orientation sessions totaled $n = 13$. By combining the new-hire caregivers who attended orientation as part of the hiring agreement and the current caregivers who were scheduled to attend the training as part of required staff development, the DNP student obtained a small, but adequate project group. It would have been optimal to have several more onboarding cycles during the data collection period. Including the night shift caregivers in the re-orientation would have promoted a cohesive team-building experience across all shifts.

Applicability. The Top Ten Need-to-Know survey recruitment was conducted on a face-to-face basis, but the forms were left with the caregivers to complete later when time permitted. A locked, opaque collection container for anonymous return was located in the nursing office. The response from this data collection was poor, with only three of 25 caregivers responding. It may have been beneficial to request that the caregivers fill in the survey at the time it was provided and have the collection container available to them where they filled out the forms. The collection container was kept in the nursing office, which was in a different location in the building than the locked, dementia care unit; the nursing office was at times locked and at times heavily trafficked. The container location presented a physical and potentially a psychological barrier to returning the forms; some caregivers may have felt reluctant to have their peers or leaders see them deposit the form in the nursing office.

In one re-orientation session, the review of the Top Ten Need-to-Know information was omitted, and data could not be collected for that post-orientation survey question. An oversite in recognizing a question had been omitted from the post-orientation survey meant no data was collected regarding the participants' perceptions of increased knowledge of mindfulness in the workplace. Another observation regarding the pre- and post-orientation quiz revealed that the

highest score on the quiz was 12 out of a possible 15; in retrospect, the quiz construction, which included three "select all that apply" questions may have been too involved. It was also noted there were practice versus theory discrepancies in the current caregiver group about dementia behavior strategies. These were discussed during the re-orientation sessions but still presented respondent difficulties in correctly answering several of the quiz questions.

The recruitment of the orientation mentors proved difficult, the criteria for selection were not fully considered before caregivers were selected for orientation mentor training; several caregivers who initially received the orientation mentor training were not chosen to function in that capacity when leadership recognized they had over-selected the number of caregivers for the role. This rescinding of the orientation mentor role resulted in some hard feelings between the caregivers and the facility leaders. In hindsight, this selection process could have benefited from the creation of predetermined, specific eligibility criteria and a predetermined number of positions available to avoid the disqualification of individuals after the orientation mentor training had been provided.

Finally, the facility experienced turnover of leadership during the planning and implementation stages of the DNP project. At the project planning stage, the facility employed one licensed nurse; this position was transitioned from a Licensed Practical Nurse (LPN) position to a Registered Nurse (RN) requirement several weeks before project implementation. The position was filled by an interim RN who was briefed on the project details. She left when a permanent RN was hired, but returned after the selected, permanent position RN left within several weeks of initiating employment. At the completion of the DNP project implementation and data collection, a new RN had been hired and was expected to start the following week. These frequent changes in the RN leadership may have impacted the caregivers as performance

and procedure guidelines were inconsistent during these staffing transitions. As indicated in the literature search, leadership support was frequently mentioned as being essential in engaging caregiver committedness and enhancing job satisfaction.

Timeframe. Because of the lack of new-hire caregivers during the data collection timeframe, data collection was expanded to include current caregivers who were provided an abbreviated, re-orientation experience. The 11 current caregivers were not exposed to the hands-on training because of the time constraints for the additional training; resident care staff were taken from caregiver duties during their regular work hours necessitating coverage by the RN and the lead caregiver. It was not possible to compare the new-hire and current caregiver data because the new-hire cohort included only two individuals.

The orientation mentors were also displaced from resident care to facilitate the sessions. The night shift caregivers were not re-oriented; facility leaders indicated there currently was not an identified orientation mentor on the night shift and it was felt the training would not benefit that group without a designated caregiver resource person to facilitate the re-orientation. Additionally, the data collection timeframe was not sufficient to determine any long-term attitudes regarding job satisfaction or an intent to remain employed by the facility.

Dissemination

The literature search results supported leadership that provides caregiver training and education combined with the provisions of autonomy and decision making opportunities to establish an environment that is conducive to job satisfaction and staff retention. The outcomes of this DNP project may be of benefit to the project facility's parent organization for use within its other facilities; the findings from the project implementation were shared with the local facility leaders and the parent organization in an executive summary. Other, local assisted living

and skilled nursing facilities present a geographically opportune possibility to introduce and avail the team-building orientation process model for use in onboarding and ongoing caregiver training. Through publishing, this model has the potential to reach caregiver leaders both nationally and internationally.

