UNDERSTANDING NURSING HOME CULTURE CHANGE: THE HIGH AND LOW

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ABSTRACT

Culture Change is the transformation of a nursing home (NH) from an institutional establishment with a top down approach to decision making to a resident-centered program that creates an environment that focuses on what is most important to residents and staff. Twenty-five care practices from the Colorado Foundation for Medical Care served as the theoretical framework for seven dimensions of *Culture Change*—home-like environment, resident-directed care, staff/resident relationships, NH staff empowerment, NH leadership, quality improvement, and shared values. Using a secondary data analysis, the overall aim of the study was to examine differences in staff and leadership reports of *Culture Change* among Kansas nursing homes with high (n = 7) and low turnover rates (n = 5). Facility turnover rates were obtained from the 2006 Kansas Medicaid Cost Report. Leadership (n=75) and staff (n=437) participants from Kansas nursing homes (6 rural and 6 urban) completed data collection with response rates ranging from 26 to 85%. We hypothesized that staff in nursing homes with low turnover rates would to report higher levels of *Culture Change* than staff in high turnover homes. Data analysis was conducted using two sample t-tests. Although both leaders and staff in low turnover nursing homes reported higher levels of *Culture Change* across all dimensions than those in high turnover homes, we only found significance (p <.05) differences in the staff/resident relationships dimension by leaders and staff, and in the leadership dimension by leaders. The results of this study revealed that turnover rates have potential to serve as a proxy measure for some aspects of *Culture Change*. However, further testing in a larger sample is needed.

INTRODUCTION

According to the U.S. Census (2008), in the year 2030, one fifth of Americans will be 65 years old or older. The growing elderly population places the spotlight on nursing homes, asking the question, 'What type of care will be provided to the estimated 57.8 million baby boomers that will be entering retirement age in the coming years?' (U.S. Census, 2008). Nursing homes typically are stereotyped as long hallways with two-person rooms where staff members make the majority of the decisions related to resident care (e.g., time of eating, bathing, and sleeping). However, in recent years, a grassroots movement called *Culture Change* has been redefining the nursing home experience. *Culture Change*, also known as resident-centered care, transforms the old institutional-styled nursing homes into environments that are more homelike where the residents and staff are empowered; and residents have choices and are involved in decisions regarding their care (Bott et al., 2007).

Purpose

Resident-centered care embodies the core values of nursing, including providing quality, individualized care for patients, regardless of age and background. Nursing practice emphasizes the importance of meticulously assessing the problem and analyzing the data before executing interventions. Problems have been identified in traditional nursing home environments. In our study, we assessed the need for *Culture Change* by investigating the beliefs of the staff members and leaders.

The overall aim of the parent study was to refine an instrument that measures nursing home staff and leaders' reports of *Culture Change*. Although numerous models of *Culture Change* have been implemented throughout the country, currently a reliable and valid instrument that effectively measures *Culture Change* has not been reported. The purpose of this study is to compare

the relationship between the reports of *Culture Change* to the staff turnover rates at each nursing home facility. By studying staff turnover rate, we hope to obtain a proxy measure for some aspect of *Culture Change*. The question that guided our research is: What are the differences in staff and leadership reports of the *Culture Change* indicators among Kansas nursing homes with high and low turnover rates? We hypothesized that staff and leaders in nursing homes with low turnover rates will report higher levels of *Culture Change.*

Literature Review

In the past, nursing homes followed the same model of care provided by hospitals, which emphasized efficiency, consistency and hierarchy for decision-making. Rosher and Robinson (2005) studied the effect of *Culture Change* on patient and family satisfaction. They described that when residents entered the traditional-styled nursing homes, residents would surrender all control to the staff under the assumption that the employees know what is best for the client. This left the elder with limited autonomy and the realization that adaptation to the rules and schedules of the facility may be the only option. The researchers defined the revolution in nursing homes as a dynamic change from a medical model toward a social model of care, known as *Culture Change*.

According to the Pioneer Network (2008), an organization of leaders striving to improve the quality of elder life in homes, communities, and long term care facilities, the beginnings of *Culture Change* in nursing homes can be traced back several decades. Although the initial movement was unofficial and not managed by any particular organization or committee, a goal was established to "create places for living and growing rather than for declining and dying" (Pioneer Network, 2008). Eventually, different models of *Culture Change* were developed and implemented throughout the country.

