



Issue Paper
***Nurses Involvement in Nursing Home Culture Change:
Overcoming Barriers, Advancing Opportunities***

**From the Hartford Institute for Geriatric Nursing
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Executive Summary (see attached)

Introduction

In nursing homes, the movement away from institutional provider-driven models of care to more humane consumer-driven models of care that embrace flexibility and resident self-determination has come to be known as *culture change*. Culture change and resident-directed care¹ has its origin in the work of the National Citizens Coalition for Nursing Home Reform (NCCHNR) and represents a true operationalization of the Nursing Home Reform Act of 1987: "...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."

In an effort to rebalance the priorities of nursing home care, the Pioneer Network, formed in 1997, developed a vision, a set of principles and goals for culture change that makes resident-directed care *the* guiding or defining standard of practice for nursing homes (<http://www.pioneernetwork.net/>). Culture change, at this time, is a young, growing, value-driven movement for change, much like the movement for restraint-free care was when it started 20 years ago. The goal of culture change is the same as with restraint free care, to free elders wherever they live from unnecessary and unwanted constraints in their pursuit of their quality of life, wherever they are, and to create a new, evidence-based model for care in nursing homes.

The principles and methods of culture change are sensitive and responsive to individual resident preferences and quality of life and promote quality of care and economic viability in a highly competitive nursing home market. A substantial number of nursing homes involved in culture change have become exemplars of care, as evidenced by the fact that the Centers for Medicare and Medicaid Services (CMS) is operationalizing principles of culture change into revised and new regulations and interpretive guidelines for its nursing home survey. Thus, in all likelihood, culture change will have an impact on more nursing homes, with implications for nursing clinical practice, administration, education and research.

As nursing homes move from an institutional to a more resident-directed care environment, the clinical care provided and directed by professional nurses^{2, 3, 4} remains

¹ In this paper, resident-directed care encompasses other similar terms such as resident-centered care and person-directed or person-centered care.

² In this paper, professional nurse or nurse refers to Registered Nurses (RNs) (diploma, associate degree and baccalaureate prepared)

³ The Expert Panel members acknowledge the importance and contribution of Licensed Practical Nurses (LPNs) in the delivery of care to residents in culture change nursing homes. The focus of this paper,

critical and central to both quality of care and quality of life. Nursing home transformation to this new model of care encompasses themes (e.g. autonomy in personal choices for the residents, consistent staffing, and a less vertical organizational approach) that directly impact nurses and their practice. For example, system change in culture change nursing homes flattens the nursing organization hierarchy and empowers direct care workers to become part of the decision-making process, which in turn calls for a renewed examination of the role of nurses.

The goals and philosophy of culture change and the goals of nursing are highly compatible. The fundamental principles of nursing care support and incorporate resident-directed care. Almost all nursing home residents are in nursing homes because they need the care of professional nurses, especially following hospitalization or for chronic disease management. Providing coordinated, evidence-based clinical nursing care in the context of a resident-directed philosophy of care requires intensive nursing participation. To foster and promote a team approach to care in which direct-care staff are involved in decision making about resident care and how the work is organized, nurses also need to be care team leaders and role models. Core competencies for nurses in a resident-directed environment, and articulation of the essential role nurses play in helping to lead culture change efforts, are necessary.

Culture change thus poses a number of dilemmas for nurses. Culture change challenges nurses' traditional notions of accountability for the clinical care of residents, especially when care-giving is distributed among nursing and non-nursing staff and decisions are being made "at the bedside" without the nurse's input. It raises issues of whether nurses are practicing within their scope of practice with regard to delegation of nursing responsibilities or whether they are violating professional and regulatory requirements. The professional nursing associations representing nurses who work in nursing homes have not had either leadership or significant participatory roles in developing a vision for the role of nurses in the evolving culture change initiative. It is, therefore, no wonder that nurses feel ill prepared and uncomfortable when asked to lead initiatives in resident-directed care.

To further explore and make recommendations about the role and competencies for nurses with regard to nursing home culture change, in 2008 the Hartford Institute for Geriatric Nursing at NYU College of Nursing, in collaboration with the Coalition for Geriatric Nursing Organizations and with the Pioneer Network convened an interdisciplinary Expert Panel of leaders in culture change and in gerontological nursing for a one and a half-day meeting. The purpose of this meeting was to foster dialogue, to identify facilitators and barriers to professional nurses' involvement in culture change, and to identify actions that the culture change movement and the broad nursing community might consider in order to promote competencies for nurses in a resident-directed care environment in nursing homes.

however, is on RNs. While a simultaneous discussion of the role of LPNs is not possible, the Expert Panel members support the need for a similar review of the role of LPNs in nursing home culture change.

