



Meeting: NURSES INVOLVEMENT IN CULTURE CHANGE  
Opportunity for Improving Residents' Quality of Care and Quality of Life  
(funded by the Commonwealth Fund)

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Topic: Principles and Content of Culture Change

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### Culture change

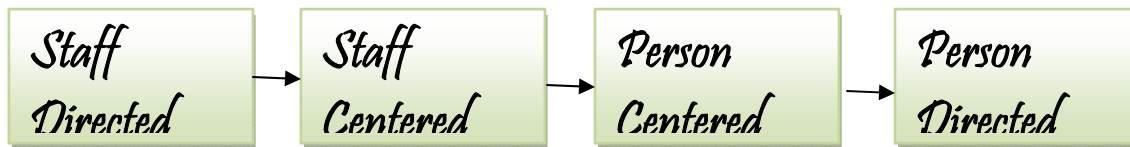
More than ten years ago, a small group of prominent professionals from across the field of long-term care came together to advocate for a radical change in the culture of aging. They wanted to assure that when our grandparents, parents—and ultimately ourselves—go to receive care in a nursing home or other community-based setting, it is to thrive, not to decline. This movement, away from institutional provider-driven models to more humane consumer-driven care that embraces flexibility and self-determination, has come to be known as *culture change*.

In a setting that embraces culture change, the person always comes before the task, and the voices of elders and those working with them are considered and respected. Respect is given to each individual regardless of age, medical condition, or limitations. Culture change—a simple concept valuing choice, dignity, respect, self-determination, and purposeful living—is transforming the way we care for elders across the nation who are in need of long-term care.

Culture change transformation supports the creation of both nursing home environments as well as home- and community-based settings, *wherever* older adults and their caregivers express choice and practice self-determination in meaningful ways at every level of daily life.

Staff-directed to Person-directed Care

Within nursing homes, culture change is most dramatically illustrated by the movement away from staff-directed to person-directed care, as illustrated and described herewith. This diagram and the descriptions that follow were developed by Sue Misorski and Joanne Rader<sup>1</sup>.



In a *staff-directed culture*, a small group of staff make most of the decisions, with little conscious consideration of the impact on residents and direct care staff. At the next level, in a *staff-centered culture*, staff consult with residents or try to put themselves in the residents' place while making the decisions. Residents accommodate staff most of the time, but have some choices within existing routines and options.

In a *person-centered culture*, residents' preferences and past patterns are now forming the basis of decision-making about some routines. Staff begin to organize their routines to accommodate articulated or observed resident preferences. Direct care staff begin to have more say in how work is organized (e.g., involvement in care planning, scheduling, peer monitoring). In a *person-directed culture*, the residents make the decisions every day about their individual routines. When residents are not capable of articulating their needs and choices, the staff honor observed preferences and lifelong habits. Direct care workers have formed relationships with residents. Staff organize their hours, patterns, and assignments to meet individual resident preferences.

Note that with each step, residents are being given more of a voice, until they ultimately direct their own care.

Misorski and Rader developed the following example to illustrate the "continuum of direction" as applied to care assignments in long-term care settings.

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<sup>1</sup> Developed by Susan Misorski and Joanne Rader for the *Getting Started* Pioneer Institute 2006.

Staff Directed Care Assignments	The nursing assistants punch in at the time clock and check the bulletin board next to the clock for their scheduled unit. The scheduling coordinator posts this daily schedule each morning. Upon reporting to their posted units, the charge nurse gives each nursing assistant their assignment after giving report.
Staff Centered Care Assignments	The nursing assistants always work on the same unit. Upon reporting to their usual unit, the nurse gives them their assignment of residents for the day, which is often different from the day before.
Person Centered Care Assignments	The nursing assistants always work with the same group of residents. The nursing assistants themselves are responsible for evaluating how their assignments are going, and they communicate fairly regularly with each other to ensure the residents' needs are met in a fair and equitable way. Each resident has a primary aide and an alternate who cares for them when the primary aide has a day off.
Person Directed Care Assignments	The nursing assistants held a team meeting to begin self scheduling and consistent assignments concurrently. They learned from the residents on their unit what time they wanted to wake up, eat, etc. They created their own schedules based upon their own availability and the times at which the residents needed their support. They created their assignments based upon their <b>existing relationships</b> with the residents—the residents are a part of deciding who will care for them.

## Person-directed Care

In the culture change journey, person-directed care most resembles the kind of care and caring most consumers desire. In practice, culture change centers on person-directed care. Residents living nursing homes that provide resident-directed care can go to bed and wake up when they want; can eat what they want when they want; and can create their own living spaces in their rooms as well as have a say about the environment of common areas. It is this *choice* that is doing away with institutionalization in nursing homes and re-creating home.