Eden Alternative model

One of the first and better known models of *Culture Change* is the *Eden Alternative*, established in 2002 at a 150-bed nursing home in the Midwest. Rosher and Robinson state, "Although the *Eden Alternative* is noted for the inclusion of animal, plants, and children to combat loneliness, helplessness, and boredom, its core philosophy is resident-centered care and the elder's right to choice and decision making." (2005, p. 190). Another vital dimension is the necessity of family involvement to help individualize the patient's care. Eden consumers believe that the family's input will help shape the care given by providing information pertaining to the resident's likes, dislikes, and hobbies. "Research has shown that homes that welcome high family involvement also have high family satisfaction ratings" (Rosher and Robinson, 2005, p. 189). They state this is especially important because of previous studies that revealed family involvement created tension for the staff because they viewed the families' presence as a sign that families didn't believe that proper care was being provided. In addition, some staff view family interaction as a distraction and interruption to the daily care given to the elders.

In their study, Rosher and Robinson (2005) conducted several educational sessions on the principles of the *Eden Alternative* over the course of a year. Every staff member attended an average of ten hours of education. The following year, the researchers interviewed the elders and their families who were part of neighborhoods (a concept of the *Eden Alternative* model). By surveying the residents, three main problems were identified and resolved: a) the residents' desire to include dogs as pets that could reside in the nursing facility, b) more time outdoors, and c) additional choices for meals. The facility continued to hold monthly meetings in which one of the ten Eden Alternative principles were discussed with the residents and families. Surveys that rated twenty-one areas of nursing home care were distributed to the residents and were compared to the same survey that was completed prior to the implementation of the educational intervention. As a result, seventeen out of the twenty-one areas improved drastically because of the *Eden Alternative* implementation. This study not only shows the positive effects of applying a social rather than a

medical model to a nursing home, but also provided researchers with insight into methods that could improve the *Culture Change* experience.

Other Culture Change Models

The following sections will briefly describe other models in efforts to provide a detailed description of the history of *Culture Change*. In 1990, Eric Haider founded the *Person Centered Care* model in hopes of improving the care given in nursing homes. Haider states,

> [Person Centered Care] gives personal attention to the people who live in Long Term Care and empowers staff to be a resident advocate. We believe in honoring each person's dignity, rights, self-respect, and independence by giving them choices, respecting their wishes, meeting their needs, involving them in decision making process, giving them the control of their life and keeping them actively involved, happy and as healthy as possible (Haider, n.d., p. 1).

Similar to the Eden Alternative, the model focuses on resident empowerment and returning the control to the elder. Resident advocacy was a new term not emphasized in the previous models. Instead of directing the majority of changes to the outer environment (i.e., adding gardens or pets), the Person Centered Care model shifts the responsibility to the staff and their actions.

The six dimensions of this particular Culture Change model include: creating neighborhoods to encourage teamwork and the feeling of community among the elders, respecting the residents by allowing them to make decisions, motivating residents to participate in activities by providing a variety of options, upgrading the dining to a buffet-style, encouraging resident to personalize their room by bringing belongings from home, and emphasizing the importance of continual growth (Haider, n.d.). The Cedars HealthCare Center, a Kansas nursing home, uses the Person Centered Care model and received a Peak Pioneer Award, an honor bestowed to nursing homes in Kansas

that exhibit exceptional outcomes of Culture Change. LeWoy Weddle, CEO of the Cedars, stated, "In my years in long-term care I don't think any change has been more important or more dramatic than the trend to person-centered care." (The Cedars, n.d.)