⁴ By focusing on nursing only, this paper does not address the importance of social workers, physicians and other health care professions in implementing culture change

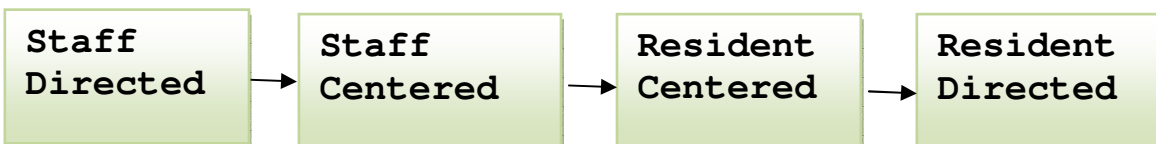
This Issue Paper *Nurses Involvement in Culture Change: Overcoming Barriers, Advancing Opportunities* summarizes the Expert Panel discussion and frames the competencies that need to be developed for professional nurses involved in culture change and resident-directed care.

The paper is divided into the five sections: culture change and research regarding culture change; nursing in nursing homes; culture change, nursing practice and nursing education; recommendations; and next steps. We hope this issues paper will promote discussion as to the actions that might be considered by the broad nursing community (e.g., educators, researchers, and practitioners), leaders of culture change, consumers and consumer advocates, interdisciplinary professional team members, and policy makers with regard to nursing competencies, nursing home culture change, and resident-directed outcomes.

Section 1: Culture Change

Nursing home culture change, a non-institutional, resident-directed model of care in nursing homes, seeks to promote autonomy and choice for residents residing in nursing homes and for those who work most closely with them. Through innovation by the pioneers of culture change over the past 20 years, we know that it is possible to deliver resident directed care that is both cost-effective and highly satisfying to those receiving the care as well as to their families and staff caregivers. While many specific approaches to promote resident-directed care have been developed, the core values that unite them are choice, dignity, respect, flexibility, and self-determination. Major components of culture change include empowerment and support of first line direct care workers, creating an environment, and leadership commitment that approaches a person’s home. In a setting that has moved from institutional to resident-centered to resident- directed care practices, the individual preferences of residents always come before the task (e.g. bathing times, fixed bed-time hours). The voices of older adults are considered and respected regardless of resident age, medical condition, or limitations.

Nationally, more than 30 states have culture change coalitions working to educate providers, policymakers, and consumers about culture change and resident-directed care. To date, only a small percentage of the nation’s 16,500± nursing homes have embraced culture change although many are on the “journey” to achieving this goal. While the majority of nursing home providers are familiar with the concept of culture change, only a third of 1,453 directors of nursing surveyed in one study describe their nursing homes as “culture change adopters (1). Of these, almost half (47%) do not allow residents to determine their own schedules—a fundamental principle of resident-directed care. Within nursing homes, the continuum of culture change is illustrated by the movement away from staff-directed to resident-directed care as illustrated below, adapted from Crotty, Misiorski, & Rader (2).



In a *staff-directed* environment of care, management makes most of the decisions, without a full understanding of their impact on residents and direct care staff. In a *staff-centered culture change* environment, staff members consult with residents or try to put themselves in the residents' place while still making many decisions. Residents accommodate and yield to staff decisions most of the time, but have some choices within existing personal care routines and activities.

In a *resident-centered culture*, residents' preferences and past patterns form the basis of decision-making about some routines of care. Staff (i.e., nurses and direct care providers) organize their work to accommodate expressed or observed resident preferences. Nurses and the direct care staff have more input in regard to how work is organized (e.g., involvement in care planning, scheduling, peer monitoring). The residents make decisions on a daily basis about their individual routines. When residents are not capable of expressing their needs and choices, the staff honors observed preferences and lifelong habits. Residents are given more of a voice, until they ultimately *direct* their own care. For this transformation to occur, staff must also be afforded more autonomy and flexibility by the management team. The table below illustrates the "continuum of direction" as applied to care assignments in long-term care settings (2).

Table

Staff Directed Care Assignments	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.
Staff Centered Care Assignments	Nurses and nursing assistants usually 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 preceding day.
Resident Centered Care Assignments	Nursing assistants, working with the same group of residents, are responsible for evaluating how their assignments are progressing. 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 is off. The nurses are also consistent, working with the same group of residents and supervising the same staff.
Resident Directed Care Assignments	Nursing assistants hold team meetings to conduct self scheduling and prepare consistent assignments. Having learned from their residents what time they want to wake up, eat, etc. the nursing assistants create their own schedules based on their own availability and the times at which the residents need their support. The residents participate in deciding who will care for them.

Resident-directed care cuts across disciplines and job duties, synthesizing best practices from multiple disciplines. As a holistic and collaborative process, resident-directed care is a platform for optimal understanding of the resident's goals of care and quality of life priorities, and can result in a new or modified approach to care.