Project Sustainability

Staff turnover is costly, and a change in practice requires consistent reinforcement over time to prevent old behaviors from re-emerging (Moore, Everly, & Bauer, 2016). The team-building orientation and re-orientation approach, supported by the facility leaders, has the potential to increase job satisfaction and employee retention; it was well accepted by the caregiver participants from an educational perspective. The participants expressed that they wanted to learn about dementia, dementia care, and the concepts of person-centered care, cultural competence, professional relationships, and mindfulness in the workplace and felt this knowledge helped them better care for residents.

It is vital for facility leaders to provide consistency in supporting the team-building process to gain and maintain the trust of caregiver staff; continued teamwork and comradery development among the caregivers can also enhance trust for peers and leaders at the facility. In other words, it is the responsibility of both the leaders and the caregivers to demonstrate a commitment to sustaining the team-building effort collaboratively; it should continue to be facilitated by the orientation mentors who are caregiver peers and serve as resources for both new and existing staff. There is room to strengthen the program support by selecting orientation mentors from the night shift and re-orient the caregivers on that shift to make team-building inclusive of all dementia caregivers at the facility.

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Tables

Table 1

Summary of the four implementation phases and 14 critical steps in the Quality Implementation Framework that are associated with quality implementation

Phase One: Initial considerations regarding the host setting

Assessment strategies

1. Conducting a needs and resources assessment
2. Conducting a fit assessment
3. Conducting a capacity/readiness assessment

Decisions about adaptation

4. Possibility for adaptation

Capacity-building strategies

5. Obtaining explicit buy-in from critical stakeholders and fostering a supportive community/organizational climate
6. Building general/organizational capacity
7. Staff recruitment/maintenance
8. Effective pre-innovation staff training

Phase Two: Creating a structure for implementation

Structural features for implementation

9. Creating implementation teams
10. Developing an implementation plan

Phase Three: Ongoing structure once implementation begins

Ongoing implementation support strategies

11. Technical assistance/coaching/supervision
12. Process evaluation
13. Supportive feedback mechanism

Phase Four: Improving future applications

14. Learning from experience

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Table 2

Critical steps in implementation, important questions to answer at each step in the Quality Implementation Framework.

Phases and steps of the quality implementation framework

Phase one: Initial considerations regarding the host setting
Assessment strategies

1. Conducting a needs and resources assessment:
Why are we doing this?
What problems or conditions will the innovation address (i.e., the need for the innovation)?
What part(s) of the organization and who in the organization will benefit from improvement efforts?

2. Conducting a fit assessment:
Does the innovation fit the setting?
How well does the innovation match the:
Identified needs of the organization/community?
Organization's mission, priorities, values, and strategy for growth?
Cultural preferences of groups/consumers who participate in activities/services provided by the organization/community?

3. Conducting a capacity/readiness assessment:
Are we ready for this?
To what degree does the organization/community have the will and the means (i.e., adequate resources, skills and motivation) to implement the innovation?
Is the organization/community ready for change?

Decisions about adaptation

4. Possibility for adaptation
Should the planned innovation be modified in any way to fit the host setting and target group?
What feedback can the host staff offer regarding how the proposed innovation needs to be changed to make it successful in a new setting and for its intended audience?
How will changes to the innovation be documented and monitored during implementation?

Capacity Building Strategies (may be optional depending on the results of previous elements)

5. Obtaining explicit buy-in from critical stakeholders and fostering a supportive community/organizational climate:
Do we have genuine and explicit buy-in for this innovation from: Leadership with decision-making power in the organization/community?
From front-line staff who will deliver the innovation?
The local community (if applicable)?

Have we effectively dealt with important concerns, questions, or resistance to this innovation? What possible barriers to implementation need to be lessened or removed?
Can we identify and recruit an innovation champion(s)?
Are there one or more individuals who can inspire and lead others to implement the innovation and its associated practices?
How can the organization/community assist the champion in the effort to foster and maintain buy-in for change?

Note. Fostering a supportive climate is also important after implementation begins and can be maintained or enhanced through such strategies as organizational policies favoring the innovation and providing incentives for use and disincentives for non-use of the innovation

6. Building general/organizational capacity:
What infrastructure, skills, and motivation of the organization/community need enhancement in order to ensure the innovation will be implemented with quality?
Of note is that this type of capacity does not directly assist with the implementation of the innovation, but instead enables the organization to function better in a number of its activities (e.g., improved communication within the organization and/or with other agencies; enhanced partnerships and linkages with other agencies and/or community stakeholders).

7. Staff recruitment/maintenance:
Who will implement the innovation?
Initially, those recruited do not necessarily need to have knowledge or expertise related to use of the innovation; however, they will ultimately need to build their capacity to use the innovation through training and on-going support
Who will support the practitioners who implement the innovation?
These individuals need expertise related to (a) the innovation, (b) its use, (c) implementation science, and (d) process evaluation so they can support the implementation effort effectively
Might roles of some existing staff need realignment to ensure that adequate person-power is put towards implementation?

