Adaptive Leadership and Person-Centered Care:
A New Approach to Solving Problems

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Successfully transitioning to person-centered care in nursing homes requires a new approach to solving care issues. The adaptive leadership framework suggests that expert providers must support frontline caregivers in their efforts to develop high-quality, person-centered solutions.

Person-centered care in nursing homes aims to shift the focus of decision making about care in such a way that providers place the patient's values and preferences first, and that they consider the patient as a whole person (rather than as a set of functional limitations) [1]. This approach to care has been a core component of the culture change movement in nursing homes, and the majority of nursing homes in the United States report engaging in aspects of culture change [2]. Figuring out how to foster and support the shift from provider-directed care to person-directed care requires new ways of thinking about how to solve long-term care issues.

Providers are expected to be the sources of expertise and to provide solutions to care issues. In this mechanistic view, nursing home administrators and directors of nursing identify residents' preferences or values in a systematic, predictable way through their policies or procedures. Care providers then respond to residents' preferences or values in routine ways. For example, a resident might be asked upon admission about his or her preferred bathing time. This choice would be captured in a systematic way as part of the admissions packet information, and the charge nurse would use the patient's response to organize the daily assignments of the nursing assistants on the unit.

However, this approach assumes that the care needs, preferences, and values of residents are predictable and known—that is, that providers know the right questions to ask, and that the work of incorporating preferences into care routines is foreseeable. In reality, however, eliciting resident preferences and values and incorporating them into the provision of care is a dynamic process involving both the direct caregiver and the resident, and there is often no way to know ahead of time what questions to ask or how the answers to these questions should be acted upon. Often, the direct caregiver (eg, the nursing assistant) and the resident must work together to create strategies to accomplish this work.

An Example of Adaptive Leadership

Let us reconsider the example of a resident's preferred bathing time. In this example, admissions data are entered into the care plan, and the morning-shift nursing assistant, Tonya, reads that Mrs. Jones prefers to bathe in the evening, as has been her lifelong habit. Tonya is accustomed to bathing residents, and she bathes many other residents in the morning. In fact, Tonya has been lauded by other staff members for her ability to bathe even the residents with cognitive impairment and difficult-to-manage behavioral symptoms. Given Mrs. Jones's stage of dementia and behavioral symptoms, she could really benefit from Tonya's care and skill [3]. Furthermore, Tonya knows that nursing assistants on the evening shift have neither the expertise nor the time to add Mrs. Jones's bath to their already-busy routine, which includes evening care for all 35 residents on the hall.

To develop a patient-centered solution that will accommodate Mrs. Jones's bathing care preferences, Tonya must collaborate with the evening-shift nursing assistants. She must simultaneously integrate Mrs. Jones's preferences and values, ensure that the solution fits with the staffing mix of the morning and evening shifts, and consider the skills of the evening-shift staff members. Such a solution is not something that currently exists; in fact, the inherently individualized nature of person-centered care means that it would be impossible to predict this particular problem and generate a solution in advance, no matter how comprehensive the policies and procedures of the nursing home.

These types of problems are referred to by complexity scientists as *adaptive challenges* [4, 5]; they are challenges with no current solution, and they cannot be solved by applying technical expertise alone. The work that Tonya must do—collaborating with the evening-shift nursing assistants and with Mrs. Jones to identify a solution that provides high-quality care while also respecting Mrs. Jones's preferences and values—is referred to as *adaptive work* [6]. With no

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known solution, Tonya and her peers must shift their current normative values and expectations about how to accomplish care (eg, "bathing occurs on the morning shift") and generate novel approaches. Bringing in the director of nursing, the medical director, or the nursing home administrator will not solve the problem of how to bathe Mrs. Jones, because only the person facing the adaptive challenge can address this challenge. Only Tonya has the knowledge and skill to bathe Mrs. Jones "without a battle," [3] so Tonya's leadership is required to support and guide her peers as they learn how to accomplish this care.

