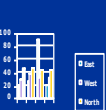


Systemically Changing Nursing Home Culture

A Project of Human Change

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The problems of long-term care are rooted in the social practices that comprise the *twin tragedies of age* in Twentieth Century America:

1) Age Segregation -- the systematic *separation by age* of individuals of every age

2) Stigmatization of the Aged -- The systematic and relentless *devaluation of elders*

Tragedy #1: The systematic segregation of individuals by age

From “pre-K” to “young adult”;
From the school-regulated teenage years
to retirement community ghettos:

*Social opportunities and norms
in modern societies are heavily
regulated by age*

Tragedy #2: The Systematic and Relentless Devaluation of Elders

- Elders are assumed to be socially uninteresting and to have little left to offer or contribute to others
- Society has tolerated and sanctioned the segregation of *dependent elders* into nursing homes
 - excluded from the normal and familiar rhythms of life
 - subject to Thomas's "*three plagues*" (boredom, helplessness and loneliness)

Plague #1: *Boredom*

- Meaningful activities few and far between
- Much time spent idle, or in passive activities
- Daily life suffers from monotony and lack of variety
- Few meaningful alternatives in how to spend one's time
- Few opportunities to take an active, constructive role in activities

Plague #2: *Helplessness*

- Elders are not expected to contribute to one's own or other's well-being
- Not consulted or even informed concerning important life choices
- Not credited with having knowledge useful to others

Plague #3: *Loneliness*

- Most personal contact focused on physical condition and needs
- With limited mobility and regulated routines and activities, elders have limited opportunities for building or sustaining meaningful relationships
- Few connections with the outside community
- An unappealing environment for family and friends to visit.

The Sources: Institutional Culture, Institutional Constraints

- *Medicalization* of Aging
 - Assumes *inevitable organismic decline* requiring *treatment*
 - Subordinates *quality of life* to professionalized treatment/service delivery
 - Depersonalizes care, assaulting elders' sense of self and identity
- The *paradox* for residents: trying to make one's "home" in a "hospital" culture .
- The *contradiction* for staff (including leadership): trying to provide genuine human care when only clinically indicated care is evaluated and rewarded.

CULTURE CHANGE ...

- from a *Medical Model* -
 - Hospital Regime
 - Emphasizes “decline” and “disengagement” as inevitable characteristics of elders
 - Emphasis on Treatment
 - Requires elders adjusting to facility’s routine
- to a *Resident-Centered Model* –
 - “Normalcy” Regime
 - Emphasizes special strengths and growth potentials of elders
 - Emphasis on Meaningful Living, of which medical treatment is part
 - Requires adjustment of facility to elders’ routine

Definition of an “Elder”

An Elder is a person who is still growing, still a learner, still with potential and whose life continues to have within it promise for and connection to the future.

An Elder is still in pursuit of happiness, joy and pleasure, and her or his birthright to these things remains in tact.

Moreover, an Elder is a person who deserves respect and honor and whose work it is to synthesize wisdom from long life experience and formulate this into a legacy for future generations.

Barry Barkan, *Live Oak Project*

Features of the Resident-Centered Model, *for Residents*

- Increased control in setting everyday life routines
- Increased opportunities for social participation
- Increased range of options for meaningful contributions to others
- New options for participation in normal activities
 - Cooking
 - Personal laundry
 - Participation in Other Household Tasks
- Children integrated into everyday life of facility
- Plants and pets integrated into everyday life
- Aging in Place – deconstructing the “resident career”

Features of the Resident-Centered Model, *for Staff*

- Greater decision-making discretion for frontline staff
- Emphasis on personal caring as well as professional practice
- Permanent work assignments -- nurturing personal relationships while increasing efficiency
- Cross-training for greater flexibility on the neighborhoods
- Enhanced appreciation of value of elders, and awareness of the cultural assaults on the aged

Project Settings

- Fairport Baptist Homes
- Jewish Home of Rochester

Fairport Baptist Homes

- Sectarian
- Not-for-profit
- Founded 1904
- 196 Beds
- Suburban location
- Longstanding reputation for excellence
- Staff drawn largely from rural areas

Jewish Home of Rochester

- Sectarian
- Not-for-profit
- Founded 1920
- 362 beds
- Suburban location
- Longstanding reputation for excellence
and innovation
- National leader in restraint-free care
- Staff drawn from diverse areas, including
central city

*EACH FACILITY DEVELOPED
ITS OWN INDEPENDENT
PLAN FOR CULTURE
CHANGE...*

Fairport Baptist Homes: *FROM HALLWAYS TO HOUSEHOLDS*

- Articulating Vision, Values and Principles
- Architectural restructuring to create a homelike environment
- Flexibility of mealtimes
- Increased opportunities for activity
- Regular contact with children
- Aging in Place
- Additional pets, including staff members' personal pets accompanying staff to work
- Community meetings
- Redefining jobs – developing broader skills through cross-training
- Staff Training and Team-building

Architectural Restructuring to Create a Homelike Environment

- *“From Hallways to Households”*
--- Units of up to 60 residents transformed to households of 10, neighborhoods of 20
- Long hallways replaced by “households” -- circular living areas encircled by rooms for about 10 residents



*Long hallways replaced by open
Living area encircling elders' rooms*



Homelikeness and Mealtime

Institutional model

- Meals served on tray
- Assigned seating for all residents
- Common time for all meals including breakfast
- No resident choice of when to get up in the morning, whatever her sleep preferences!