And yet, these very changes that are creating home for residents are often difficult changes for nursing home staff to make. Many nursing home residents are in fact medically complex, and staff members worry that chaotic medication passes, weight loss, pressure ulcers, and other conditions that will result from poor choices will exacerbate residents' health. In fact, most residents do well with these kinds of choices and freedoms, and when good medical and nursing care support the person-directed environment, the residents who are at risk for these adverse outcomes are easily identified. In all cases, *quality* care remains the primary goal as well as outcome.

Nursing staff in nursing homes have responsibility for the clinical care of residents. When nursing looks to supporting self-determination and choice, culture change, medical care, and clinical responsibilities are consistent with one another. Focusing on the human spirit does not detract the focus from a person's medical needs.

A recent article<sup>2</sup> on the findings from the Commonwealth Fund 2007 national survey of Directors of Nursing observed that in nursing homes which embraced culture change, residents enjoy much of the privacy and choice they would experience if they were still living in their own homes. Residents' needs and preferences come first, and the home's operations are shaped by

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<sup>2</sup> Doty, Michelle M.; Koren, Mary Jane; Sturla, Elizabeth. Culture Change in Nursing Homes: How Far Have we Come? Findings from The Commonwealth Fund 2007 National Survey of Nursing Homes. Editor: Lorber, Deborah. May 9, 2008; 91. [http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=684709](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=684709). Retrieved 09/04/2008.

the awareness of these. Large hospital-like units with long, wide corridors are transformed into either neighborhoods or household units where small groups of residents are cared for by a consistent team. The survey characterized nursing homes into three categories:

- **Culture change adopters** – nursing homes that report the definition of culture change or person-directed care completely or partially fits their homes.
- **Culture change strivers** – nursing homes that feel the definition of person-directed care or culture change describes their homes in a few respects or not at all, but are committed to adopting culture change.
- **Traditional nursing homes** – nursing homes that say the definition describes their nursing home not at all or in a few respects and the leadership is not very committed to culture change.

While the majority of nursing homes fell into the “traditional” nursing home category, findings suggest that it is the culture change adopters who are most likely to implement person-directed care in their organizations, and who have initiated a range of staff-empowerment initiatives that are part of the culture change journey. And perhaps most important, findings suggest that it is the *leadership* of a nursing home that will bring about change in the culture of aging.

A recent article<sup>3</sup> by Charlene Boyd and Bruce Johansen paints a vivid picture of what person-directed care is and how it makes staff and residents feel. That is,

- It is a transformation from a traditional, institutional approach to care to one that is person-directed.
- Both residents and staff are empowered in decision-making; residents make decisions about daily routines and service.
- Staff assignments do not rotate, making their jobs relationship-centered.

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<sup>3</sup> Boyd, Charlene; Johansen, Bruce. A Cultural Shift: Resident-Directed Care at Providence Mount St. Vincent in Seattle Places Elders at the Center of the Universe. *Health Progress*. January-February 2008; pp. 37-42.

- Schedules are arranged to reflect residents' individual needs and preferences.
- Residents feel at home and valued, as members of a community.
- Activities are spontaneous and more frequent.
- The environment created has the feeling of home.
- Residents have independence, privacy; a sense of home, and dignity; they have choices about when they eat; how their living space is furnished; when they get out of bed; what they do; and who they will see.

Person-directed care cuts across disciplines and job duties, synthesizing best practices from multiple disciplines. This is an ideal methodology for the chronic care of older adults because of the complexity of the issues involved and the variety of needs expressed. As a holistic and collaborative process, person-directed care provides for optimal understanding of the clinical and quality of life indicators for individuals, and can result in a new or modified approach to care. It should not be assumed that culture change and person-directed care can be instituted without effort because in practice, it requires deep system change in institutions—changes in organizational practices, physical environments, relationships at all levels and workforce models. These efforts, however, are yielding dramatic and meaningful rewards for the residents, their families, and the staff caring for them.

How far have we come

Person-directed care represents a true operationalization of the Nursing Home Reform Act (OBRA '87) which states that “each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.” Despite the law, however, only a very small percentage of the 17,000 nursing homes in the country have *fully* embraced culture change.

Where culture change is headed—pathways and challenges

As culture change becomes more widespread—impacting medicine, nursing, allied health professionals, social and human service providers and consumers themselves—several directions begin to emerge. I will touch on three of these: the expansion of the culture change movement through education, through research-based business cases, and through knowledgeable consumers.

