

Culture Change in Long-Term Care

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The American long-term care (LTC)

system, based on a medical model, regards residents as sick patients, unable to care for themselves. Routines are organized for the efficient operation of the facility, rather than the needs of residents.¹ The focus of care is to treat the residents' weaknesses, not to develop their strengths.

Culture change is a movement that departs from the traditional institutionalized care model, towards "person-centered" care.² This change places the residents and their direct care workers at the center of the organizational structure. Residents are allowed to determine their own care and daily experiences. Culture change promotes quality of life and quality of care.

LTC facilities' "pioneer practices" have implemented this change, and several "care-models" have emerged.

The "individualized care" model helps residents return to familiar routines: residents decide what is important to them, and how they want to live out the rest of their lives.³

The "regenerative community" model downplays illness and builds upon residents' strengths, helping residents flourish despite declining health.³

The "resident-directed care" model separates facilities into small home-like neighborhoods, with resident choice at the heart of the community. Each neighborhood has a permanently assigned, cross-trained staff team.³ (Table 1)

The Wellspring model is based on a charter group of 11 freestanding not-for-profit homes in eastern Wisconsin (The Wellspring Alliance). This model developed in 1994 in response to managed care oversight. This model seeks both to enhance quality of resident care and to enhance the quality of work-life for staff. The Wellspring model has hired geriatric nurse practitioners, and given employees necessary skills and a voice in how their work should be performed. The Wellspring homes share staff training, comparative data on resident outcomes and multidisciplinary resource teams.^{4, 5}

The Eden Alternative is the most recognized model of successful culture

change. Dr. William Thomas created The Eden Alternative in 1991 to alleviate the three "plagues" of LTC: loneliness, helplessness, and boredom. This community-centered approach seeks to "create a human habitat where life revolves around close and continuing contact with plants, animals, and children."² Seeing the animals, children and gardens of an Eden facility, many onlookers erroneously equate "Edenizing" with these elements. However, "Edenizing" includes a change in philosophy. Much like resident-directed care, Eden emphasizes community and neighborhoods, with staff organized into interdisciplinary teams. The major tenets of the Eden philosophy are:⁶

- Decision-making is placed in the hands of those closest to the residents, which often is the direct care staff. This inverts the usual organizational structure.
- The individuality of each older adult is addressed through permanent staffing: the same caregivers are assigned to the same residents every shift. Also, in "neighborhoods," caregivers form close relationships with older adults.
- Staff members are encouraged to become members of self-directed teams where they can participate in decision-making.
- Companion animals, plants, and children create a diverse environment to reduce loneliness, helplessness, and boredom.

ness, and boredom.

Elmhurst Extended Care is the only nursing home in Rhode Island to achieve Eden Certification status thus far.

With culture change, the role of front-line caregivers will change. This change is imperative, because turnover among staff in LTC can average between 70 to 100% per year,⁷ spurred by low wages, lack of control, lack of respect, heavy workloads, lack of teamwork, and lack of communication. A person-centered culture resolves some of these issues. Caregivers have consistent assignments and are highly involved in decision-making and care-planning. The locus of control shifts from managers to residents and their caregivers. This transfer of control promotes independence and individuality in the framework of strong caregiving relationships. Nursing assistants are cross-trained in housekeeping, meal service and activities. Caregivers find their jobs more satisfying because they are in leadership roles, are involved with care planning and decision-making, are developing new skills and deepening relationships with residents.⁷

The Eden training program demonstrates that human caring is powerful medicine. Eden homes have shown reductions in the number of medications administered to residents. This in turn decreases pharmacy costs and reduces nursing time required for med passes. Eden homes have lower rates of anxiety and depression, further aiding in the re-

Table 1. Practices in a Resident-Centered Culture

- Food is accessible to residents at all times.
- Food is served family style at kitchen or dining room tables.
- Residents have consistent caregivers who know them as individuals.
- Residents' rooms are filled with personal belongings.
- Activities occur spontaneously, in addition to planned events.
- Residents direct the decisions affecting their lives in the home.
- Workers are empowered to listen and respond to residents' needs.
- Residents live in neighborhoods or households staffed with empowered teams of caregivers and other supporting personnel.
- Decisions previously made by facility managers are made at the household level.
- Residents are actively involved in all aspects of daily life, continuing to perform household functions such as cooking or cleaning if they desire.