Phases and steps of the quality implementation framework Frequency

8. Effective pre-innovation staff training
Can we provide sufficient training to teach the why, what, when, where, and how regarding the intended innovation?
How can we ensure that the training covers the theory, philosophy, values of the innovation, and the skill-based competencies needed for practitioners to achieve self-efficacy, proficiency, and correct application of the innovation?

Phase two: Creating a structure for implementation
Structural features for implementation

9. Creating implementation teams:
Who will have organizational responsibility for implementation?

Can we develop a support team of qualified staff to work with front-line workers who are delivering the innovation?
Can we specify the roles, processes, and responsibilities of these team members?

10. Developing an implementation plan:
Can we create a clear plan that includes specific tasks and timelines to enhance accountability during implementation?
What challenges to effective implementation can we foresee that we can address proactively?

Phase three: Ongoing structure once implementation begins
Ongoing implementation support strategies

11. Technical assistance/coaching/supervision:
Can we provide the necessary technical assistance to help the organization/community and practitioners deal with the inevitable practical problems that will develop once the innovation begins?
These problems might involve a need for further training and practice in administering more challenging parts of the innovation, resolving administrative or scheduling conflicts that arise, acquiring more support or resources, or making some required changes in the application of the innovation

12. Process evaluation
Do we have a plan to evaluate the relative strengths and limitations in the innovation's implementation as it unfolds over time?
Data are needed on how well different aspects of the innovation are being conducted as well as the performance of different individuals implementing the innovation

13. Supportive feedback mechanism
Is there an effective process through which key findings from process data related to implementation are communicated, discussed, and acted upon?
How will process data on implementation be shared with all those involved in the innovation (e.g., stakeholders, administrators, implementation support staff, and front-line practitioners)?
This feedback should be offered in the spirit of providing opportunities for further personal learning and skill development and organizational growth that leads to quality improvement in implementation

Phase four: Improving future applications
14. Learning from experience
What lessons have been learned about implementing this innovation that we can share with others who have an interest in its use?

Researchers and innovation developers can learn how to improve future implementation efforts if they critically reflect on their experiences and create genuine collaborative relationships with those in the host setting

Collaborative relationships appreciate the perspectives and insights of those in the host setting and create open avenues for constructive feedback from practitioners on such potentially important matters as: (a) the use, modification, or application of the innovation; and (b) factors that may have affected the quality of its implementation

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Table 3

Top Ten Need-to-Know Information for New-Hire Caregivers

1. Arrive early, not just "on time" a range of 5 to 30 minutes was given
2. Don't expect to leave exactly on time
3. Get a list of all residents and room numbers (map of floorplan)
4. Get a report on all residents – "who's who" info
5. Have the pager, radio, and telephone explained
6. Have the documents and how to complete explained
7. Expect to be sore if you are not used to the physical activity of caring for people
8. Leave you problems and drama at the door
9. Rules about BC Hospital accessing: bringing a patient vs. calling 311 or 911, discharging a resident
10. Not a money making job, it is a great experience
11. It is inevitable you will form attachments with residents, they become like family
12. Death happens
13. Your friends and family may not understand your work and what is expected of you as a caregiver
14. You have to learn to leave work at work, it is difficult to stop thinking about work once you leave
15. If you are a med tech, ask to be trained on orders, tax numbers, pharmacy book, important phone numbers, office and where to find things like reports

Qualitative information offered from current dementia caregivers at the project facility.

Table 4

Post-Orientation Survey Results

Question	1	2	3	4	5
1. I believe it was beneficial for me to meet my caregiver coworkers during orientation.				2	11
2. I am able to identify the top items the current caregivers feel are important for new caregivers to know. (only 11 respondents)				2	9
3. I have acquired new skills as a result of the hands-on skills practice as part of the orientation program. (only 2 respondents)					2
4. I have more knowledge about caring for persons who have dementia.			1	1	11
5. I have more knowledge about person-centered care.				1	12
6. I have more knowledge about cultural competence in caring for residents.				3	10
7. I have more knowledge about maintaining mindfulness in caring for residents. (Inadvertently omitted from survey form)					
8. I have more knowledge about the importance of developing professional relationships with the residents and their families.				4	9
9. I feel I have the knowledge and the skills to perform my caregiver role.				2	11
10. I feel I have the confidence to perform my caregiver role.				1	12

