JOB SATISFACTION OF SOCIAL WORKERS IN NURSING HOMES:

TYPE OF FACILITY AND CULTURE CHANGE AFFILIATION

By

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ABSTRACT

Abuse, neglect, and deficits in quality of life still persist for residents in the nation's nursing homes. Best practices in this area recommend the implementation of humanistic, culture change initiatives to ameliorate this situation. However, there is scant research on the subject of culture change, and fewer still on social workers in culture change nursing homes. The studies that do exist have been affiliated with hospital settings, finding that the implementation of culture change had little to no impact on the job satisfaction of social workers. To test these findings, and further explore the role of social workers in non-hospital affiliated nursing homes, this study sent out 700 job satisfaction questionnaires to social workers in 12 mid-western states. The study looked at job satisfaction in regard to nursing home type (traditional, combination, humanistic), as well as culture change affiliation. Using a General Linear Model (GLM), it was found that in regard to nursing home type, the humanistic category had a higher level of job satisfaction than did the traditional or combination types. It was additionally found that social workers who identified themselves as practicing in a culture change nursing home had a higher level of job satisfaction than did those social workers not employed in a culture change home. These findings were statistically significant. It was concluded that at least in non-hospital settings, both nursing home type (traditional, combination, humanistic) and culture change affiliation did have a positive impact on the job satisfaction of nursing home social workers. Further empirical studies of social workers in culture change nursing homes are highly recommended and essential to the continued deliverance of resident-centered services that enhance the quality of life for nursing home residents.

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I must add that I have felt the presence of my mother throughout this process, and cannot help from being uplifted by her short life and her unconditional positive regard for me. I often attempt to summon her strength, endurance, and ability to laugh through adversity. By far, she was the biggest influence in my life. I therefore dedicate this endeavor to the memory of my mother:

Edna Louise (Taylor) Dye (1933 – 1988)

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CHAPTER 1

INTRODUCTION

Despite decades of consumer and media outrage, legislation, and various attempts at reformation, residents in nursing home (NH) facilities still experience a poor quality of care and quality of life (Castle & Mor, 1998; Pioneer Network, 2010; Weiner & Ronch, 2003). For many older, dependent Americans, the thought of spending the end of their lives in a nursing home is a fearful prospect. In fact, given a choice, elders consistently state they would rather die than be placed in any sort of long-term care facility (Kane & Kane, 2001). In part, this fear stems from the many decades of abuse and neglect suffered by nursing home residents.

The humanistic trend in nursing homes today is derived from two separate approaches. The first has its origins in the business world, derived from theories of organizational change in the past. During the industrial age, administrative authority and power was soon established by the bureaucratic hierarchies as theorized by Max Weber. Following World War II, even though the bureaucratic approach strongly continued, change theorists such as Edwards Deming branched off from the bureaucratic trend, and began to implement more humanistic approaches in organizations. One way to explore the humanistic organizational approach is to develop a way to classify nursing homes in terms of their organizational style. In this study, for example, an overarching classification of nursing home types was developed, to include a traditional nursing home type, one that is humanistic, and a combination type of nursing home.

The second approach is consistent with the history of social, moralistic, or ethical movements that are concerned with social justice, addressing the quality of life of people in society. This approach, although perhaps provided historically to institutionalized elders by more caring individuals or personal caregivers, did not become prevalent until society and legislative

bodies became aware of the abuse and neglect of residents. A full response to the quality of life issues facing residents did not occur until the Nursing Home Reform Act (NHRA) of 1987 was enacted. For the first time, federal law made it clear that the quality of life of nursing home residents was equal to the quality of care they received. From this legislation, many piecemeal efforts were made to address the quality of life of residents. The premiere effort to date has been the "culture change" movement, a humanistic approach that is resident-centered, and dedicated to resident self-determination.

The Organizational Evolution of Nursing Homes

Due to the abbreviated lifespan of people in early American society, many people today would assume that aging was not a problem to be addressed during that period. However, in seventeenth century Massachusetts, the public's response to poverty did include a concern over poverty and advanced age (Trattner, 1999). During that time, and into the eighteenth century, when an individual became dependent due to infirmity or illness in old age, families were expected to assume all responsibilities in regard to nurturance and care. For those without familial ties, small townships often provided assistance to their elderly residents in the form of direct care (feeding and clothing), or by fostering older individuals in private homes or domiciles (Tobin, 2003).

As the population grew, and more individuals became dependent on their local townships for aid and support, it soon became apparent that the mere provision of food or clothing was inadequate in providing the amount of care needed by all segments of the local population. This gave rise to the idea that public aid would be more efficiently delivered in an institutional setting, most notably in county almshouses or poorhouses of the day. Following the example of the

Elizabethan Poor Laws, those placed in such settings were considered “worthy” of assistance, particularly if they were physically infirm or otherwise displaying conditions beyond their control (Trattner, 1999).