(Adapted from Misiorski, S. What is culture change? www.almosthomedoc.org/changing/culture_change_essay.cfm)

duction of medications, particularly antipsychotics and benzodiazepines. A 151-bed Midwest Eden home demonstrated, for cognitively intact residents, a mean pretest and posttest Geriatric Depression Scale score significant decrease ($p < .01$), from 4.89 to 2.61, respectively. For cognitively impaired residents, mean Cornell Depression in Dementia Scores demonstrated a significant decrease ($p < .01$), from 8.36 to 6.55, respectively.⁶ Eden homes also demonstrate a lower rate of somatic complaints, leading to fewer telephone calls to the physician from the facility, allowing the physician increased efficiency while rounding. Fall rates have also been shown to decrease, in part from a reduction in medication use and an increase in activity. These outcomes contribute to an overall improvement in quality indicators.^{8,9}

The SW Texas State University Institute for Quality Improvement in Long Term Care conducted a two-year study, from 1996 to 1998, on quality outcomes in nursing homes adapting the Eden Alternative philosophy. Five Texas nursing homes were involved, with a bed total of 734. The findings are impressive:¹⁰

- 60% decrease in behavioral incidents
- 57% decrease in Stage I -Stage II pressure sores
- 25% decrease in bedfast residents
- 18% decrease in restraints
- 11% increase in resident census
- 48% decrease in staff absenteeism
- 11% decrease in employee injuries

In 2004, Quality Partners of Rhode Island led a national pilot project sponsored by the Centers for Medicare and Medicaid Services called "Improving Nursing Home Culture." The primary objective was to help nursing homes move from an institutionalized culture to an individualized culture.¹¹ Two-hundred-and-fifty-four nursing homes participated: 168 homes saw a relative decline of 5.4% in their pain quality measure rates. These same facilities experienced a 14.5% decline in their use of physical restraints.¹¹

"Edenizing" a home takes approximately two years. It is vital not to rush the process, because it requires both a change of management philosophy and

reorganization of the physical environment. The educational and implementation processes often overlap. "Edenizing" requires leadership that is committed to this change.¹² To adapt to change, there must be collaboration, flexibility and mutual respect among administration, staff and residents.

Culture change occurs in phases. In phase one, the facility commits to the change. The long-range goal is to create high involvement of residents, their families, and staff. During this phase, the institution explores their organizational structure. Staff evaluate how their organization's culture promotes or hinders the ability of residents to live their lives as fully as possible.¹³ Quantitative data may be collected on resident depression and staff and family satisfaction. Phase one provides intensive education to staff, residents, and families. Typically the administrator, director of nursing and a core group of staff members complete an Eden Associate training session. They then provide in-service training sessions with staff on all shifts.⁶

Phases two and three occur quickly, often concurrently. Phase two involves planning the organizational restructuring and additional education of all staff, residents and families. Plans are outlined in detail, recognizing that adjustments will be made as the journey progresses. In Phase three, the facility forms self-directed work teams; e.g., neighborhood, spiritual dining, pet, gardening, and children's teams. The teams explore how life should be lived within their teams. These work teams move into phase four by beginning the inversion of the organizational structure, with the goal of placing decision-making with residents or those closest to the residents. Once in phase four, teams work with residents to make decisions.⁶ Culture change is a dynamic process. Once the phases are achieved, culture change must be nurtured.

Dr. Thomas identified likely barriers to culture change. First is apathy. Facility administrations and management teams, which do not experience the three "plagues" of loneliness, helplessness, and boredom, feel that as long as operations are running smoothly, no systemic change is required. Another barrier is fear. The administration often fears the impact of

culture change on the survey process. The staff fears that change will add to their work-load. Another barrier is resistance to change. Staff and leadership believe that nothing is wrong with the system: "we have always done it this way." Facilities also falsely believe that there is not enough time or money to implement change. On average, homes spent \$30,000 over the first two years of implementation. The majority of the expense was for training. In the long run, culture change is thought to save money. Nursing homes generally have waiting lists, with less staff absenteeism. Last, negativity often surfaces with change in ideology.

Scalzi evaluated barriers and enablers to changing organizational culture in three nursing home. The first barrier was the exclusion of nurses from the culture change training. Resistance to change resulted when one group was excluded and did not share the values or knowledge of the changes to be implemented.¹⁴ Scalzi concluded that true culture change can work only when the values are shared, pervasive, and preserved throughout the entire organization.¹⁴

The second barrier was competing and/or conflicting goals. Staff perceived that the corporate emphasis was on compliance with regulations and the "bottom line," not on developing an environment that values respect, empowerment, and choice for residents and staff.¹⁴

A third barrier was the high turnover of administrators. Leadership vacancies delayed the implementation of culture change as well as destabilized the organization.¹⁴