Key: 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree

Figure 1

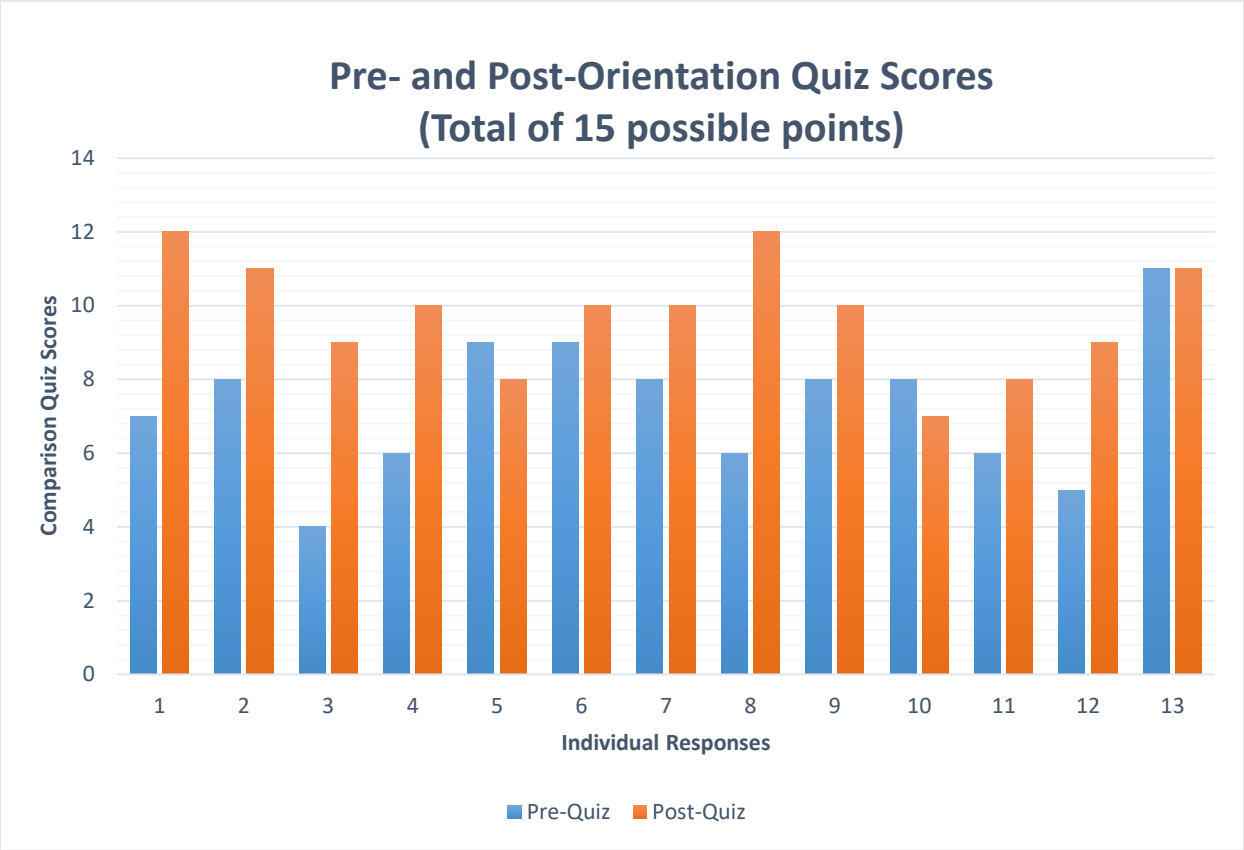
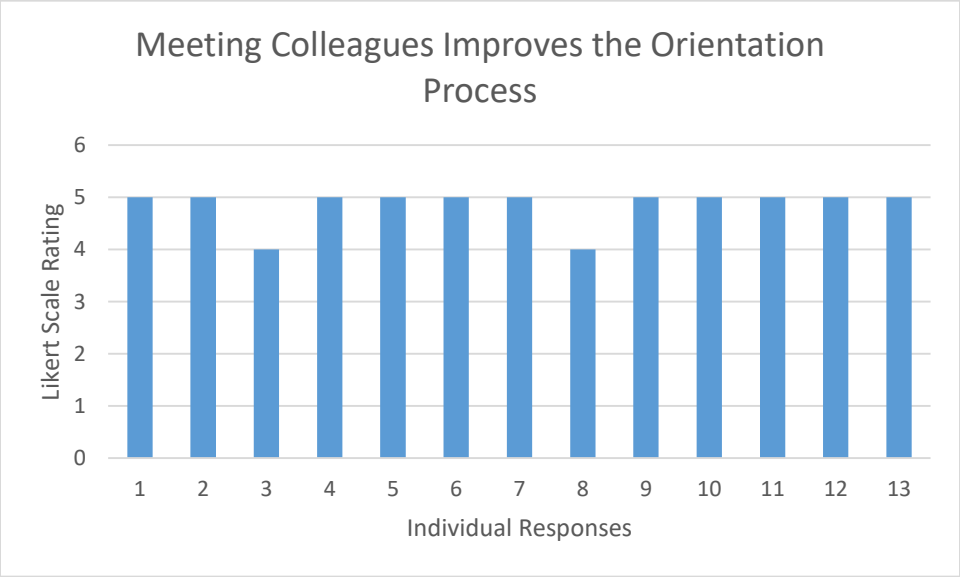
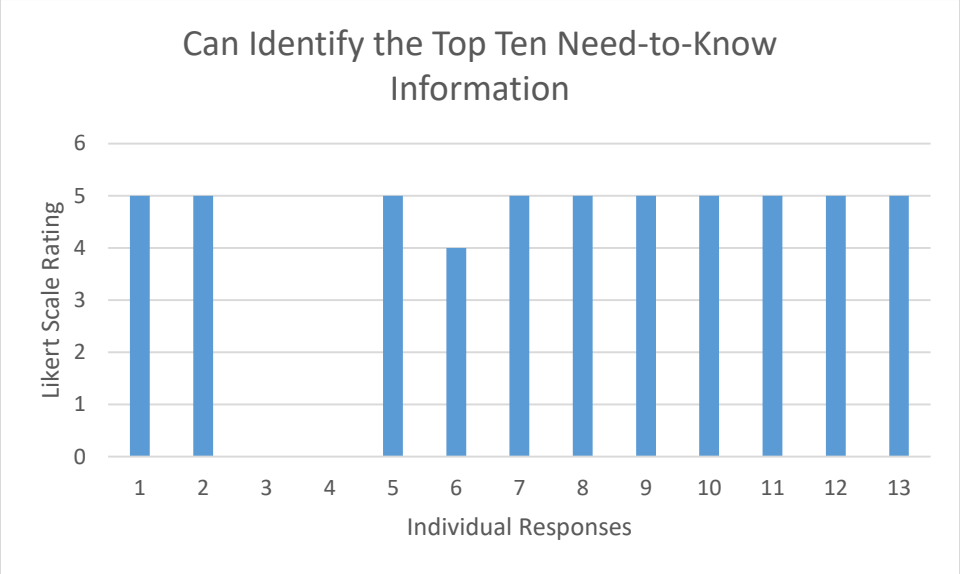

