Turnaround in an aged persons' mental health service in crisis: a case study of organisational renewal

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Abstract

This case study demonstrates how leadership was harnessed to turn around a decline in the performance of an aged persons' mental health service — the Namarra Nursing Home at Caulfield General Medical Centre in Melbourne, Australia. In 2000 the nursing home faced a crisis of public confidence due to failings in the management of quality, clinical risk and human resources within the service. These problems reflected structural and operational shortcomings in the clinical directorate and wider organisation. In this article, we detail the process of turnaround from the perspective of senior executive managers with professional and operational responsibility for the service. This turnaround required attention to local clinical accountability and transformation of the mental health program from a collocated but operationally isolated service to one integrated within the governance structures of the auspicing organisation.

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What is known about the topic?

Leadership is often identified as a requirement for organisational success, but we have limited knowledge of what has seemed to work in practice in enhancing organisational performance.

What does this paper add?

This paper outlines the leadership techniques focused on culture, education and staff development, flexibility, clinical improvement and professional standards that were used to turn around an ailing aged persons' mental health service.

What are the implications for practitioners?

The authors suggest that commitment to organisation-wide values, a well articulated vision, consistency in management practice, engagement of staff and attention to risk and clinical outcomes with a leadership team that does not distinguish between the core business of the organisation and that of the mental health service are essential leadership requirements.

IN ITS FIRST TERM from 1992–1996, the Victorian Liberal government undertook structural reform of the metropolitan health system. Governance was centralised and 35 independent hospitals in Melbourne were merged to form seven health care networks. Casemix was also introduced as the dominant funding model, first in the acute care sector and later in the sub-acute health and residential aged care sectors.[1,2] The organisational impact of these changes on Caulfield General Medical Centre (CGMC) was substantial. In the period 1995–2000 the hospital was governed by no less than three health care entities of varying size. In its second term from 1996–1999, the Victorian Liberal government prepared state-owned residential aged care services for privatisation.[3] This policy was reversed by the newly elected Labor government following its unexpected victory in October 1999.

A parallel reform of mental health services was undertaken. Community and bed-based mental health services were integrated to form area mental health services. Stand-alone psychiatric hospitals were closed. Services were relocated to stand-alone sites in the community or collocated with public health facilities under the banner of "mainstreaming". Governance was assumed by public health care networks.[4]

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As part of this process, the Inner South Aged Persons Mental Health Service (APMHS) was established at CGMC in 1995. The clinical directorate included a 15-bed acute inpatient unit, a community assessment and treatment service and a 30-bed high-care residential service, the Namarra Nursing Home. The latter was added to an existing 120 generic high-care residential beds, in four separate locations, on site at CGMC.

Sequence of events

Crisis in the psychogeriatric nursing home

In November 1999, following election of the state Labor government, an external audit of all residential aged care services at CGMC was undertaken. This review identified declining standards, non-compliance with a majority of residential aged care standards, and operational structures that did not facilitate effective accountability and reporting.[5] As the organisation prepared to reverse a period of neglect, a former member of staff approached a number of media outlets to disclose inadequate standards of care in the Namarra Nursing Home. Newspaper reports (Box) of "ants found on patient",[6] "an alleged lack of infection control at a nursing home"[7] and "fly spraying of patient(s)"[8] raised legitimate concerns about resident safety. These allegations were severely damaging to the reputation of the organisation and led to questions being asked in Parliament of the then Minister for Aged Care.[9]

The crisis in public trust triggered by these allegations led to a number of reviews in mid-2000 by the Aged Care Standards and Accreditation Agency, the health care network and the mental health branch of the Victorian Department of Human Services. Ultimately, the reviews concluded that the care provided to residents was satisfactory but organisation-wide deficiencies were identified in the management of information, human resources and quality and clinical risk.

By mid-2000, Moss Kanter's "spiral of decline" could be identified in the organisation.[10] An exodus of staff in senior management positions in the late 1990s led to a loss of corporate knowledge. The external audit revealed a degradation of nurse training and education, clinical care standards and the clinical quality and risk infrastructure. There was further evidence of neglect of the physical environment and poor staff morale.[5] A cultural audit undertaken in early 2001 also revealed problems with communication between managers and clinical staff. Managers isolated themselves to avoid blame and accountability and competed for scarce resources.[11] As desribed by Moss Kanter,[10] the organisational culture was dominated by denial, passivity and increasing helplessness.