Given its goals, culture change requires deep system change in institutions, changes in organizational practices, physical environments, relationships at all levels and innovative workforce models. In 2005, CMS, state survey agencies, long-term care ombudsmen, citizen advocates, quality improvement organizations and others attended the Pioneer Network and Quality Partners of Rhode Island national meeting, “The St. Louis Accord.” In 2006, CMS released the Artifacts of Culture Change, a self-study tool for nursing homes. This instrument was used in the Staff Time and Resource Intensity Verification Project (STRIVE) to identify nursing homes’ progress on the culture change pathway. CMS has also supported the Advancing Excellence Campaign for America’s Nursing Homes, which has incorporated culture change structural measures on staff turnover and consistent assignment (3).

In 2007, CMS conducted four Webinars under the culture change rubric of “From Institutional to Individualized Care.” CMS also joined with AHCA, AAHSA, and the Pioneer Network for a one-day workshop (2008) on the physical environment in nursing homes which federal and state survey agencies participated. Subsequently, a small group of stakeholders met to recommend changes in the survey criteria that reflect culture change practices. Some of those recommendations have been included in F tags that will be posted on the Internet as advance copy. Surveyor and provider practice should change as a result.

Research Regarding Culture Change: Rigorous study of nursing home culture change is in its infancy. As noted by Rahman and Schnelle (3), the culture change movement has spread in advance of a solid research base to support its claims. However, research suggests that in culture change nursing homes, residents’ quality of life is better and staff are more satisfied with their work and the care they provide to residents, and these nursing homes are not experiencing negative financial outcomes.

Instruments to measure culture change: Evaluation of the effectiveness of nursing home culture change requires reliable and valid strategies and measurement tools. Existing instruments report varying degrees of validity, but limited evidence for reliability (4; 5; 6; 7). The face and content validity of the *Artifacts of Culture Change Instrument* (8) was evaluated by experts in the field but reliability has yet to be reported.

Research on models of culture change: Mueller (2008, unpublished) identified 16 studies evaluating different models of resident-directed care in publications, dissertations, and foundation reports: nine (60%) of the Eden Alternative model (9; 10; 11; 12; 13; 14; 15; 16; 17), three of the Greenhouse house model (18; 19; 20); one of the Wellspring model (21), and three of resident-directed practices generally (17). All of these studies are descriptive. The number of facilities in the study samples range from one to 17 (both intervention and control facilities). Reliability and validity of the measures vary. The studies examine resident, family, staff, organizational, and financial outcomes but none of the studies use the same outcome measures. Thus, evidence demonstrating the impact of these nursing home culture change models is weak, at best. Studies with larger samples and quasi-experimental designs (4; 18; 19), however, all report positive improvements in resident, staff and organizational outcomes. The Commonwealth Fund 2007 National

Survey of Directors of Nursing (1) found that residents in culture change nursing homes report that they have privacy and choice similar to what they would have if they were still living in their own homes.

Section 2: Nursing Homes and Nursing

At any point in time, approximately 1.6 million people age 65 and over reside in the nation's 16,500+ Medicare skilled and Medicaid nursing facilities (24). Approximately 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 (25). Whereas short-stay residents are in a nursing home for a period of rehabilitation following a hospitalization, long-stay residents tend to be frail with many chronic physical illnesses and changes in mental status. Given residents' medical, functional and cognitive complexity, one in every three nursing home residents is hospitalized each year.

Risk factors for admission to a nursing home include advanced age, having a diagnosed medical condition, living alone, loss of self-care ability, decreased mental status, lack of informal supports, poverty, hospital admission, bed immobility and female gender (26). Virtually all nursing homes provide rehabilitative services, but the intensity of the service (skilled or maintenance) varies with the home's program operation and Medicare participation. More than 3,000 nursing homes have formally defined special care units (e.g. respirator units, dementia care units), constituting almost 7% of all beds.

Registered nurses (RNs) and Licensed Practical Nurses (LPNs) together constitute the licensed nurse workforce in nursing homes. In 2004, only 6.3% of the working 2.6 million RNs were employed in nursing homes. Approximately 32% of the nation's 596,000 LPN/LVNs are employed in long-term care. Certified nursing assistants (CNAs) constitute 70% of the total nursing workforce in long-term care.

Registered nurses typically do not deliver direct care to nursing home residents. The nursing delivery model in nursing homes tends to be pyramidal. At the top is the Director of Nursing (DON), an administrative position (except in small nursing homes of under 60 beds in which the DON may also be the RN supervisor). In most nursing homes, there is generally a nursing supervisor on each shift. An RN on the day shift (i.e., head nurse, nurse manager, etc) heads the nursing team; another RN or LPN is assigned to medications and treatments. The evening shift licensed nurse is commonly an LPN rather than an RN but this varies considerably. The CNAs constitute over two-thirds of the nursing staff in most nursing homes and provide the direct hands-on care; they are the eyes and ears of the nurses.