In the early twentieth century, although life expectancy was low by today’s standards (around fifty years), being old, dependent and poor was beginning to be recognized as a problem (Dunkle, 1984). Institutionalization for the dependent elderly without friend or family connections evolved into housing for those with more illness and incapacity, and soon became the norm whether an individual had family or not. These homes for the aged, developed by religious groups, began to make their appearance (Tobin, 2003).

Population increases in the twentieth century created more urbanization and changes in multi-generational family structures. Consequently, there arose a need for family substitutes, especially for older individuals who were mentally ill, impoverished, or socially isolated (Tobin, 2003). The answer was the for-profit boarding home, the forerunner of the modern day nursing home. During the 1920s and beyond, the nation saw an increase in the development of proprietary nursing homes, where profit was often valued over the well-being of the resident. Conditions were often cited as deplorable and unsafe, with many residents suffering from exploitation, neglect, or abuse. Even though the enactment of the Social Security Act in 1935 did make some provisions for economic aid directed at the elderly population (Old Age Assistance), this was not extended to nursing home residents (Trattner, 1999).

The Medical Model and Nursing Homes

Following World War II, nursing homes became medicalized, reflected not only in their hospital-like architectural designs, but in how they were organized internally (Vladeck, 1980).

While the 1950s saw occasional ripples in the media, citing negative quality of care in NHs across the nation, it was not until the 1961 publication of Erving Goffman's book *Asylums* that the public became aware of the deplorable state of institutional care. In his book, Goffman indicted prisons, nursing homes, and other aggregate institutions for their environments of neglect and abuse, created by bureaucratic hierarchies and the need for efficiency. He referred to these facilities as "total institutions," where residents were socially controlled through rigid, inflexible schedules and regulations.

The passage of Medicare and Medicaid in 1965 did offer financial assistance for the elderly poor who required medical care in nursing homes. However, this further medicalized nursing homes, and the stringent regulations that followed only created difficulties in NH compliance. The need for efficiency, attained through scheduling and timetables that essentially deny a resident personal freedom and a sense of being in a homelike environment, is an unfortunate outcome of the medical model. Oftentimes, the result was an environment ripe for abuse and neglect (Vladeck, 1980). During the remainder of the 1960s, and especially during the 1970s, the media as well as the academic community began to expose the neglect and abuse of the elderly in nursing home facilities (Butler, 1975; Mendelson, 1974). In the 1970s and beyond, many nursing homes began to focus on temporary or short-term programs and interventions. These efforts were designed to enhance resident quality of care and quality of life, in an attempt to bring efficiency and quality closer together. However, these piecemeal initiatives did not transform the culture of the medical model. As most nursing home reformers have noted, the entire complex of nursing homes must be transformed before a new culture can be embedded (Tobin, 2003).

Humanistic Organizational Trends

The underpinnings of humanistic organizational trends are found in organizational change theory. Corporate culture and its influence on an organization's effectiveness have been studied as far back as the 1930s (Scott, Mannion, Davies, & Marshall, 2003). As previously mentioned, the work of Max Weber and his theories on bureaucracy and hierarchical authority, as well as the seminal work of W. Edwards Deming, have been influential throughout the 20th century in examining corporate management and the traditional hierarchies that exist within them. Deming especially noted that hierarchical organizations often lead to poor quality outcomes, low job satisfaction in workers, management styles that prohibit collaboration, and little concern for the expressed needs of customers. Deming's work is more currently echoed in Kotter's eight-step process of corporate culture change (Kotter, 1996), and Senge's focus on organizational learning (Senge, 1990). These organizational change models have variously influenced the social services arena, most notably described in the work of Charles Glisson (2007). His research on the social context of organizations, and the importance of culture and climate in organizational change, parallels the tenets found in the humanistic trends found in nursing home organizations today.

The Evolution of the Culture Change Movement

In 1980, Bruce Vladeck published *Unloving Care: The Nursing Home Tragedy,* exposing institutional policy blunders and the consequent abuse and neglect of NH residents. Due in part to this publication, additional public outcries, and the media's exposure of deplorable and punitive conditions in nursing homes, legislators in the 1980s requested that the Institute of Medicine (IOM) investigate the entire NH industry (IOM, 1986). Following the inquiry, the IOM came back with a number of recommendations that addressed not just quality of care issues, but

quality of life as well. With few changes or alterations, the recommendations proposed by the IOM became law in 1987 through the enactment of the Nursing Home Reform Act [NHRA], part of the Omnibus Budget Reconciliation Act [OBRA] of 1987. Through the NHRA, OBRA mandated an exacting set of reforms that placed quality of life on a par with quality of care entitlements.