Scalzi identified several enablers. First, a critical mass of "change champions" with shared values and goals appeared to facilitate culture change. These individuals tended to be staff who attended the offsite educational training sessions, then motivated other staff to implement changes.¹⁴

A second enabler was management style. When the leader's management style incorporated respect for others, enhancement of relationships and community, individualized person-centered care, and quality of work life for staff, implementing culture change became a natural extension of those values rather than a corporate dictum.¹⁴

The **Omnibus Budget Reconciliation Act of 1987 (OBRA)** introduced to new nursing homes new standards of care, a resident-focused, outcome-oriented survey process, and a range of federal enforcement remedies.¹⁵ OBRA stated that “residents in nursing homes need a home where they can live for the rest of their lives as individuals.” Residents’ social, spiritual, emotional, occupational, recreational and cultural needs were considered as important as their physical needs. The focus became providing the highest quality of life attainable for the frail elderly living in nursing homes.³ However, despite OBRA guidelines, nursing homes have been hesitant to implement culture change for fear that loosening their rules might produce worse clinical outcomes and generate penalties during the survey process. Administrators believe that surveyors will punish facilities for implementing the innovative changes and resident-centered approaches. To address these perceptions, The **Rhode Island Department of Health (RIDOH)** has been awarded a grant by the Commonwealth Fund for a study, “Resident-Centered Regulation: Using the Regulatory System to Transform Nursing Homes.” The proposed project will use Rhode Island as a test site for new regulatory process tools.¹⁶

As stated in the grant abstract, “during Phase 1 of the project, RIDOH will identify how culture change can be accomplished within the existing regulations, as well as how culture change can provide solutions to problems experienced by nursing homes in meeting regulations and fulfilling the legislative intent.” They will seek input from technical experts, including ways to remove barriers and create incentives, and will work with an evaluator to define outcome indicators and develop a research design.

“During Phase 2, RIDOH will train all Rhode Island surveyors on supplemented survey protocols, implement the enhanced survey process in a sample group of nursing homes as a pilot test, review results and assess the impact of the survey materials on nursing home facilities, nursing home residents, and the state survey agency.” They will develop a plan to disseminate the survey materials through publications and conferences.”¹⁶

We look forward toward culture change in LTC facilities. Future generations of elders will demand community environments that promote both quality of life and quality of care.

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REFERENCES

- Misiorski, S. What is culture change? www.almosthomedoc.org/changing/culture_change_essay.cfm
- Roth DE. Culture change in long-term care. *J Gerontol Soc Work* 2005;45:233-48.
- Niederer M. An introduction to culture change in long term care through pioneer practices. Prepared for the Illinois long-term care council, March 22, 2005: 1-10.
- Stone RI, Reinhard SC, et al. Evaluation of the Wellspring Model for Improving Nursing Home Quality. The Commonwealth Fund, August 2002.
- Wellspring Model. <http://www.wellspringis.org>
- Robinson SB, Rosher RB. Tangling with the barriers to culture change. *J Gerontol Nur*. 2006;32:19-25.
- Sherman E, Culture change in long-term care. Alzheimer’s Association, Massachusetts Chapter Newsletter. 2000; 18(3).

- Thomas WH. *The Eden Alternative handbook: The art of building human habitats*. Sherburne, NY: Summer Hill. 1999.
- Thomas WH. Evolution of Eden. In AS Weiner & JL Ronch (eds.) *Culture change in long-term care*. New York: Haworth Press, 2003:141-57.
- Ransom S, et al. Quality outcomes in nursing homes adapting the Eden Alternative philosophy and operative principles. Statistical summary report. SW Texas State University, Institute for Quality Improvement in Long Term Health Care. 1999.
- McLaughlin MA, Patry G. Improving nursing home culture pilot. *Med & Health/RI* 2006; 89:150-1.
- Tavormina CE. Embracing the Eden Alternative in long-term care environments. *Geriatr Nurs* 1999;20:158-61.
- Deutschman M. Interventions to nurture excellence in the nursing home culture. *J Gerontol Nurs* 2001;27:37-43.
- Scalzi CC, Evans LK, et al. Barriers and enablers to changing organizational culture in nursing homes. *Nurs Adm Q* 2006;30:368-72.
- Hawes C, Mor V, et al. The OBRA-87 nursing home regulations and implementation of the Resident Assessment Instrument. *J Am Geriatr Soc* 1997;45:977-85.
- Gifford D, et al. Rhode Island Department of Health, excerpt from, “Resident-Centered Regulation: Using the Regulatory System to Transform Nursing Homes,” Grant awarded by the Commonwealth Fund. 2006.

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