Pre- and Post-Orientation Quiz Scores
(Total of 15 possible points)
Comparison Quiz Scores
14
12
10
8
6
4
2
0
1
2
3
4
5
6
7
8
9
10
11
12
13
Individual Responses
Pre-Quiz
Post-Quiz

Figure 2



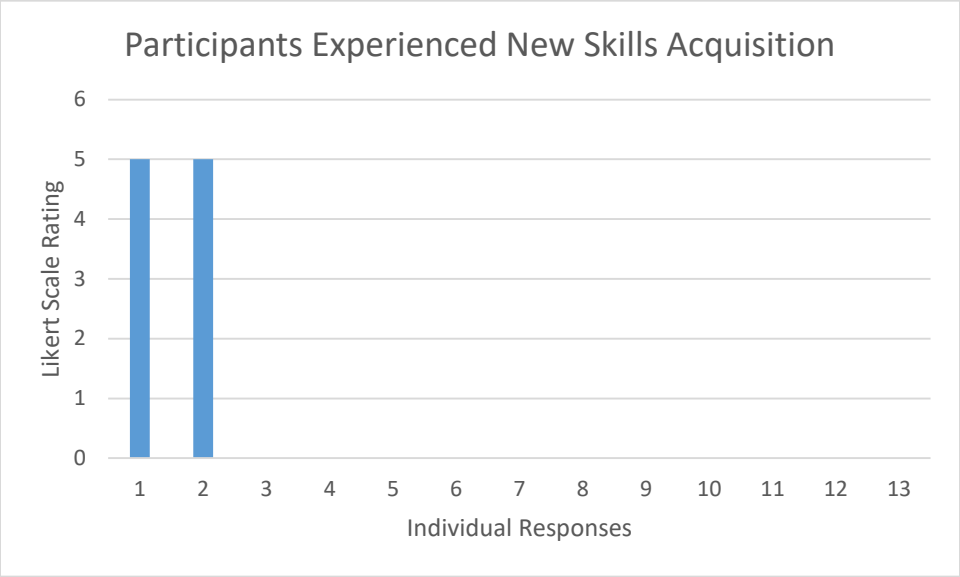
Likert Scale Key:
1 = Strongly Disagree, 2 = Disagree, 3 = Neither Disagree or Agree, 4 = Agree, 5 = Strongly Agree