It is reported by CMS that, on average, nursing home residents receive 3.7 hours of care each day or 222 minutes (i.e., 74 minutes per eight hour shift). Of these hours of care, RNs provide only an average of 0.6 hours (24) but are accountable for all of the nursing components of resident care, including admission assessment, care plan development (including care at the end of life); monitoring and evaluation of the resident's care; discharge planning; resident, family and staff education; and management/administration tasks (including responsibilities such as ordering supplies).

LPNs, on average, provide 0.8 hours of care daily and are usually responsible for task-oriented duties such as medication and treatment administration, and collection of clinical data. While the LPN role clinically and legally differs from that of the RN, in many nursing homes LPN activities/work appears similar to that of the RN. RNs oversee the CNAs, who provide an average of 2.3 hours of resident care daily, including assisting with eating, toileting, bathing, dressing, mobility and many other personal and restorative needs.

A 1986 Institute of Medicine (IOM) study of nursing homes found the overall quality of care was poor. The IOM recommended sweeping reforms regarding resident rights, measurable goals of care, interdisciplinary team approach for individualized resident assessment and care planning, and a revised, resident-centered quality of care survey. With few exceptions, outcomes of nursing and quality of care in nursing homes are associated with staffing types and amounts. Overall, higher nurse staffing hours and higher total nurse staffing are significantly related to improved functionality of short-stay residents and decreased probability of death (27), improved resident functionality and fewer medication errors and survey deficiencies (28), reduced adverse outcomes and costs (29), and to improved performance of CNA-administered care processes (30)

Section 3: Culture Change, Nursing Practice and Nursing Education

Nursing Practice

Culture change is not a nursing model of care, and to date the movement has been minimally attentive or responsive to licensed nurses' plight in having to accommodate to new ways of delivering care. In implementing culture change, nursing homes report anecdotally that nurses have difficulty in making the operational changes associated with resident-directed care. RNs are perceived as resistant to culture change (25), a stance associated with perceived or real threats to nursing autonomy, regulatory-related issues and the professional nurse's scope of practice and accountability.

Research on the role of nursing in nursing home culture change is almost non-existent. Scalzi et al. (22) found that the greatest barrier to implementing nursing home culture change was excluding nurses from decision-making about culture change activities. A survey of licensed nurses in WellSpring facilities (32) indicated three significant issues related to nurses involvement in culture change: 1) confusion over the role of the licensed nurse; 2) conflict over the transformation of a traditional care model to a resident-centered care model; and 3) reconciling individualized care with quality nursing care.

In culture change environments, decentralized organizational models suggest that nurse managers require both clinical and management skill sets, as they are accountable for all the management functions traditionally performed by the Director of Nursing. The Director of Nursing in this model is free to lead by being a knowledge broker or consultant (K. Anderson, personal communication). This role change, for which nurses are generally unprepared, raises concerns as to nurses' job security and status in the management hierarchy. Because nurses have either excluded themselves or been ignored in creating new job descriptions and responsibilities associated with culture change, they

feel at best disconnected from decisions about resident-directed care, or at worst, they resist implementation of such decisions. In addition, it would not be uncommon for nurses to be asked to take on this new “resource-bearing” role while continuing most or all of their prior job duties. This is not simply a leadership/managerial challenge; nurses are already frustrated in their ability to meet existing job demands, let alone take on additional roles and tasks.

Some of the apparent disparities between culture change and nursing stem from conceptualization of nursing care and the language used to describe desired outcomes. Within a culture change environment, care, defined as “helping people grow” (33), is both a primary goal and an outcome. Central to the culture change model is resident self-determination, i.e. empowering residents to make meaningful choices and honoring those choices. The language in documents describing culture change rarely, if ever, reflect language used by nurses to describe their practice and their goals of care. Nurses tend to define goals and outcomes in terms of lowering risk and placing residents in a position to enhance their potential by avoiding harm and untoward outcomes such as weight loss, pressure ulcers, and other conditions, outcomes nursing is responsible for avoiding by tradition, scope of practice, and regulation. Materials on culture change make little or no reference to physical care, resident health status, disease, illness, functional status, cognitive impairment, or geriatric syndromes that guide nurses’ role in nursing homes.

One explanation for the lack of attention to nursing in early culture change facilities is that these homes were already exemplars of good nursing practice, i.e., deficiency-free and/or low citation homes (e.g., Providence Mount St. Vincent, Seattle WA; Teresian, House, Albany, NY; Meadowlark Hills, Manhattan; and KS, Perham Memorial Hospital and Home). Thus, good nursing care was in place and homes concentrated on different aspects of evolution from institutionalization to resident-directed care. Nevertheless, disparity in language and focus between the culture change literature and nursing practice partially explains nursing’s resistance to participation in culture change.

The Professional Nurse Practice Model and Culture Change: A professional nurse practice model is a standard against which to assess the breadth and depth of nursing in the practice environment. Professional nurse practice models are systems that support nurses’ accountability for the delivery of clinical nursing care and the environment in which that care is delivered (34). These systems are composed of structures, processes, and values. An important structural element of a professional nursing practice model is shared governance, operationalized by the inclusion of nurses in decision making about such things as the hiring of nursing staff, staffing plans and practices, and the development of policies and procedures that promote and reflect evidence-based practice. A key value in professional nurse practice models is professional development, operationalized as the provision of relevant continuing education, staffing structures that support best practices, and a process for professional recognition and advancement.