In the state of Pennsylvania lies the Live Oak Institute, a long-term care facility and originator of the *Regenerative Care* model since 1977. The *Regenerative Care* model, "views aging as another stage of life and respects individual needs. A regenerative nursing home allows residents more control over their lives." (Kovner, Feuerberg, & Eaton, 2001, p. 1) Barry and Debora Barkan, founders of Live Oak Institute, have been acknowledged for their contribution to *Culture Change* by numerous affiliations, including National Citizen Coalition for Nursing Home, California Department of Health Service (Barkan, 2005). Barkan's new model is described as an, "approach [that] shifts the focus from what elders need to what they can contribute and helps nursing homes create a culture of respect and support in which the elders have themselves become the antidote to the circumstances of civic disgrace that have institutionalized the environments that care for them" (Ashoka, 2004). In addition to residents having control over their decisions, the *Regenerative Care* model accentuates the need for the elders to reconnect to the community and to continue learning, emphasizing that age is not a number that means to cease education or wisdom (Kovner, Feuerberg, & Eaton, 2001).

The *Wellspring* model is an alternative style of *Culture Change* that utilizes the collaboration of several nursing homes to serve as a strong unit and foundation. Since 1994, the Wellspring Alliance has grown from the original eleven nursing homes to eighty facilities that either have adopted the *Wellspring* model or have joined the Alliance. The goal of the *Wellspring* model is similar to previous models in regards to improving the quality of resident care. However, the unique contribution of this model focuses on nursing home staff and leaders (Ashoka, 2004), "*Wellspring* believes the key to an improved resident experience and success is collaboration and

cooperation among facilities, staff empowerment, data-based decision-making and accountability between partner organizations for improved resident outcomes" (Well Spring, 2005, p. 1). Another factor that has made the *Wellspring* model successful is the emphasis of staff education. A select group of employees, known as the Care Resource Team (CRT), attended an educational conference to learn about the structure of the model and solutions to common problems. After this two-day event, the team returned to the facility to teach their coworkers.

By studying and comparing this sample of *Culture Change* models, similar ideas and methods can be identified. The center theme of the models is providing care that is focused on the residents. For selected models, this meant restructuring the facility to represent a home or neighborhood setting. Other options include increasing the choices provided to residents, including hobbies such as gardening, more dinner options, and a flexible living schedule. Proponents of the *Regenerative* model promote the understanding that older age does not limit an elder's ability to learn and continue growing. A final dimension reviewed in the *Wellspring* model is the need for proper staff education and leader involvement. When combined, these dimensions help create a strong *Culture Change* effect on traditional nursing homes.

Existing studies and knowledge have provided researchers with a clear vision and description of *Culture Change (*Scalzi, Evans, Barstow & Hostvedt. 2006; *Stone,* 2003). In order to better understand *Culture Change*, we need to understand what inhibits and also what promotes *Culture Change*. Nursing home organizations and institutions have developed and tested resident-centered care models throughout the past couple of decades. These studies have identified common barriers in order to make nursing homes more aware of potential problems. However, a current gap of knowledge that inhibits future research studies is the lack of an instrument that effectively measures the level of *Culture Change* in a nursing home setting.

Obstacles to implementing *Culture Change* include high turnover in nursing homes. Robinson and Rosher (2006) found that only one-third of the staff who participated in a survey still worked at the facility two years later when they attempted to resurvey staff about changes related to the implementation of *Culture Change* in an organization. High turnover rates not only affect the accuracy of the data collected, but most importantly, it affects the staff-resident relationship. High staff turnover in nursing homes is not uncommon. Turnover rates range from 30% to 143% for certified nurses aides (CNAs), from 27% to 61% for licensed practical nurses (LPNs), and from 28% to 59% for registered nurses (RNs). Improving staff empowerment and decision-making is one dimension of *Culture Change*. Examining the relationship between *Culture Change* and turnover has not been examined in previous studies. Consequently, the focus of this study is to determine if a relationship exists between turnover and *Culture Change*.

METHODS

A cross-sectional design was used to measure the dimensions of *Culture Change*. Using a secondary data analysis, the purpose of this study was to determine if there was a relationship among the dimensions of *Culture Change* and turnover in nursing homes.

Setting and sample

Data were collected from twelve purposely-selected Kansas nursing homes that were stratified by location and turnover. The sample had an equal number of urban (n = 6) and rural nursing homes (n = 6). Using turnover data from the 2006 Kansas Medicaid Report, seven facilities were in the top third of nursing homes and classified as high turnover (M = 108%; *Range* = 80% - 141%); five facilities were in the bottom third and classified as low turnover (M = 56%; *Range* = 41% - 67%). The number of beds at these nursing homes ranged from 52 to 104 beds, with the

median of 72 beds. There was a mix of ownership types: five were not-for-profit, six were for-profit, and one was not identified.