Figure 3



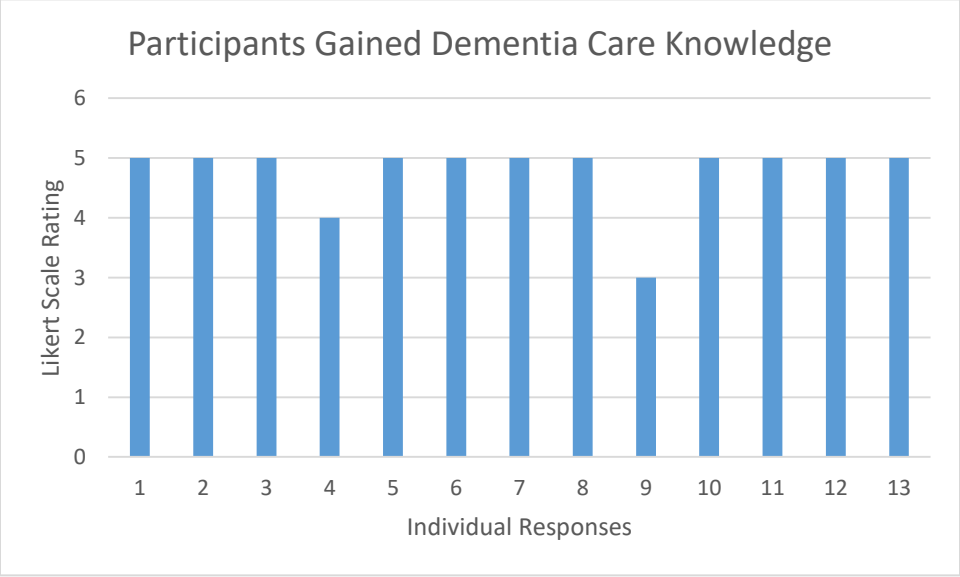
Likert Scale Key:
1 = Strongly Disagree, 2 = Disagree, 3 = Neither Disagree or Agree, 4 = Agree, 5 = Strongly Agree

Figure 4



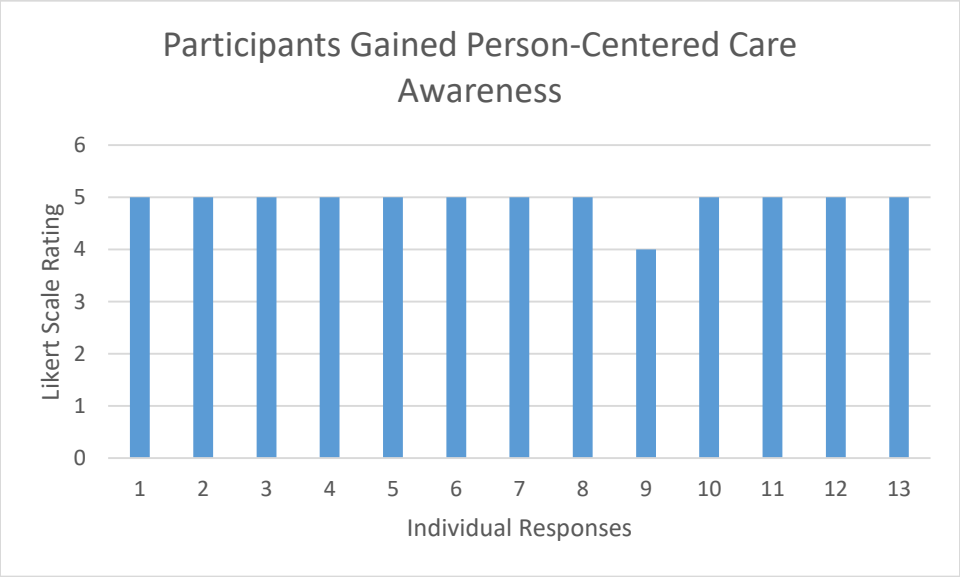
Likert Scale Key:
1 = Strongly Disagree, 2 = Disagree, 3 = Neither Disagree or Agree, 4 = Agree, 5 = Strongly Agree