Before renovation, elders were rushed into dining rooms serving up to 60, to eat meals served on trays



Household model

- All meals served family style
- Breakfast:
 - Prepared individually for each elder in household kitchen
 - Elders decide when to arise in the morning
 - Elders control breakfast menu and timing
 - Morning kitchen smells add homelikeness
 - Elders may use kitchen for cooking, fixing snacks, personal food storage, etc.
 - Kitchen also used for cookie baking and other resident activities

In household model, food is served family style to household groups of about 10, staff may eat themselves at the same time they assist elders



Replacing traditional nurses' station with workspace integral to household



Before renovation, a nurses' station insulated staff from residents



In the households, staff work space is integrated into household space

Childcare Center adjoining Nursing Home

- Children regularly visit households
- Household kitchens used for intergenerational projects



Community Meetings -- Regular Neighborhood-based events for elders



Community and Personal Connections Objectified in Neighborhood Displays which Residents Help to Create



Aging in Place

- Enables elders to remain in familiar and comfortable surroundings as long as they choose
- Eliminates the discouraging *resident career* of decline and “downward mobility”
- Requires integration of diverse levels of care needs on each unit (except for at-risk wandering)

Jewish Home of Rochester:

Relationship-Centered Care

- Articulating Vision, Values and Principles
- Community-building –
 - Among JHR families – Partnering with families
 - Staff Training and Team-Building
 - Community Meetings
 - Regular contact with children
- Zack, the Therapy Dog
- Active Resident Involvement in Home
 - Resident participation in staff hiring
 - Resident-Created and Resident-Led Culture Change Group
 - Cooking via the Portable Cooking Cart
- Buffet Breakfast
- Staff Training and Team-Building

Breakfast on Trays replaced by fresh *Buffet Breakfast*



- Breakfast trucked from central kitchen eliminated
- Breakfast buffet card provides for fresh-cooked breakfast on each unit
- Wonderful morning smells of cooking can again be enjoyed by residents
- Elders convey preferences directly to cooking staff
- Preliminary studies have indicated improved food intake and reduced waste



Zack, the Therapy Dog



- Zack joined JHR as a “permanent resident” in late 1999
- Specially training for interacting with elders
- Cared for by staff members of the “Friends of Zack Committee”!



“Cooking Cart” invites active participation



- Mobile “Cooking Cart” takes the joys of cooking to the units
- Residents actively participate in cooking projects
- Many recreational staff now based on units, increasing accessibility and contact with elders



Other Culture Change Initiatives

- Expanded use of “permanent assignments”, nurturing personal connections between elders and staff
- Partnering with Families
- Team-building and leadership training for front-line staff
- Relocation of Resident Services (Therapeutic Rec, Social Work) to Units
- Regular visits by school classes
- Liberalization of policies on diets and food

Common Challenges

- To make major changes in practices and in staff values “without missing a beat” in the delivery of services and provision of care
- To manage change-related costs effectively
- Deal with Resistance to Change from
 - Widespread fears of “new” and “unknown” among staff
 - Concern that attention to quality of life issues would compromise nursing and medical care
 - Regulatory requirements that reinforce “status quo” practices
 - Culture change innovations in both facilities caused deficiencies in State Survey process
 - High levels of specialization, standardization and regimentation in “SOP” difficult to change

Responding to Challenges

- Use of Pioneer experts for training in new values, new practices, including
 - Valuing and respecting elders
 - Resident-centered care
 - Community meetings
 - Resident-centered bathing
- Organizational consultants for staff training in team-building and leadership
 - Clarifying lines of authority and
 - Clarifying expanded arenas of discretionary decision-making for front-line staff
 - Enabling increased communication among staff and between staff and supervisors

Evaluation

- Did the effort to implement culture change lead to a changed culture?
- To the extent that change occurred, what were its consequences for elders and staff members?

Defining and Assessing *Culture*

- *Culture* is the totality of a social world, which includes
 - norms and values
 - language and other symbolic systems
 - interaction patterns and styles
 - nature of personal relationships
 - physical context, including artifacts and architecture
 - organization of temporal routines
 - relationship with nature

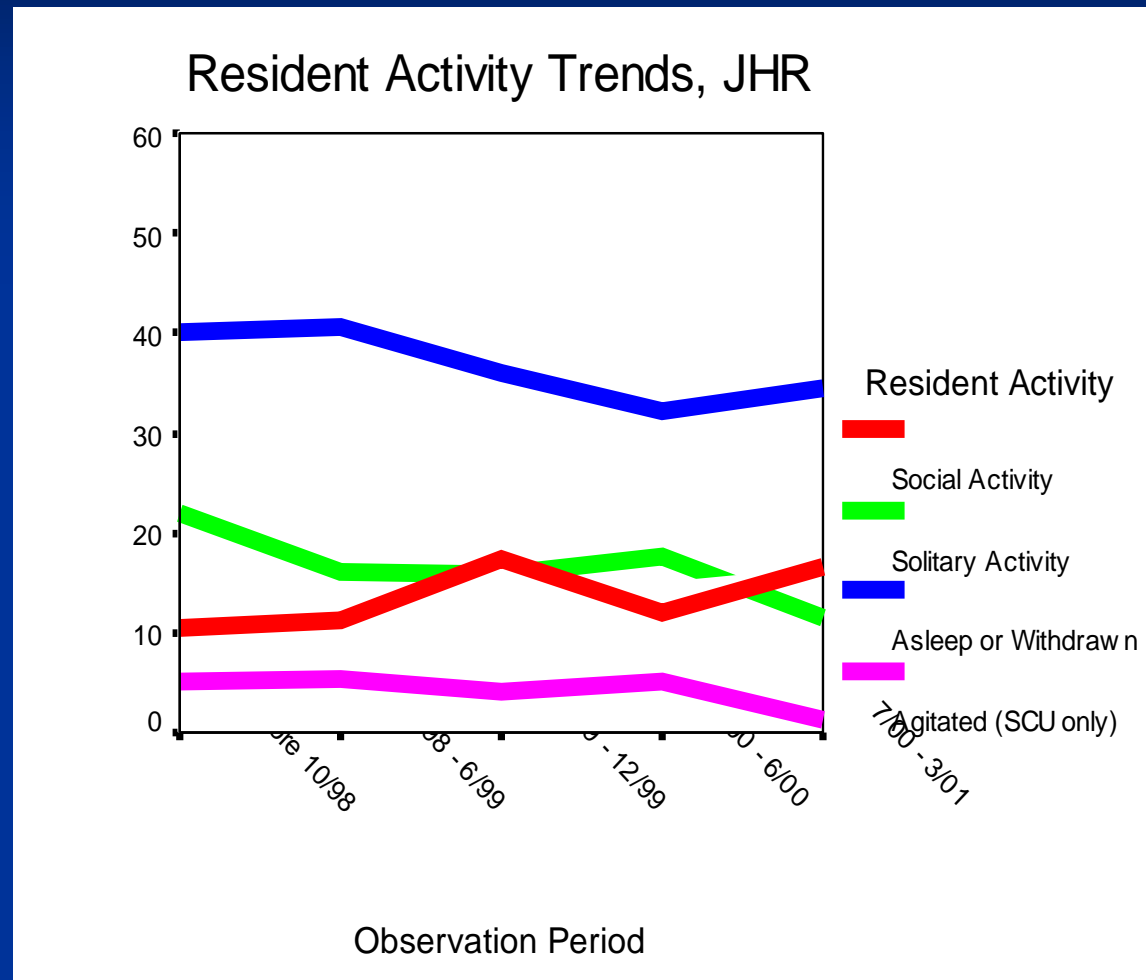
Measuring culture - a multi-dimensional task