The impact on the organisation was substantial. In mid-January 2001 the nursing home had a vacancy rate of 46.7% and agency nurse staffing of 46.1% against a staffing profile of about 28.56 equivalent full-time (EFT) employees. At the same time, the hospital-wide vacancy level was 26.1% and agency nurse staffing levels were at 17.2% against a hospital staffing profile of 255.02 EFT at a cost of $1.2–$2 million per year in premium alone. Problems with staffing were directly responsible for the closure of five of the 30 beds in the Namarra Nursing Home.[12]

Organisational turnaround

Under the organisational structure prevailing in 2000, the mental health service was isolated. Operational responsibility for the Namarra Nursing Home rested with the Director of the Aged Psychiatry Service. The Associate Director of Nursing (Residential Care Services) was available to provide operational support on an "as needs" basis. These arrangements had evolved since establishment of the Namarra Nursing Home in 1995 and in many ways reflected the "separateness" of the APMHS within CGMC. As a result, the Namarra Nursing Home staff relied heavily on the leadership of the Nurse Manager at a local level. In the absence of adequate organisational oversight, when standards of care declined, there was little opportunity for detection within and remediation by the broader organisation.

In 2000, the executive team at CGMC underwent substantial renewal in the context of a

change in governance and the establishment of a new health service structure. As program directors of Aged Psychiatry and Nursing and Residential Care Services, we resolved to improve service integration of the APMHS. Following the review, the directors appointed an Associate Director of Nursing for the Aged Psychiatry Service (ADON-APS) with joint reporting relationships to both. This position focused on the development and maintenance of clinical care standards and facilitated a link between residential care and the APMHS. This link was enhanced by the leadership role assumed by the ADON-APS in the new nursing executive. Through this linkage, many nursing-led initiatives being implemented throughout the health service could be extended into the Aged Psychiatry Service (APS) more broadly and the Namarra Nursing Home more specifically.

A process of staff engagement was deployed throughout the nursing service as a whole and extended into the APS. This was achieved through open forums with all nursing staff and optional completion of a written survey. Priorities for action were identified and then regularly monitored and reported through open forums and regular newsletters to all nursing staff.

Shortcomings in clinical service delivery were identified, as were issues affecting nursing recruitment and retention. Many of these related to perceived gaps in leadership and management practices and, in addition, concerns about the standard of clinical care and risk management. There was a strong sense that nursing staff had become deskilled over a period of time and that contemporary mental health nursing practice was not well understood, let alone practised. Multiple strategies were developed and implemented throughout the organisation, and these provided initial and sustainable positive results for the nursing home. The strategies were grouped into five broad areas:

- Leadership and culture
- Education and staff development
- Flexibility
- Clinical improvement
- Professional standards.

Leadership and culture focused on creating the optimal environment to attract, retain and motivate staff while communicating and "living" the organisation's core values. The focus on leadership was characterised by the development of a distinct motto for the nursing service, the establishment of a reward and recognition program, the implementation of a new performance review system and the establishment of a Nursing Services Consultative Council (to provide opportunity for elected staff representatives to meet, provide feedback and work with senior nursing staff on agreed service priorities). A charter for residential care services was developed (known locally as "Our Commitment to Residents") and articulated the philosophy for residential care services at CGMC. The senior nursing leadership team provided regular personal contact with all staff in their respective areas, and similar initiatives impacted on other professional groups. Operational and educational links with the adult mental health service enhanced the specialist training and continuing education requirements of mental health professionals in all disciplines and clinical programs.

Education and staff development focused on providing initial and continuing learning opportunities for all nursing staff. This commenced with the introduction of a local orientation program for all casual and permanent staff and was followed by an annual "mandatory training day" which provided regular practice updates for staff. The establishment of the Gerontic Nursing Professorial Unit in conjunction with La Trobe University was a successful venture. This jointly funded initiative provided a focal point for undergraduate, continuing and postgraduate learning. A graduate program for Division 1 Registered Nurses was implemented (in conjunction with Alfred Psychiatry, Bayside Health) in order to attract and retain staff in specialist mental health services. The development of conversion programs (offering opportunities for Division 2 Registered Nurses to become Division 1 Registered Nurses), specialised "refresher" courses (for Registered Nurses wishing to return to work or change area of specialty) and the ongoing provi-

sion of Supervised Practice programs (for nurses who need to re-register) were extremely popular. These included programs targeting aged persons' mental health practice. Additionally, access to postgraduate studies for Division 2 Registered Nurses was actively promoted and subsidised, and this resulted in many nurses undertaking specific courses in caring for people in the mental health setting. At a hospital-wide level, these measures resulted in 78% of nurses enrolled in these programs moving into permanent positions.

Flexibility focused on providing working options for staff who did not want the "traditional" rosters associated with many wards and departments. These included the implementation of six-hour shifts (to attract those staff who wanted to work shorter hours), family friendly shifts (eg, starting at 09:00) and the establishment of an innovative Nurse Pool (a Nurse Pool provides all the flexibility of a casual staff appointment, but with part-time or full-time commitments for both employer and employee). The Nurse Pool was the single most effective strategy in attracting staff and appealed very much to those who wanted the security of regular employment with maximum flexibility. Nurses accepting positions on the Nurse Pool were all led to expect that their roles would include rotations to the Namarra Nursing Home. Professional support and education was provided to enhance performance in the specialist setting. Namarra Nursing Home had traditionally struggled to compete with other program areas for staff. The Nurse Pool therefore provided a steady supply of staff to fill vacant shifts as required, but, importantly, also served as a conduit to permanent employee placement.