From the perspective of culture change, professional nurse practice models are relevant to nursing homes at every stage of the culture change process. Professional practice models are “site-specific innovations that nurses design, implement, and sustain to address the particular health needs of patients or residents in the organizational context of their workplace” (35). The professional nurse practice initiatives identified by Lyons et al. are similar to and supportive of nursing homes’ efforts to transform their practice and their environment, e.g. “resident-centered care with a focus on excellence, an articulation of a shared philosophy or values statement, employee-friendly personnel policies, lifelong learning, interdisciplinary collaboration, community involvement, participatory leadership, and quality improvement” (35). Interdisciplinary teams are often the vehicle for leading culture change initiatives. Social workers and possibly other health care professionals, have coordinated culture change efforts. The Culture Change Coordinator Manual (36) cites nurses as another logical discipline to lead and coordinate culture change activities.

Points of synergy with culture change, as well as potential causes of nurses’ perceived resistance to culture change, can be analyzed using the “Artifacts of Culture Change” instrument (8) as a framework. The Artifacts instrument is a guideline for tracking concrete changes that nursing homes have made with regard to five critical domains: care practices, the environment, family and community, leadership, and workplace practices. Thus, concurrent examination of the “Artifacts of Culture Change” and the professional nurse practice model is a useful platform for identifying real and perceived resistance as well as identifying how a professional nursing practice model is consistent with these domains.

The “care practice” Artifacts refer to offering residents choices in their personal care scheduling. These practices are consistent with the underlying philosophy of nursing, that is, to encourage both residents’ independence and autonomy and nursing care that is resident-directed rather than task-centered. However, broad implementation of resident autonomy can be perceived by nurses as problematic on several levels. It creates an ethical quandary as the nurse weighs the benefit of resident decision-making against the risk of resident injury or illness exacerbation, especially since in many instances the nurse is held accountable for the risk. In addition, the nurse must balance what is good for one resident against the needs of all the other residents. For example, if residents choose when they sleep and eat, RNs may perceive a conflict with their routines of giving medications according to prescribed schedules or their responsibility for residents’ adherence to prescribed diets. Care plans written in the first person format (i.e., from the resident’s point of view) may also be foreign to RNs who were not educated to develop a care plan in the resident’s voice or have never worked in a facility with such care plans.

Because the majority of RNs practicing in nursing homes have not had a geriatric nursing focus in their nursing education program, their preparation as a gerontological nurse is limited. Very few nurses were exposed to a culture change organization either in their training or in prior jobs. Care responsibilities and staffing demands leave little time for nurses to engage in on-the-job educational activities that would expose them to new ideas. As such, they tend to fall back on institutional, traditional care routines and a more

authoritative form of interaction with both residents and staff. Thus, resident-directed care can appear as a threat to nurses' accountability, as well as a sense of inadequacy in fulfilling their stated job responsibilities. It is not that nurses are indifferent or antagonistic to culture change; rather, they need to be at the table to discourse on what culture change should look like in practice. The Expert Panel recommended that nurses be involved in shaping culture change, and that culture change and nursing use the professional nurse practice model to provide the tools to address these and other care issues.

The "environment" Artifacts are also consistent with nursing's philosophy of maintaining resident's dignity and autonomy. However, changes such as relocation of the once highly visible nurses station can have a negative impact on nurses' self perception of status. The physical structure of the nurses' station is a long-time symbol of the central role of the nurse, a location where the nurse is seen as "doing her job," thereby legitimizing his/her role. Removal of the nurses' station can be psychologically threatening and also raise the nurses' perception of level of risk, e.g. in not having a direct view of the residents. Here too, professional nurse practice models guide by providing nurses with the skill set to analyze the structures and processes that create desired resident outcomes.

The "family and community" Artifacts are consistent with nursing's philosophy regarding the important role of the family in care. With culture change, nursing homes become more open systems in which family members have greater access to and more, not less, interaction in resident care and processes. This is a positive feature in professional nurse practice models, where nurses are expected to have the necessary resources and facts to focus on the system of care. For nurses in nursing homes, however, greater involvement and presence of family and community can be seen as an added burden as nurses find themselves explaining care to families and adjusting care practices without any system attention to the consequences of these increased demands.