- Contextual Dimensions
 - Physical surroundings
 - Presence of plants and animals
 - Opportunities for contact with others
- Elder Activity – *how do elders spend their time?*
- Staff Activity – *how do staff spend their time?*
- Formal systems – *structure of authority, division of labor, job definitions, officially defined terms*
- Informal systems – *relationships and meaning systems shared by elders and/or staff in everyday life*

Activity Mapping Procedure

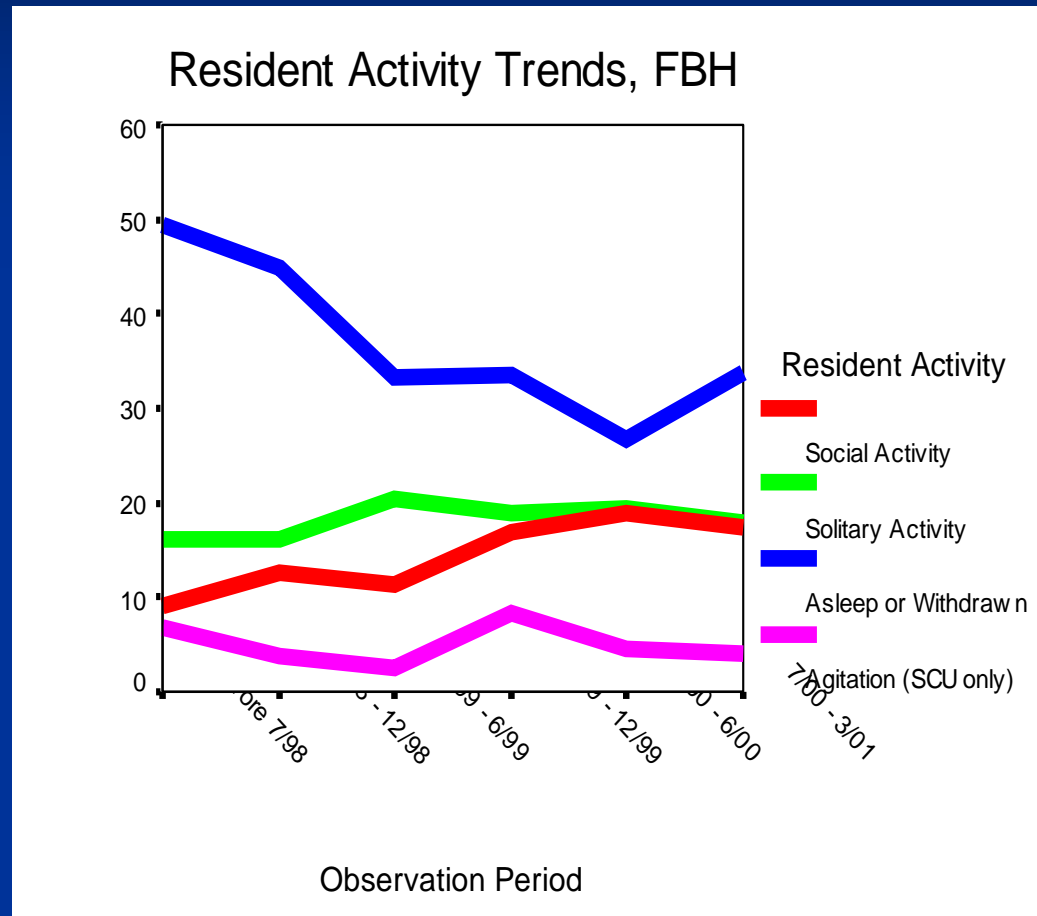
- Direct observation of activity -- avoiding selective memory, social desirability and other problems of self-reported data
- Systematic, structured procedure permits quantification of observed activities
- Systematic sampling of activities of elders and staff throughout the day provides representative picture on each day of observation
- Repeated sampling over duration of study period permits construction of three-year trend

Figure 1. Elder Activity Trends 1998-2001, Jewish Home of Rochester



Note: Vertical axis indicates the percentage of total activity comprised by each discrete activity

Figure 2. Elder Activity Trends 1997-2001, Fairport Baptist Homes



Note: Vertical axis indicates the percentage of total activity comprised by each discrete activity