Because adaptive work occurs in the larger context of the organizational administrative structure, adaptive leadership is also needed on the part of the charge nurse, the director of nursing, and perhaps the nursing home administrator. For example, they can foster this collaborative work and support whatever solution the nursing assistants develop. The director of nursing might approve a temporary change in Tonya's schedule so that she can help the evening-shift nursing assistants learn to bathe Mrs. Jones. The charge nurse might have nursing assistants come together at the beginning and end of shifts to raise issues and offer suggestions for solutions. Adaptive leadership is needed at all levels to encourage and support the work of frontline caregivers.

Adaptive leadership also includes rewarding new behaviors. For example, after Tonya mentors and coaches an evening-shift nursing assistant regarding how to bathe residents with behavioral symptoms, Tonya could be awarded a bonus. Perhaps the morning- and evening-shift nursing assistants will identify the need for a "floater" nursing assistant, who could free up time among current staff to reconfigure current care schedules in response to resident care preferences. The director of nursing and the nursing home administrator would need to provide resources to support such a position.

Preparing Clinical Leaders to Support Adaptive Work

Our challenge as a practice community is to prepare clinical leaders to support the adaptive work that must be done by those who face adaptive challenges. In a work environment replete with policies, rules, and regulations, it may cause considerable discomfort for nursing home administrators, directors of nursing, and medical directors to acknowledge that their technical expertise cannot solve adaptive challenges, and for them to recognize that solutions must come from direct caregivers, residents, and family members. One way of reconciling this discomfort is to acknowledge that many of the problems for which technical solutions prove inadequate are inherently adaptive challenges, and such situations often result in frustration when a technical solution does not accomplish the desired outcome. The adaptive leadership framework provides a useful explanation of why such solutions fail, and it challenges us to develop a new way of thinking about problem solving [7].

The Duke University School of Nursing's Adaptive Leadership for Cognitive/Affective Symptom Science Center (the ADAPT Center) is collecting empirical knowledge about the specific behaviors and strategies that people at all levels of an organization can use to support the use of adaptive work to accomplish high-quality, person-centered care. Funded by the National Institute of Nursing Research of the National Institutes of Health, the ADAPT Center supports investigator research regarding the operationalization and measurement of adaptive leadership in many clinical care settings, including long-term care facilities; it also promotes research regarding the organizational supports required to grow and sustain adaptive leadership, and the impact of adaptive leadership on quality-of-care outcomes.

Several initiatives are currently being implemented in North Carolina nursing homes using these ideas. As part of an ongoing study supported in part by the ADAPT Center [8], we are identifying examples of the ways in which directors of nursing and medical directors can facilitate adaptive work. For example, a director of nursing described how the medical director in her nursing home is particularly effective at bringing together families and staff members to collaboratively identify barriers to the provision of person-centered care:

> Our medical director is really good about calling family meetings whenever we find . . . something is way out there . . . [because] . . . we all have different pieces of the puzzle, and if we don't all put it on the care plan or all look at the care plan, then you know we're not going to know.

This director of nursing and medical director understand that they do not have the expertise to address certain problems, and they know that individuals who are not in traditional clinical leadership roles (eg, nursing assistants) may hold key pieces of the puzzle. From such examples, we can begin to identify the skills that will help to prepare adaptive leaders throughout an organization so that they can support the adaptive work essential for high-quality, person-centered care.

A New Vision of Person-Centered Care: The Adaptive Leadership Framework

In the old, mechanistic view of problem solving, person-centered care would be achieved by having the evening shift bathe Mrs. Jones, based on the preference recorded in her admissions forms. Nursing assistants likely would have significant difficulty bathing her, and Mrs. Jones might be treated pharmacologically for her behavioral symptoms; alternatively, she might be bathed by the morning-shift team in order to avoid pharmacological management. By reframing the problem as an adaptive challenge, however, other options may become apparent. Under this new paradigm, the administration would support Tonya and her peers as they collaboratively generate new ways of organizing care. This solution could allow Mrs. Jones to be bathed in the eve-

ning, in keeping with lifelong habits that help her relax before bed, and she could be bathed in a manner that minimizes her distress and maximizes her dignity and quality of life.

Rethinking our values and the way we normally provide care to nursing home residents necessarily means rethinking how we understand and tackle problems. The adaptive leadership framework helps us begin to differentiate between technical and adaptive problems and to support the work of the frontline caregivers and residents who must collaboratively accomplish this new kind of care. NCMJ

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