The "leadership" Artifacts are perhaps the area in which there is the most potential conflict and opportunity for nursing and culture change. Transformational leadership style is the heart of professional nurse practice models. Yet many formal and continuing education nursing programs still teach a leadership /supervisory style that is primarily autocratic. As such, RNs may be uncomfortable with self-directed work teams, cross training and the involvement of CNAs in resident care conferences. Few RNs have access to education programs that provide current knowledge about coaching and team building. Thus, they fall back into rule-driven, autocratic and authoritarian supervision that accentuates power differences and punitive approaches, characterized by a "we/they" approach, rather than one that is respectful and inclusive. When RNs are exposed to supervision/education that includes coaching skills and listening skills such as those in the Coaching Supervision program of PHI, they are more able to be a transformational leader and move culture change closer to its goals. (37).

The "workplace practice" Artifacts that focus on consistent assignment, job development and career advancement are in keeping both with nursing's philosophy of

patient-centered care and with professional nursing practice models. Artifacts that may be difficult for RNs to accept are the self-scheduling of work shifts and the cross training of staff. Accountability for practice includes managing the work schedules of staff, not necessarily for purposes of control, per se, but to assure, in a cost-effective manner, an adequate number and mix of staff 24 hours a day, seven days a week. Thus, turning the scheduling task (and control) over to CNAs may be difficult, especially if the RN has not participated in the process and is unsure as to whether the organization has thought through the implications of self-scheduling, for example, sick call coverage. Moreover, the nurse may be concerned about supervising CNA activities for which the CNA has no training or experience, such as dietary activities (e.g. portion control) and housekeeping. Nurses may also perceive, accurately or not, that delegation of skilled nursing tasks to CNAs in culture change facilities is in conflict with state Nurse Practice Acts and state regulations, without having the resources to fully examine whether this is truly the case.

Several additional issues can impede implementation of a professional nurse practice model in nursing homes and also have an impact on culture change. One issue for nurses in long-term care is the lack of clear differentiation between the role and responsibilities of the LPN and the RN and the indiscriminate substitution of LPNs for RNs. LPNs and RNs appear to be performing similar tasks. But the interpretation, analysis and subsequent outcome of the task will vary based on the education of these two licensed providers. Thus, lack of differentiation is at odds with a professional nurse practice model.

A second issue relates to the responsibility for the multiple roles that RNs are asked to assume in culture change that broaches several roles: expert clinician, educator, coach, and counselor. Culture change requires that RNs become clinical care partners, serve as role models, teachers, and mentors for staff, be gerontological nurse experts, and have the leadership skills to build care teams. While this is consistent with a professional nurse practice model, the current role for most RNs in nursing homes involves a substantial amount of indirect care including documentation, supervision, and management that is typically done away from the bedside on behalf of the resident. Thus, many of the areas in which nurses have been seen as resistant to culture change are precisely those areas in which they have not yet achieved the common components (or competencies) of professional nursing practice as a result of lack of opportunities for preparedness.

Nursing Education

Most educational efforts related to culture change have been directed at the nursing home community, and tangentially at nursing homes nurses. “Toolkits” (38), books (39; 40; 41; 42), training manuals (43; Institute for Caregiver Education, <http://www.caregivereducation.org>; <http://www.culturechangenow.com/#resources>) and videos (Action Pact, <http://www.culturechangenow.com/videos.html>) are constructed to help nursing homes embrace culture change. Some national organizations (e.g. the American Society on Aging, American Association of Homes and Services for the Aging, American Health Care Association) offer culture change track programs at their national conferences. The National Advancing Excellence Campaign

(www.nhqualitycampaign.org) and CMS (www.cmsinternetstreaming.com) provide Webinars and other educational and training material to facilities and consumers. A few initiatives (e.g., 44; Pioneer Conference sessions; the American Association for Long Term Care Nursing; the American Association of Nurse Assessment Coordinators) provide manuals, trainings and certificate programs specifically directed at practicing nursing home nurses. Evaluation studies of these initiatives have not been reported.

Virtually no educational efforts related to culture change have been directed at undergraduate or graduate nursing education. This is seen as a major barrier to advancing culture change (38). Anecdotally, a few schools of nursing (University of Minnesota and Oregon Health Science University) have incorporated aspects of culture change into their curricula. A coaching/supervision training model (37) developed for nurses in nursing homes and home care agencies was tested by faculty and students in three nursing schools in 2008 and is in the process of broader dissemination

Lack of involvement of culture change in nursing education programs stems, in part, from the fact that few culture change pioneers have had connections to schools of nursing and academia. Academics are unfamiliar with the culture change literature and unprepared or unsure how to conceptualize basic geriatric/gerontology content, concepts of resident-directed care, ethical issues such as autonomy versus safety, and the Professional Nurse Practice Model.

Two issues further impede curricula adoption of culture change. The first of these is the paucity of translational research. Curricular development traditionally builds on a foundation of research that identifies best, effective, and cost-beneficial practices. For many academicians, lack of clinical and cost outcomes for culture change limits infusion into the curriculum. These concerns are now being addressed by research into, and the development of, a business case for culture change. The second reason for the absence of culture change in nursing education is the need to define the knowledge base and skills of culture change. Practitioners and educators need to learn about the attitudes and skills associated with culture change, what culture change “looks like” in long-term care facilities, and how to re-organize operational processes that accompany resident-directed care. This will change with the development of core competencies, guidelines and academic materials.