Activity Map Findings

- At beginning of project, elders spent most of the time when in public view asleep or withdrawn
- More than 14,000 acts of elders observed over course of project
- In both facilities, the proportion of time elders were asleep was reduced, and while engagement in social activity increased
- These changes were substantial and statistically significant in both facilities, and were especially dramatic at FBH

Elder Outcomes

■ Quality of Life Indicators

- *Rebuilding elders' sense of self*
- *Developing cherished relationships*
- *Sense of community evident in residents' joint initiation of new projects*

■ Medication Use

- *On some units, use of psychotropic medications was reduced*

■ Health Indicators

- *Incidents (falls, accidents, pressure wounds)*
- *Infections*
- *Mortality*

Rebuilding a Sense of Self: Entering nursing home entails an “assault on self”

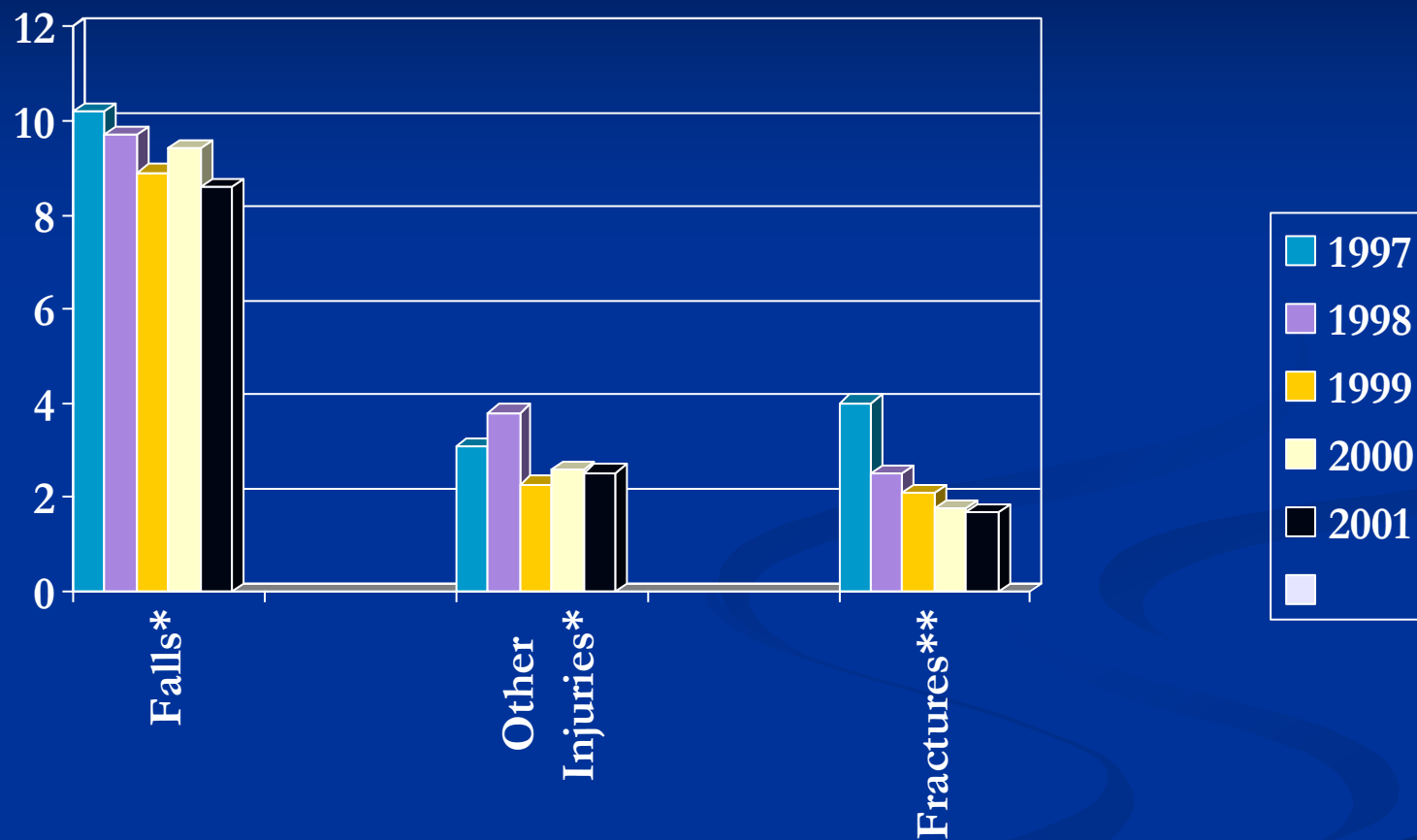
IDENTITY COHERENCE – a psychological index of self-integrity

- Narrative technique, measuring degree of “self-integration” encompassing past, present and anticipated events into a meaningful account of identity (Barclay, 1993)
- Pre-change (T1) self narrative stories of were generally *temporally disassociated*:
 - *past divorced from present*
 - *future indescribable.*
- Important relationships situated outside of nursing home setting
- Affective focus disconnected from immediate events and experiences.
- Some mid-change narratives (especially in new household at FBH) evidenced contrast to T1:
 - *self-stories assimilating nursing home life into the composition of self*
 - *care relationships entering emotional meaning*
 - *household histories integrating with biographical narratives.*

Other Indications of *Quality of Life*

- Cherished relationships -- many examples of residents developing *increased attachment to others, and to place*
- Sense of Community evident in *new projects initiated by elders*, sometimes challenging staff or management in surprising and welcome ways
 - At JHR, residents organized to create a discussion group regarding culture change and a consultation resource for administration.
 - At FBH, residents mobilize to preserve memories of household members
- Regular use of *cooking opportunities*
- Other new opportunities for participating in homemaking and other everyday tasks