Clinical improvement strategies had a notable influence on the effectiveness of the nursing home. Tight restrictions in funding led to adoption of a consultation–liaison model of specialist mental health care. A multidisciplinary clinical case conference was introduced in 2001 involving a psychiatrist, a psychiatry registrar, a diversional therapist, a social worker, nursing staff and members of the resident's family. Its purpose was to review behavioural management in the care planning of each resident at least 3-monthly. General practitioners were invited and typically contributed through a booked telephone call. Furthermore, a comprehensive falls-reduction strategy was implemented throughout all residential aged care services in 2003, and the scope of the multidisciplinary conference was extended to reviewing falls prevention strategies at the same time.

Attention was also paid to oversight of the management of quality and clinical risk. Given the specialist nature of the service and where it sat within the organisation, the Namarra Nursing Home formed part of the quality, risk and accreditation systems in both aged psychiatry and residential care. These processes ensured that the focus on specialist mental health care was maintained while at the same time the specific requirements of operating a residential care facility were met.

Professional standards ensured that while the service remained attentive to the creation of an environment that could attract and retain staff, there was also a concerted effort to maintain professional standards in clinical practice.

The appointment of the ADON-APS and a renewed focus on nurse education lifted standards of care through clinical supervision and training around issues such as aggression management, medication management, falls and suicide risk. Further improvement was achieved through attention to the management of performance and disciplinary issues among staff. This impacted on perceptions of fairness and equity within the organisation. Previously, violations of professional standards had been dealt with inconsistently. This practice sent a confusing message to staff about the organisation's approach to practice standards and acted as a de-motivator for those staff who continued to act and behave professionally. The adoption of a consistent approach to disciplinary issues by senior staff sent a powerful message that unprofessional behaviour would not be tolerated. In turn, this gave local managers and supervisors the confidence to confront such problems with staff, in the knowledge that support would be provided should action other than counselling

of offending staff members be required. The impact on morale was immediate, though for some staff this approach challenged their local norms.

Outcomes

The new leadership approach from the program directors and the appointment to the new ADON-APS position was successful in achieving its short and medium-term objectives. Since 2000, the Namarra Nursing Home has been reviewed by the Aged Care Standards and Accreditation Agency (ACSAA) on no less than six occasions, of which two were full ACSAA accreditation reviews in 2003 and 2006. In addition, the Namarra Nursing Home was reviewed as part of an in-depth mental health review by the Australian Council on Healthcare Standards in 2006. All standards were met in all reviews, and following each survey, the feedback was extremely positive. Importantly, in the case of the ACSAA reviews, there has been no non-compliance throughout this period of time. This comes at a time when there has been much industry concern about the care provided in mental health residential care facilities in Victoria.

The focus on clinical care delivery generally resulted in improved outcomes for residents in the Namarra Nursing Home. Incidents of "clinical aggression" decreased by 62% in just 12 months from April 2002 to April 2003 and were sustained since with little variation. Falls also decreased substantially from 2002 to 2005, with an overall reduction of 61% during that time. The latter was sustained in Namarra Nursing Home well beyond the end of the health service-wide falls prevention strategy, in a manner not replicated in the non-specialist nursing homes. The rigour with which follow-up and review of all clinical incidents occurred has contributed to this success along with ensuring that follow-up is a responsibility of all staff. Recruitment and retention strategies have also yielded positive results. As of December 2006, the vacancy rate in the Namarra Nursing Home was 5.7% and agency utilisation was averaging 1.4%. This change in the staffing situation improved operating financial performance by between $360 000 and $500 000 per annum. There have been no bed closures since 2000, and through the key outcomes outlined, the improvements in the standard of care and environment are self-evident.

Discussion

The outcomes in this case study illustrate the risk of managing mental health services in isolation and the benefits that accrue from a commitment to organisation-wide values, supported by integrated governance structures that incorporate mental health services. Turnaround of a mental health service in decline was achieved through a well articulated vision for the broader health organisation, consistency in management practice, engagement of staff and attention to risk and clinical outcome. The vehicle for these changes was a leadership team that did not distinguish between the core business of the organisation and that of the mental health service, but rather sought to integrate the latter and re-establish professional links across clinical programs. Importantly, much of this local change occurred concurrently with a complementary values-based transformation at a broader organisational level, which aimed to develop a culture orientated towards quality improvement and effective clinical risk management.

Given the purported benefits of organisational integration illustrated in this case study, one can only ponder the effects of the (new) Ministerial Portfolio for Mental Health Services announced in Victoria in 2006 and the need once again to ensure that the positive and sustainable effects of successful mainstreaming are not lost in the pursuit of attracting a higher profile for mental health services.

Competing interests

The authors declare that they have no competing interests.

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