Within the twelve facilities, the total sample (N = 512) was comprised of 437 staff members including registered nurses (RNs), licensed practical nurses (LPNs), certified nursing assistants (CNAs), and other direct care staff (e.g., restorative aides, dietary staff, activity staff, etc.) and 75 leaders comprised of administrators directors/assistant directors of nursing, and department managers (e.g., environmental services, maintenance, etc.). The response rate for staff and leaders within the facilities ranged from 26 to 85 percent. There were no significant differences (p = .66) for response rates between high (M = 50%; SD = 17%) and low (M = 56%; SD = 12%) turnover homes.

Measures

The Colorado Foundation for Medical Care (CFMC), a project funded by Center for Medicare and Medicaid Services (CMS), developed six culture change constructs associated with the Commonwealth fund definition of culture change, and further delineated 25 key care practices. They found evidence in the literature that supports the relationship between a number of the care practices and resident outcomes (Palmer, 2007). Using the 25 care practices as the conceptual framework and the foundation for the development for the staff and leadership questionnaires, Bott and associates (2007) identified seven dimensions of *Culture Change.*

Six experts from the field of *Culture Change* in long term care were asked to read and rate the 86 items on the original instrument on a four-point scale (1= content is not relevant to 4 = content is highly relevant). The item content validity index (I-CVI) was computed for each item, and those items that met the established criteria of .78 or higher were considered acceptable (Polit & Beck, 2006). Of the 85 items, 54 met or exceeded the I-CVI criteria, 20 items were deleted, 12 items were revised, and 23 items were added for a total of 88 items used for pilot testing. Factor analysis and reliability analysis resulted in the final versions of the questionnaires that were used for this

study. Table 2 provides the numbers of items for each dimension along with the coefficient alphas for the seven dimensions of *Culture Change* for both the staff and leader versions of the questionnaires. All reliabilities exceeded the .70 minimum criteria for new scale development (Nunnally, 1978).

The staff version of the questionnaire was comprised of 73 items and the leadership questionnaire was comprised of 81items. Demographics characteristics were comprised of seven items representing gender, race, and ethnicity, education levels, role in the facility, shift worked, and length of time worked in the nursing home. The seven dimensions of *Culture Change* were resident care; home environment; relationships; staff empowerment; leadership; quality improvement; and shared values. Sample items for each of the dimensions are provided in Table 1. Table 2 reports the number of items in each dimension for staff and leaders. Response options for all dimensions except quality improvement range from 1(never) to 4(always). Resident-direct care and activities was comprised of nine items and was defined as the care and all resident related activities that are directed by the resident. Home environment was a 13-item scale that was defined as a living environment that was designed to be a home rather than an institution. The relationships dimension was depicted as the close relationships that exist between residents, family members, staff and community and was comprised of ten items. Ten items made up the staff empowerment scale that was defined as the work that was organized to support and empower all staff to respond to residents' needs and desires. Leadership was defined as management enabling collaborative and decentralized decision-making. There were nine items for staff and eleven items for leaders. Quality improvement was an eight-item (staff) to twelve-item (leaders) scale that represented the systemic processes that are comprehensive and measurement-based, and that are utilized for continuous quality improvement (CQI). The likert scale ranged from 1 (strongly disagree) to 4 (strongly agree) and had an option for staff to answer "don't know". Shared values represented a snapshot of *Culture Change* and measured the similarity of staff and leader views of

Culture Change. Each item was a marker items that represented each of the dimensions of *Culture Change.*

Additionally, leaders were asked two other questions. The first question was, "Is your nursing home currently involved in *Culture Change*?" The five response options ranged from 'no discussion of culture change' to 'culture change has completely changed the way we take care of residents'. The second question asked how many years their nursing home had been involved in *Culture Change* activities. The six response categories were 'not involved in culture change', 'less than 1 year', '1-2 years', '3-4 years', '5 or more years', and 'don't know'

Turnover rates were collected using the 2006 Kansas Medicaid Cost Reports. Kansas is one of the few states that reports turnover rates on the Medicaid Cost reports. Data from the 2007 Medicaid Cost Reports were not available at the time of this study. When comparing 2005 with 2006 turnover data, we found a moderately strong relationship (r = .69).