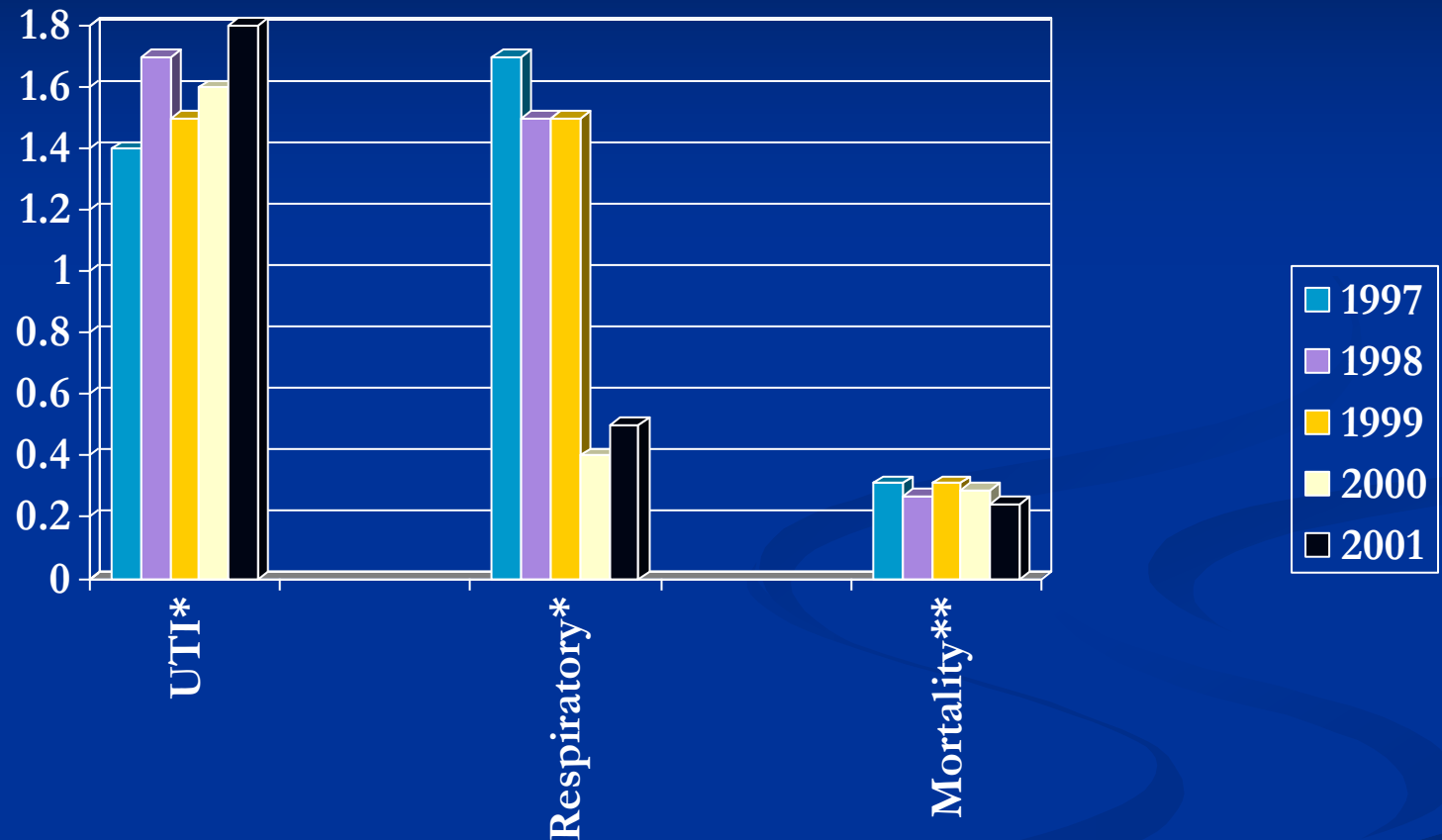
Falls and Injuries 1997-2001, JHR



*Per 1000 bed days

**Average per month

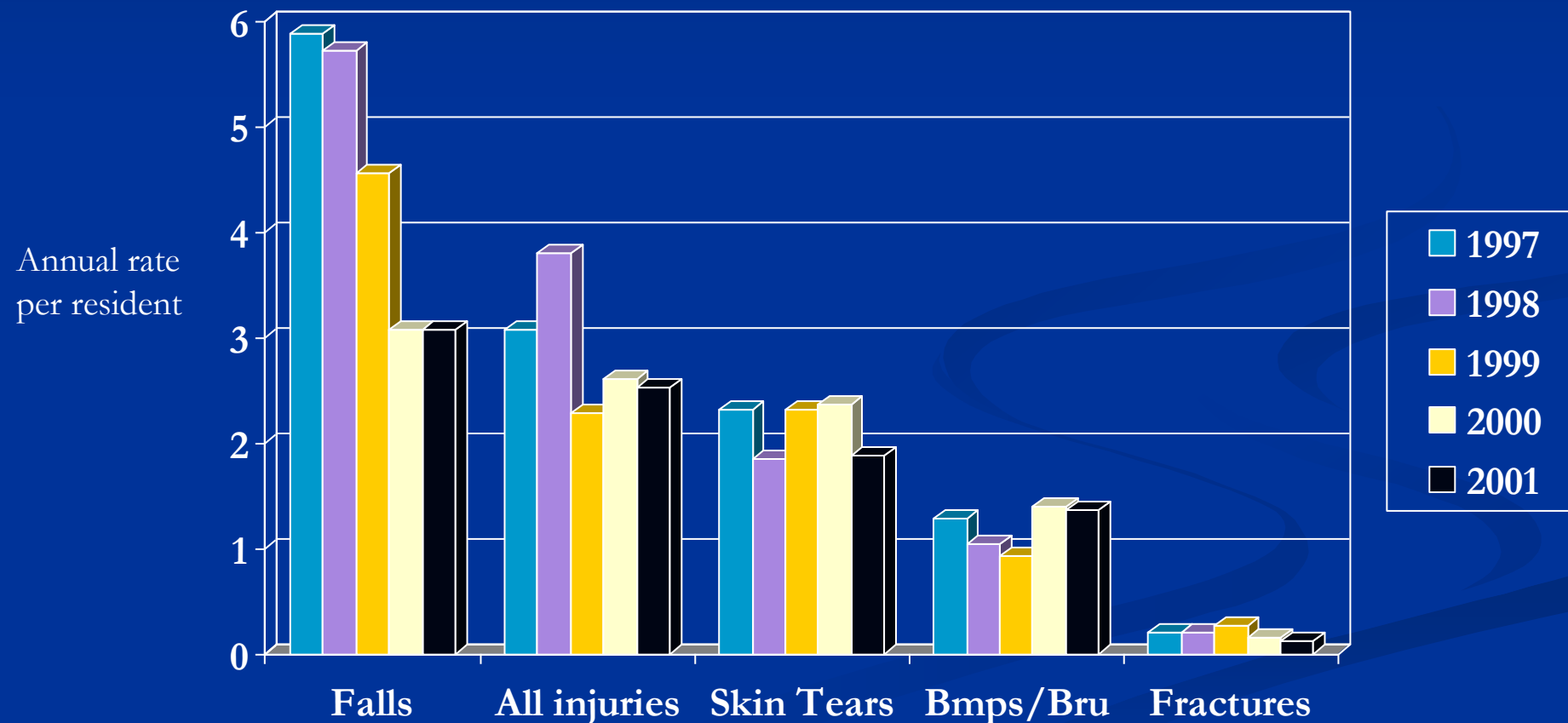
Infections 1997-2001, JHR



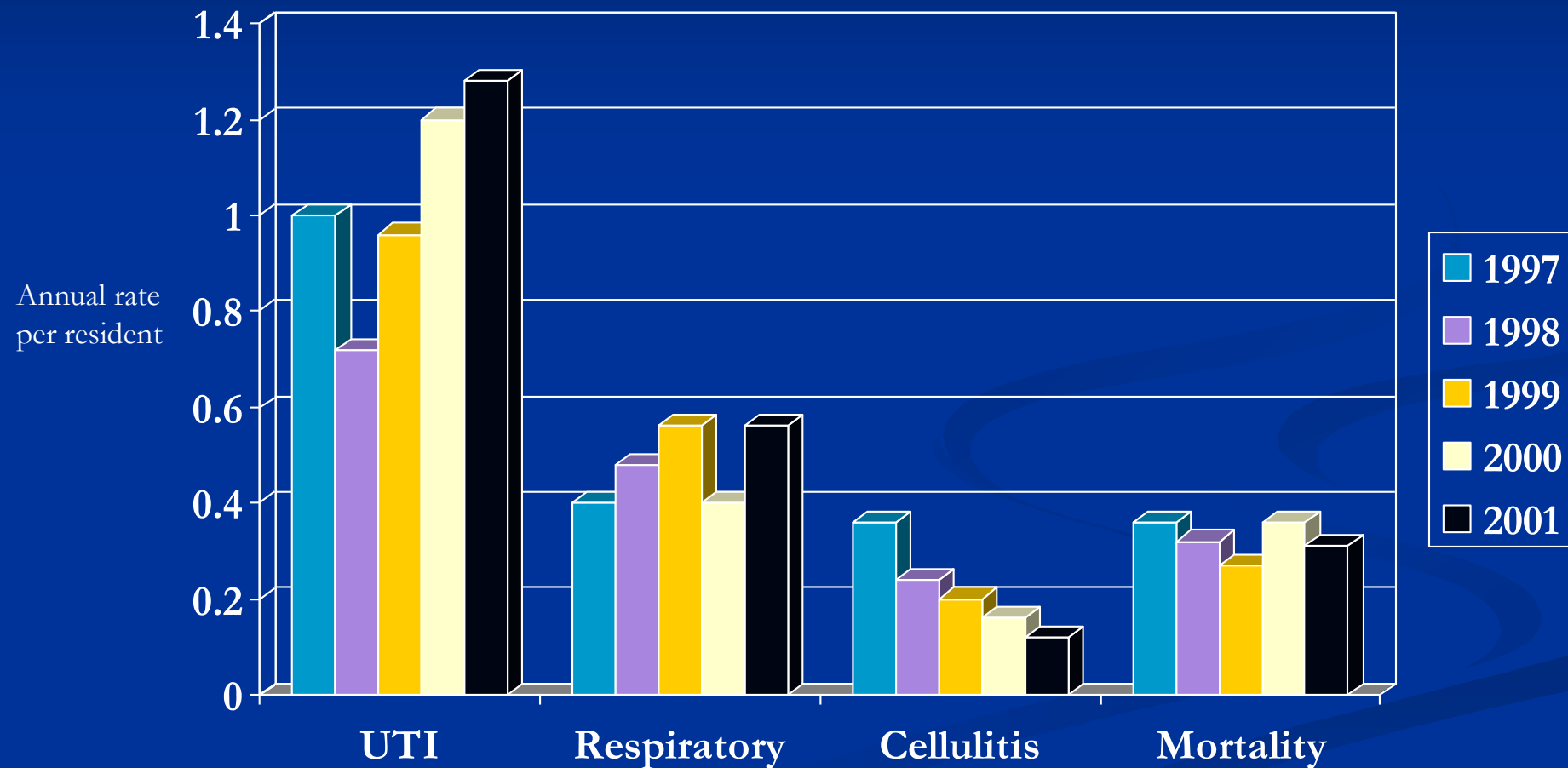
*Per 1000 bed days

**Annual rate (based on 362 residents)

Falls and Injuries 1997-2001, FBH



Infections and Mortality 1997-2001, FBH



Interpreting Incident, Infection and Mortality Data

- No clear trend of change in infections
- Mortality trends downward overall, despite some fluctuation.
 - Is culture change making life more worth living?
- Substantial reductions in both facilities, in
 - Falls
 - Injuries
 - Fractures
 - Higher levels of resident activity have not increased incident risk