The goal of the Pioneer Network and its partners is to incorporate culture change into medical and nursing curricula, nursing home administrator licensing examinations, and executive and continuing education programs across the country. In a first step to influence education, the Pioneer Network is working with the American Medical Directors Association to develop competencies for physicians in nursing homes (46) and will use a similar framework partnering with nursing organizations to identify core competencies and curricula for nursing.

Section 4: Recommendations for the Nursing Profession

The recommendations of the Expert Panel are presented in two parts: recommendation for the practicing nurse in culture change nursing homes, and

recommendations for academic programs preparing professional nurses. These recommendations address issues of importance to nursing home administrators, nurse educators, and policy makers. Though un-addressed in this document, the Expert Panel recognized that there is an important need to address the roles for all nursing and other personnel in culture change, nurse staffing patterns that are conducive to adequately implement culture change, and the reimbursement for nursing home culture change needed to support these staffing recommendations.

Recommendations for Nursing Homes Regarding Practicing Professional Nurse

Culture change can enhance the role of the nurse by helping the profession describe and enact specific competencies, especially those related to relationships, a hallmark culture change principle. Culture change has the capacity to enhance the professional practice role of nurses as they care for residents with complex and profound care needs. Given the trust that the public has in nursing, engaging nurses' voice in culture change can add to consumers' and regulators' confidence regarding culture change initiatives. The Expert Panel Recommendations 1 and 2 are directed at the practicing nurse in culture change nursing homes

Recommendation 1: Develop and distribute a statement of goals for practicing nurses in culture change nursing homes. Professional associations that represent practicing nurses in nursing homes should develop and endorse jointly with culture change nursing homes a Statement of Goals for Professional Nurses Practicing in Nursing Homes. The purpose of this statement is to set out the goals of the culture change movement and the integral role that excellent nursing care plays in resident-directed care. This statement would speak to the mutual commitment of the culture change movement and professional nursing to position nurses to maximize quality of care within a resident-directed care environment.

Recommendation 2: Develop competencies for nurses practicing in culture change nursing homes. Competencies form the basis for role delineations, educational programs, and regulatory and professional accountability. The Pioneer Network plans to partner with Hartford Institute Coalition of Geriatric Nursing Organizations (CGNOs) and the John A. Hartford Foundation Centers of Geriatric Nursing Excellence to develop core competencies and quality indicators in nursing practice that are guided by evidence or research-based practice, a professional nurse practice model, culture change principles, and an interdisciplinary approach to care.

A possible first step to competency development would be to convene a Nursing Advisory Panel that would begin with a review of current competencies. Before proposing new competencies, there is a need to examine existing competencies in nursing practice and/or education as they apply to nursing homes generally and to determine the degree to which these competencies need to be modified or new competencies developed. As they apply to culture change, it is important that competencies for nurses build on the competencies delineated in the professional practice model. With this in mind, at a minimum, the Expert Panel proposes competencies for nurses in nursing homes that:

- Position the nurse for leadership consistent with the principles of culture change and the climate of promoting a self-directed team of licensed and unlicensed staff (a core principle of a professional nurse practice model)
- Reflect the inclusion of nurses in decision making (e.g., hiring of nursing staff; staffing plans and practices; the development of policies and procedures) that promote and reflect evidence-based nursing practice in a culture change environment
- Relate to professional development (e.g. provision of relevant continuing education; a process for professional recognition and advancement) in a culture change environment
- Address the care needs of different populations within the home (e.g., long-stay and short-stay residents, residents with profound cognitive deficits; residents receiving palliative and end of life care)
- Address nursing accountability for clinical care in a culture change environment
- Address nurse-sensitive resident outcomes to enable facilities that have adopted the components associated with the Artifacts of Culture Change instrument to measure their process and progress on the culture change pathway
- Address relationships among all nursing staff (e.g. advanced practice nurses, licensed practical nurses, certified nursing assistants) in culture change nursing homes
- Relate to evaluation and application of culture change research for nursing practice
- Relate to understanding the value of, and being able to operate effectively within, interdisciplinary teams, recognizing the importance of disciplines other than nursing (e.g., social work, pharmacy, physical and occupational therapy) to the essential health of the resident

Recommendations for Nursing Education Preparing Professional Nurses

If the culture change movement is to enter the mainstream and become the norm, the principles of resident-directed care need to be introduced into the education programs of professional nurses, and to be integrated into academic curricula and research agendas.

In general, undergraduate and graduate programs in nursing have been slow to incorporate competencies related to care of older adults including nurses' relationships with residents into the curriculum. Moreover, the ways in which nursing homes are used as clinical training sites varies substantially across programs, and very few programs have specific competencies related to nursing home care (47). Anecdotally, only a handful of nursing programs have been identified that specifically address resident-directed care and the culture change movement in their undergraduate or graduate nursing programs. The Expert Panel Recommendations 3, 4, 5, and 6 relate to culture change for academic programs preparing professional nurses.