Procedures

The study received approval from the Institutional Review Board through the Kansas University Medical Center Human Subjects Committee. Surveys were distributed to staff and leaders following an in-service related to improving resident care that was provided by the research team. Leadership and staff completed surveys in separate locations to help ensure confidentiality of responses.

Data Analysis

Data were analyzed using SPSS/PC 15.0. Scale reliabilities were examined using co-efficient alpha, and demographic characteristics were summarized using frequencies. T-tests were used to test the hypothesis that staff in low turnover nursing homes would report higher *Culture Change* than staff in high turnover nursing homes.

RESULTS

Demographic characteristics of the staff and leaders of the nursing homes are presented in Table 3. The majority of staff were direct care staff, such as certified nursing assistants (CNAs), rather than registered nurses (RNs) or licensed practical nurses (LPNs). In addition, the staff members worked a variety of shifts, including days, evening, and nights, while the leaders worked primarily day shifts. The majority of leaders had worked at the nursing home between one and five years. On the other hand, one interesting note is that the majority of the staff had worked at the facility for less than one year, which is consistent with the high turnover rates found in nursing homes nationally.

For the staff, there was a significant ($p < .05$) difference between high (M=2.74) and low (M=3.38) turnover homes for the relationship dimension (See Table 4). Staff in the low turnover homes reported higher shared values for *Culture Change* (M = 3.45) when compared to high turnover homes (M = 3.01). However, this difference was not significant ($p \geq .05$) due to statistical adjustment to control for Type I error. Although there were not significant differences between the high and low turnover homes, the staff in the low turnover nursing homes reported higher levels of *Culture Change* on the other five dimensions (resident care, home environment, staff empowerment, management, and quality improvement).

For the leadership staff, there were significant ($p <.05$) differences between high and low turnover homes for the relationships and the leadership dimensions (See Table 5). Of the remaining five dimensions (resident care, home environment, staff empowerment, quality improvement, and shared values), all of the low turnover nursing home leadership staff reported that *Culture Change* was higher than in the high turnover homes even though the findings were not statistically significant after controlling for Type I error ($p \geq .05$). However, the leadership team reported higher staff empowerment (M = 2.60) than the high turnover nursing homes (M = 2.46).

Staff in low turnover homes reported higher levels of *Culture Change* across all dimensions of *Culture Change* than their respective leaders (See Tables 4 and 5). The findings in high turnover homes were not consistent. Leaders reported more home-like environments and staff empowerment in high turnover homes while their respective staff reported more resident-centered care and quality improvement initiatives.

DISCUSSION AND CONCLUSIONS

Partial support was found for the hypothesis that *Culture Change* was reported to be higher in low turnover nursing homes. Findings showed that both staff and leaders in low turnover homes reported higher levels of *Culture Change* related to the relationships among staff, residents, and their families. One might expect that when initiating *Culture Change*, staff and leaders may focus on improving the relationships between the staff and the residents along with their families in comparison to high turnover homes. Examples could include assigning the same staff members to the same group of residents or involving community participants and families in the activities of the residents.

Leaders also reported differences in the leadership dimension in nursing home that are reporting low turnover rates. Involving staff in decisions regarding resident care, showing respect for staff, and being available to talk with staff are ways that leaders can promote *Culture Change*. Generally, the leaders make decisions to implement *Culture Change* and the impact of this decision may not have extended to the other aspects of *Culture Change* if enough time has not elapsed.

Findings from our study indicate that nursing homes with lower turnover rates exhibited higher scores from both the staff and leaders on all dimensions of *Culture Change when* comparing them to high turnover homes. It is noteworthy that staff from the low turnover homes reported higher levels of *Culture Change* on all dimensions than their corresponding leaders. Based on the

principles of *Culture Change*, one might anticipate that staff and leaders would be more congruent in what they report than staff and leaders in nursing homes that have not implemented *Culture Change* principles. However, this remains to be tested in further studies along with the need for further evidence about whether turnover rates can be used to measure any aspects of *Culture Change*.