Staff Outcomes

- Attitudes and Experiences
- Activity Patterns
- Staff Turnover

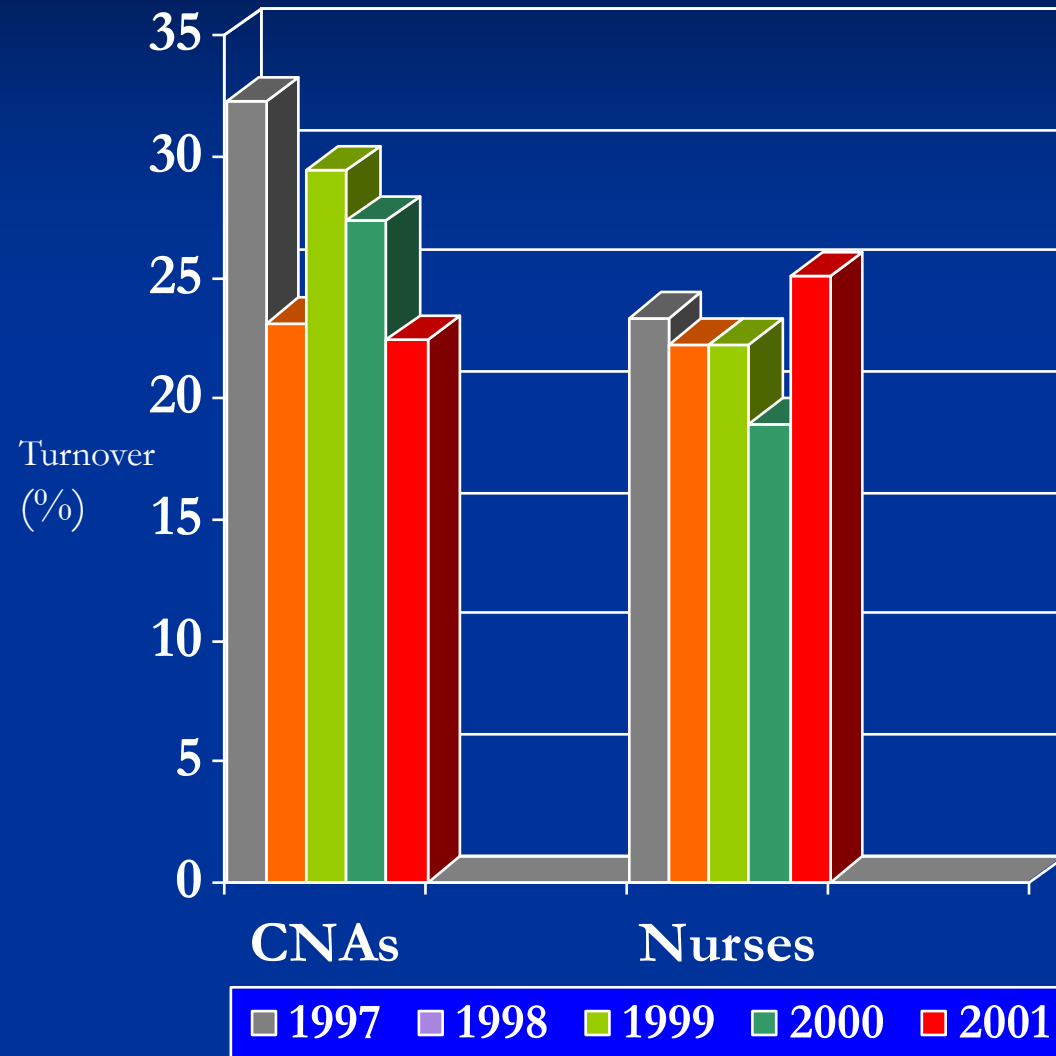
Staff *Activities, Attitudes, Experiences*

- No clear trends of change observed in staff activities was observed, except staff *increased time spent in paperwork*
(based on Activity Mapping)
- Staff indicated an increased awareness of “resident-centeredness”
- Numerous examples of staff bringing their own dogs/other pets regularly to work and bringing their children to visit elders
- A Paradox? At FBH, working in new environment produced simultaneously
 - Increased stress and feelings of burnout
 - Increased expression of commitment and engagement