Figure 5



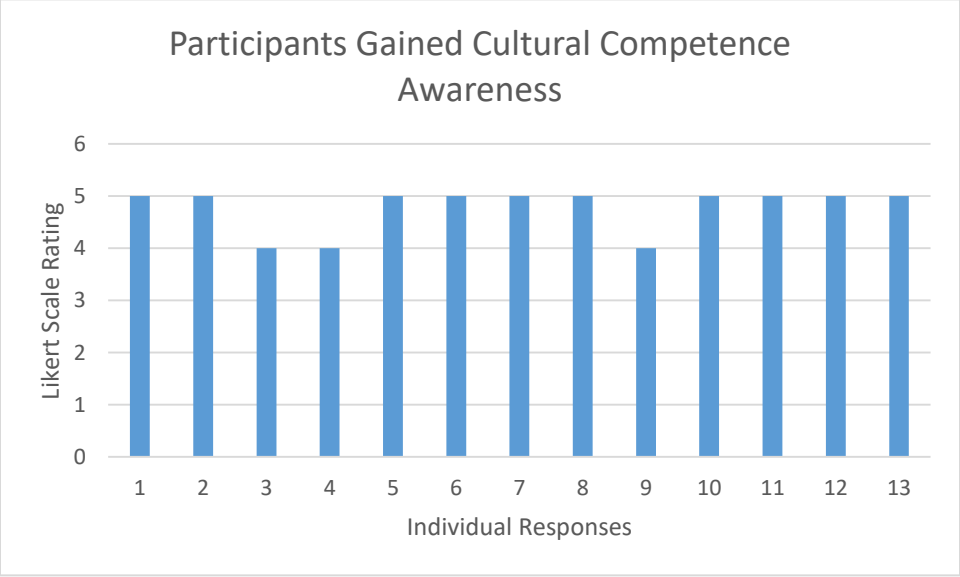
Likert Scale Key:
1 = Strongly Disagree, 2 = Disagree, 3 = Neither Disagree or Agree, 4 = Agree, 5 = Strongly Agree

Figure 6



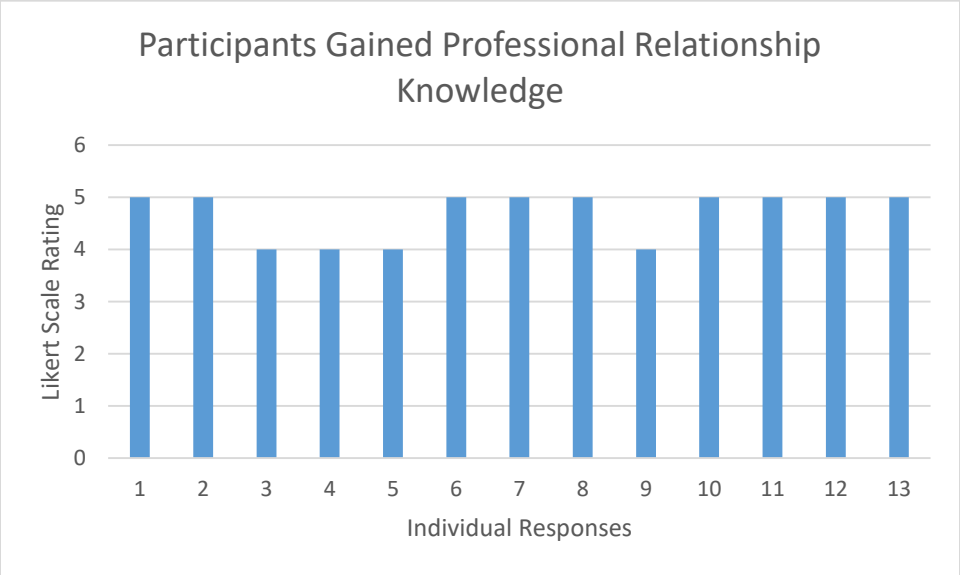
Likert Scale Key:
1 = Strongly Disagree, 2 = Disagree, 3 = Neither Disagree or Agree, 4 = Agree, 5 = Strongly Agree

Figure 7



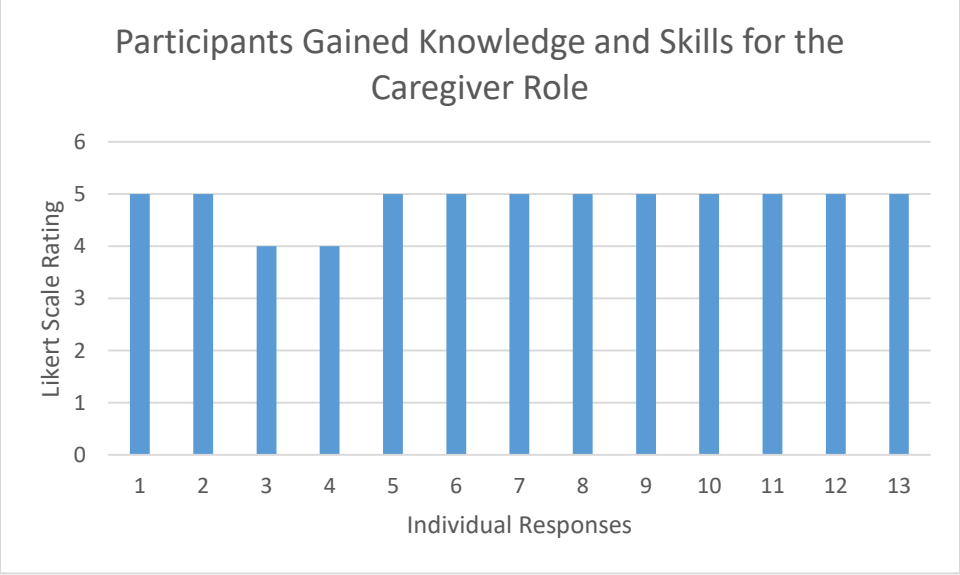
Likert Scale Key:
1 = Strongly Disagree, 2 = Disagree, 3 = Neither Disagree or Agree, 4 = Agree, 5 = Strongly Agree