A limitation of this study was the small sample size of only twelve nursing homes. Further testing of the instrument in larger sample certainly is warranted. A second limitation was the convenience rather than random sample of nursing homes used for the study, thus limiting the generalizability of the findings. Only having turnover data that were available from 2006 for the 2007 data collection was another areas that could have affected the results of the study. Timeliness of available data is an issue when conducting studies of this nature.

This study provided beginning evidence that turnover was related to some aspects of *Culture Change* and possibly could be considered as a possible proxy measure in future studies. Further research also may be warranted in comparing the levels of *Culture Change* in a nursing home with satisfaction of the residents living in a particular nursing home.

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TABLE 1

Sample Items for the Seven Dimensions of Culture Change

Dimension	**Sample Items**
Resident Care	Menus are based on resident request Residents choose the time of day they bathe
Home Environment	Residents live in small households or neighborhoods This nursing home looks and "feels" like home
Relationships	Staff get to know residents as people Family members are involved in decisions about their loved one's care
Staff Empowerment	Certified aides take part in resident care plan meetings Staff are empowered to contact family directly when a resident has a personal need
Leadership	Nursing home leaders hire staff who really care, not "just anyone" Nursing home leaders are available to talk when staff need to talk
Quality Improvement	This nursing home has a plan for lowering turnover Staff ideas are used to reduce wasted time and effort
Shared Values	Nursing home leaders and staff share values and common goals related to: homelike environment and choice for residents

TABLE 2

Number of items and Co-efficient Alphas for the Seven Dimensions of Culture Change

	Staff		**Leaders**	
Dimension	**No. of items**	α	**No. of items**	α
Resident	9	.87	9	.88
Home Environment	13	.80	13	.76
Relationships	10	.85	10	.89
Staff Empowerment	10	.87	10	.84
Leadership	9	.88	11	.90
Quality Improvement	8	.90	12	.85
Shared Values	7	.95	7	.96

TABLE 3

Demographic Characteristics of Staff and Leaders (N = 512)

	Staff (*n* = 437)		**Leaders (*n* = 75)**	
	Category	%	Category	%
Role	RN	4.4	Administrator	13.3
	LPN	8.5	Director of Nursing	30.6
	CNA	42.8	Department Head	46.7
	Other	55.3	Other	17.3
Shift Worked	Days	57.0	Days	97.3
	Evenings	22.5	Other	2.7
	Nights	9.8		
Length of Employment	< 1 year	40.0	< 1 year	28.0
	1-5 years	37.6	1-5 years	50.7
	> 5 years	22.4	> 5 years	21.3

TABLE 4

Means, Standard Deviations, and p Values for Staff Reports on the Seven Dimensions of Culture Change

	Low Turnover ***n = 5***	**High Turnover** ***n = 7***	
Scale Scores	*M (SD)*	*M (SD)*	*p*
Resident Care	2.96 (0.41)	2.69 (0.51)	.37
Home Environment	2.74 (0.44)	2.52 (0.38)	.40
Relationships	3.38 (0.28)	2.74 (0.26)	.00**
Staff Empowerment	2.64 (0.30)	2.25 (0.39)	.10
Leadership	2.95 (0.34)	2.63 (0.40)	.18
Quality Improvement	3.32 (0.42)	3.11 (0.26)	.34
Shared Values	3.45 (0.36)	3.01 (0.30)	.05

**Significant at $p < .01$ level using bonferroni correction

TABLE 5

Means, Standard Deviations, and p Values for Leaders Reports on the Seven Dimensions of Culture Change

	Low Turnover ***n = 5***	**High Turnover** ***n = 7***	
Scale Scores	*M (SD)*	*M (SD)*	*p*
Resident Care	2.88 (0.37)	2.55 (0.47)	.22
Home Environment	2.74 (0.37)	2.66 (0.28)	.66
Relationships	3.03 (0.19)	2.75 (0.18)	.03*
Staff Empowerment	2.60 (0.14)	2.46 (0.12)	.05
Leadership	2.84 (0.22)	2.61 (0.10)	.03*
Quality Improvement	3.01 (0.18)	2.85 (0.17)	.15
Shared Values	3.14 (0.23)	2.96 (0.18)	.18

*Significant at $p<.05$ level using bonferroni correction

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