Staff *Turnover*

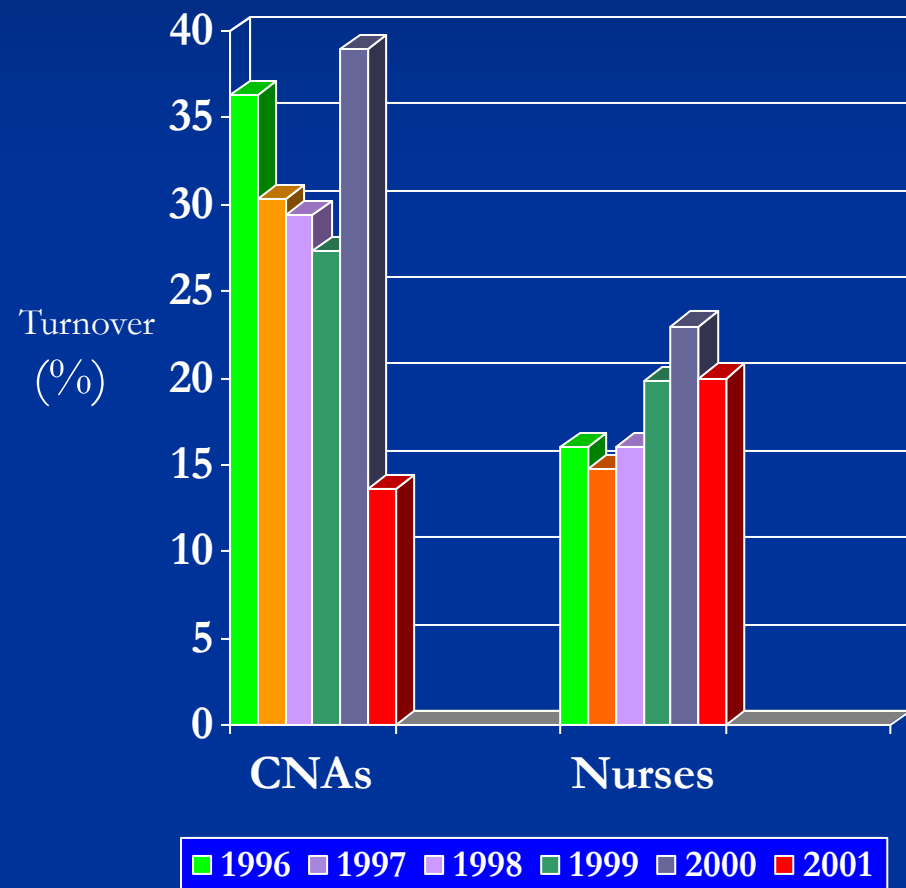
- Shortages of both nurses and certified aides is a growing national crisis
- High staff turnover reflects the shortage, is frustrating for elders, and costly for institutions
- Can culture change encourage staff retention through providing a more feasible and meaningful job description and better work conditions?

Staff Turnover At JHR, 1997-2001



- CNA (Certified Nursing Assistant) Turnover declined by a third -- from 33% in 1997 to 22% in early 2001
- Nurse Turnover is relatively stable, with no clear trend of change
- Turnover for 2001 is projected here, based only on data for the first quarter
- These trends square with other evidence indicating that culture change encourages positive changes in attitudes and work commitment among CNAs

Staff Turnover At FBH, 1996-2001



- CRA (Certified Resident Assistant) Turnover has, with one exception, decreased each year -- from 36% in 1996 to 14% in early 2001.
- The exception to the general trend was the year 2000, when turnover spiked upward to 39%
- Nurse Turnover has edged upward, but was down slightly in 2001
- 2001 data projected from first quarter
- For CRAs, trends converge other evidence indicating that culture change encourages positive changes in attitudes and work commitment

Observations on Staff Turnover

- Overall, both facilities appear to have “bucked” a national trend toward increasing and high levels of turnover for frontline care staff (CNAs/CRAs). (The exception was a sharp increase at FBH only, in the year 2000)
- In both facilities, nursing turnover shows greater year-to-year stability than CNA turnover, although there was
 - a slight trend of decrease at JHR, reversed in 2001
 - a slight trend of increase at FBH, reversed in 2001
- Given the growing national nursing and CNA shortage, these overall trends are remarkable. Both the stability in nurse turnover, and the overall picture of reduction in aide turnover, support the hypothesis that the culture change efforts have helped to retain staff

What Have We Learned?

Part I:

Possibilities of change

- Broad-based culture change in LTC is urgently needed
 - For the quality of life of elders
 - For the quality of work of staff
- Culture Change efforts encounter multiple sources of resistance
- Creating and sustaining meaningful change requires
 - Addressing not only values and good intentions but also
 - Organizational processes and structures, and
 - Staff development and training
- Attention to the former without dedicated leadership in dealing with the latter is unlikely to succeed
- Changing physical architecture (replacing hallways with more home-like areas) facilitates but is not essential for culture change

What Have We Learned? Part I:

Possibilities of Change (continued)

- Culture Change runs counter to State and Federal regulations based on logic of
 - punitiveness – *negative sanctions* rather than *affirmation*
 - medicalization – focused on medical *treatment of illness* rather than *nurturing of wellness*

What Have We Learned? Part II:

Consequences of Change Effort

Even under difficult circumstances, culture change efforts demonstrated positive results for

- *Culture*
- *Elders*
- *Staff*

What Have We Learned? (Part II,continued): Consequences of Change Effort -- for *Culture*

- Increased options for elder participation in daily life
- Increased levels of elder activity
- “Aging in place” permits development of enduring relationships
- Increased local “sense of belonging” on units
- Increased awareness of “resident-centeredness” as a norm
- “New culture” architecture is helpful, but not essential for meaningful, enduring change

What Have We Learned? (Part II, continued):

Consequences of Change Effort -- for *Elders*

- Increased options for controlling scheduling of activities
- Aging in place
 - removes dread of forced relocation
 - nourishes “sense of place” – attachment to space
 - nourishes relationships with others
- Mixing residents with different functional abilities provides opportunities for elders to be helpful to others
- Reduction in Falls, fractures and other incidents despite increased activity levels

What Have We Learned? (Part II, continued):

Consequences of Change Effort -- for *Staff*

Many are

- Secure in their own knowledge of resident needs
- Welcome opportunity for expanded decision-making authority vis-à-vis residents
- Welcome the greater personal connectedness afforded by
 - Permanent assignment
 - Aging in place

What Have We Learned? Part III:

Looking back and ahead

- Despite the difficulties, the strong view in both facilities that quality of life and quality of work have been improved
- “Going back” to traditional operations is unthinkable
- Culture change is never a “completed” project
- Culture change is an ongoing process of critical self-reflection and struggle for change

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