### 1. Culture Change and Education

The culture change movement is at a crossroads. Although culture change continues to gain more advocates, widespread implementation of person-directed practice has not occurred. If the culture change movement—and the philosophy and practice of person-directed care—are going to enter the mainstream and become the norm, it must be fully integrated into academic curricula, research agendas, and training programs, for in truth, academia has been noticeably absent from the culture change movement.

Its absence, in large part, can be attributed to two concerns:

The first of these is “**the paucity of translational research.**” Curricular development traditionally builds upon a foundation of research that identifies best, effective, and cost beneficial practices. Thus, the paucity of translational research further impedes curricula adaptation. For many academicians and professionals, culture change cannot be embraced until it can be measured in terms of its quality outcomes and its assumed and associated costs. These concerns are important since cost escalations and financial declines are ongoing threats to the nursing home industry. These concerns are being now addressed by the development of a business case for culture change, which is shining a light on the research-based outcomes of culture change.

The second reason for the absence of culture change in education is “**a need to define the knowledge and skills of culture change.**” Practitioners and professionals lack the

knowledge about the attitudes and skills required of them, what culture change “looks like” in long-term care facilities, and how to recognize operational processes and changes that accompany person-directed care. This is changing as well, with the development of guidelines and academic materials that clearly articulate the competencies and skills which define culture change and person-directed care. Once completed, these will be incorporated into medical and nursing curricula, nursing home administrator licensing examinations, and executive and continuing education across the country.

For the culture change movement to grow, we must assure that the principles of person-directed care are taught in training and education programs. For, while people may listen, and while they may believe in “aging with dignity” and consumer choice, this belief is not enough to extend the culture change movement, particularly into academia where we are training our future practitioners. For educators and researchers to be part of the culture change movement, for them to come to the table, culture change must demonstrate precisely—through translational research, and education and training for the entire team—the efficacy, practicality, and validity of the culture change movement. Without this demonstration, we cannot fully change the culture of aging. With this demonstration, as our providers and educators learn more about culture change and witness person-directed care, they will themselves become change agents for aging with choice, dignity, and self-determination.

## **2. Business Case for Culture Change**

A business case for culture change is beginning to emerge through multi-year research studies; and practitioners, educators, and administrators are beginning to listen. What they are hearing is that the research-based evidence on early adopter homes clearly shows that the implementation of culture change principles and practices has the potential to improve resident outcomes without inflicting detrimental costs on providers.

Controlled studies to date show that transformed nursing homes had better operating margins than traditional homes, with contributing factors identified as reduced staff turnover and

subsequent retraining. With turnover rates at nursing homes hovering between 70% and 100% annually, homes embracing culture change have already seen reductions of 15%, significant when the cost of advertising for new staff, hiring, and training is calculated into the savings. Forecasts determined by recent evidence from culture change adopters project that for a 100-bed home, person-directed practice could account for as much as \$378,000 per year in increased revenue, and decreases in expenses associated with the incidence of pressure sores alone could account for \$30,000 in reduced costs.

Embarking on the journey of organizational culture change toward person-directed care is not only the *right* thing to do, it also makes perfect business sense as well.

### **3. Culture Change and the Consumer**

The impact and understanding of culture change has begun to reach outside of the original professional boundaries of culture change and into the world of the consumer. This can be directly attributed to the aging of the Baby Boomers. The Baby Boomer generation's parents are aging, and the Boomers themselves are not far behind. Groups working in the long-term care arena are helping Baby Boomers to be discerning consumers. Because, in truth, until consumers demand that we, as a country, embrace culture change, it won't happen. Just by their sheer numbers, this generation of consumers is becoming a powerful voice for change.

#### Closing Note

According to the *Alliance for Health Reform*, roughly one third of the people turning age 65 in 2010 will need nursing home care for either a short- or long-term stay during their lifetimes. This "age wave," created by the aging of baby boomers, is having a dramatic effect on how we live, work, and plan for longer life. It is already beginning to change the delivery of long-term care across the nation.

When we are receiving long-term care services—whether in a residential or community-based setting—our daily lives can be meaningful. This is the message of the culture change

movement. The culture change movement has made much progress since it began in the 1990s. Nationally, more than 30 state culture change coalitions are working hard in their respective states to change the culture of aging by educating providers, policymakers, and consumers about culture change and resident-directed care and, in some states, helping individual nursing homes undergo transformation. We can be assured that culture change will continue to spread throughout the country as professionals and consumers alike understand that we can thrive in old age, no matter our health condition, when our voices and the voices of those working with us are considered and respected.