Recommendation 3: Conduct a comprehensive review of culture change content in pre-licensure (associate degree and baccalaureate) nursing programs. The Expert

Panel recommends that the culture change organizations collaborate with the appropriate academic nursing organizations (e.g. the American Association of College of Nursing and the National League for Nursing) to conduct a survey of academic nursing programs to ascertain the extent to which the principles of culture change are incorporated into nursing education programs, faculty knowledge of culture change, existing resources used in curricula to teach information about nursing homes and culture change, and what new tools/resources faculty identify as needed to incorporate these concepts into academic nursing programs.

Recommendation 4: Disseminate existing tools/resources on culture change and nursing's role in culture change to academic nursing programs, including strategies for incorporating this content into the curriculum. Dissemination could be facilitated by partnering with the American Association of Colleges of Nursing Geriatric Nurse Education Consortium (GNEC), the National League for Nursing, and the Hartford Centers for Geriatric Nursing Excellence, as well as other state and regional nursing education coalitions. Efforts should also be made to foster the integration of coaching supervision skills into the nursing curricula at a variety of levels.

Recommendation 5: Create new tools/resources based on the competencies for practicing nurses in nursing homes. The basis for these tools/resources should be to assist faculty in the selection and structure of didactic content and student clinical experiences in culture change nursing homes.

Recommendation 6: Identify research priorities for examining the role of nurses in nursing home culture change. These include agreement on operational definitions for key concepts in culture change (e.g., consistent assignment), further psychometric evaluation of culture change measures, and the need for a guiding framework for culture change research. Organizational structures to support research on nursing and culture change should speak to the leadership and conduct of the research initiative and reflect questions such as:

- How have RNs in various roles (director of nursing, MDS coordinator, nurse manager) in culture change organizations modified/adapted their role?
- What are the skills, knowledge and abilities needed by professional nurses for nursing home culture change?
- What impact does nursing home culture change have on nurses' job satisfaction and retention?
- How can the nursing profession assure that the nursing hours per resident (HPRD) required by residents is actually being provided when universal workers are providing nursing services among other responsibilities?
- Do residents, families, and visitors have expectations related to roles (e.g., charge nurse, CNA) and unit layouts (e.g., nursing station/desk) in nursing homes that are at odds with roles and layouts in small house models?
- What methods of assessment and care planning are used by nurses in nursing homes with resident-directed care in comparison to "standard practice" nursing homes, and what is the impact of each method?

- What strategies do culture change nursing homes use to improve nurse-sensitive outcomes related to “hand-offs” during a resident’s transition to other settings?
- How do nurse-sensitive resident, nursing home, and costs of care outcomes in culture change nursing homes compare to non-culture change homes?

Section 5: Next Steps

Culture change, resident-directed care and nursing share similar and well-aligned values and goals. The culture change movement takes as a given that culture change builds on excellence in nursing and the holistic principles and processes that nursing espouses. Many of the key principles nurses worked to implement in OBRA are principles that are essential to culture change. This value convergence needs to be made more explicit and to form the basis on which to strengthen the relationship among the nursing and culture change communities.

The scope of nursing is not a barrier to nursing participation and leadership in culture change. However, some of the roles that have evolved from nursing’s historical and traditional scope of practice need to be examined, clarified and possibly modified within a resident-directed care environment. The professional nurse practice model is not only congruent with culture change; arguably, culture change is an expression of the professional nurse practice model. While development of a professional nurse practice model can occur before or during culture change processes, it might be easier to facilitate culture change if a nursing home has already adopted a functioning professional nurse practice model.

Currently, nursing homes involved in “deep” culture change should be exemplars. CMS is in the process of clarifying and enhancing the interpretive guidelines to further advance the intent of the Nursing Home Reform Act of 1987. The growing interest in implementing resident-centered care among policy makers, regulators, providers and consumers makes it likely that culture change will spread to more nursing homes. Yet to evolve are goals with regard to the desired/expected penetration of the nursing home sector. Culture change requires extensive system realignment. Evidence of adoption of culture change goes beyond changing the physical environment or making single changes related to resident care, such as bathing. Thus the extent to which culture change is appropriate for every nursing home or whether it best fits the goals of a discrete number of homes is unclear at this time.

Culture change involves changing physical structures, organizational practices, and personal beliefs. It involves an ongoing process of visioning, educating, implementing and evaluating. Each step in the journey provides further opportunities to transform the home. The extent of culture change infusion in nursing homes has significant implications for nursing practice, education and research. Quality care and quality of life through culture change will not occur in the absence of a sufficient number of knowledgeable nurses or in the absence of sufficient human resources to carry out the work and the goals of care.

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