Figure 8



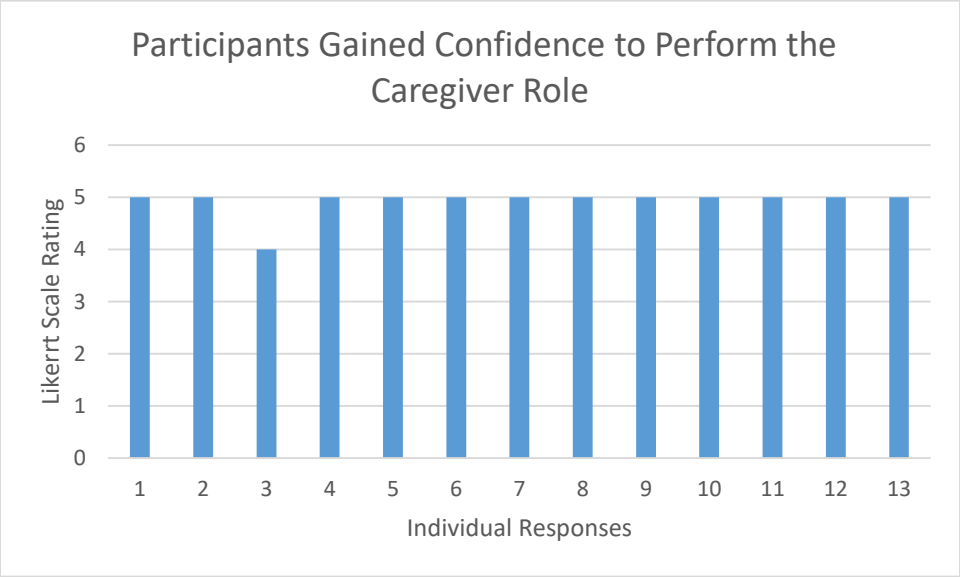
Likert Scale Key:
1 = Strongly Disagree, 2 = Disagree, 3 = Neither Disagree or Agree, 4 = Agree, 5 = Strongly Agree

Figure 9



Likert Scale Key:
1 = Strongly Disagree, 2 = Disagree, 3 = Neither Disagree or Agree, 4 = Agree, 5 = Strongly Agree

Figure 10



Likert Scale Key:
1 = Strongly Disagree, 2 = Disagree, 3 = Neither Disagree or Agree, 4 = Agree, 5 = Strongly Agree

Appendix A

Caregiver Orientation Survey Date _____

Directions: Please read each statement and circle the number that best represents your opinion. Include your comments regarding the value of this orientation and any other topics you would like to hear about in the future.

	Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
1. I believe it was beneficial for me to meet my caregiver coworkers during orientation.	1	2	3	4	5

	Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
2. I am able to identify the top items the current caregivers feel are important for new caregivers to know.	1	2	3	4	5

	Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
3. I have acquired new skills as a result of the hands-on skills practice as part of the orientation program.	1	2	3	4	5

	Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
4. I have more knowledge about caring for persons who have dementia.	1	2	3	4	5

	Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
5. I have more knowledge about person-centered care.	1	2	3	4	5

	Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
6. I have more knowledge about cultural competence in caring for residents.	1	2	3	4	5

	Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
7. I have more knowledge about maintaining mindfulness in caring for residents.	1	2	3	4	5

	Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
8. I have more knowledge about the importance of developing professional relationships with the residents and their families.	1	2	3	4	5

	Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
9. I feel I have the knowledge and the skills to perform my caregiver role.	1	2	3	4	5

	Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
10. I feel I have the confidence to perform my caregiver role.	1	2	3	4	5

The best part of the orientation was:

I wish I had learned about/learned more about:

Other comments:

Thank you for taking time to complete the survey. Your opinions are valuable to me.
Eva Fischer, MSN-Ed, RN-BC, DNP Student

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