OBRA's Sweeping Reforms

In stipulating that quality of life be commensurate with quality of care, regulations under OBRA put forth the most sweeping set of reforms to date, addressing not just the abuse and neglect of NH residents, but mandating minimal standards of clinical and psychosocial care. For the first time, social workers in NHs were given specific mandates to deliver psychosocial services to residents in this setting. Despite this, OBRA has been nebulous about the criteria to be met by those providing such services. For example, federal law states that skilled nursing facilities (SNFs) with 120 or more beds must hire a full-time social worker with at least a bachelor's degree in social work (BSW) or an individual with similar professional qualifications (OBRA, 1987). Therefore, many individuals given the title of "social worker" in the nursing home may not have a social work degree, yet are viewed the same as those who do. In addition, while nurses, frontline workers, and others in nursing homes are required to be licensed or certified, there is no such mandate for social workers in this environment. The lack of consistent standards under OBRA for NH social workers undermines the professionalism of social workers, and sets the stage for the underutilization of social work knowledge and skills in this setting. OBRA has therefore been criticized as laying the groundwork for the subordination of the social work role throughout the NH industry. Nursing home reformers, including NASW, have

advocated for an amendment to social work standards in OBRA's legislation, to include licensure and adequate levels of education and training (NASW, 2010).

Despite NHRA, the NH industry continued to have difficulties in quality of care and quality of life domains. The medical model has been the primary approach embedded in nursing homes across the nation and its inflexible tenets and emphasis on efficiency have done little to actualize the intentions of this legislation. Throughout the years, the passage of OBRA '87 has not resulted in the development of humanistic cultures or quality of life enhancements (Tobin, 2003). Subsequently, reformers at the present time are focused on introducing humanistic culture change models into the NH industry, in an effort to transform the traditional medical model.

For the last decade or so, the predominant effort to address quality of care (QOC) and especially quality of life (QOL) deficits for elders has involved reformist approaches that are exclusively resident-centered, and pervasively referred to as *culture change* (CC). Unlike reformist efforts in the past, proponents in the culture change movement are not focused on piecemeal changes or enhancements to existing programs. Instead, the intent is to transform the existing culture of the traditional or medical model so facilities will provide an environment that is homelike and centered on the needs and desires of resident elders (Lustbader & Williams, 2006; Misiorski & Kahn, 2005). The culture change approach provides care ". . . that is respectful of and responsive to individual patient preferences [and] needs . . . ensuring that patient values guide all clinical decisions" (Reynolds, 2003, p. 399). Pertinent to the context of nursing homes, "culture" involves the patterns of meaning that keep an organization together through the values and beliefs shared by all employees (Siehl & Martin, 1984).

Nursing homes adopting an approach from the culture change movement emphasize the dignity and worth of residents and staff, and in developing environments that promote the

enhancement of each person as a unique individual (Rahman & Schnelle, 2008; Tobin, 2003). The needs and desires of resident elders provide the driving force, and set the standards for care and service delivery (Castle, Ferguson, & Hughes, 2009; Gilbert & Bridges, 2003). Elders residing in a culture change environment are given self-determining opportunities to choose and define their level of care, personal involvement in activities, and other features that are significant to a quality of life. This might involve choices of when and where to eat meals, to forego invasive and non-essential treatments, or to make personal decisions regarding one's total experience within the NH facility. Rules and regulations can become flexible to maximize needs and desires. For residents suffering from Alzheimer's Disease or other cognitive impairments, culture change reformists suggest that choices reflective of a resident's desires can be uncovered through information obtained from relatives, friends, or even staff members who know the essential nature of the resident. In this way, quality of life can be maintained, even when choices are obtained by proxy (The Joint Commission, 2009; Pioneer Network, 2010; Weiner & Ronch, 2003).

Minimal Culture Change Research

Although the concepts within the culture change movement have been pervasively disseminated, empirical assessments of such are extremely limited, with most claiming success with anecdotal reports and/or case studies (Rahman & Schnelle, 2008). In addition, these studies often focus on NH nurses or certified nursing assistants (CNAs), with scant attention paid to the role and importance of social workers in these settings. This is a serious omission for several reasons. First, nursing homes today are responding to market forces and the demands of the baby boom generation, and find themselves in the throes of inevitable change and transformation. In this working environment, social workers are in the midst of this upheaval, and how they

respond to this new direction will not only determine their role in the nursing home arena, but whether they will remain a core discipline in this setting (Gibson & Barsade, 2003). Second, if culture change is indeed a "best practices" approach, social workers have much to offer, since the tenets and strategies of resident-centered care are integral to the values, knowledge, and skills of the profession.

Social Work's Lack of History in Nursing Homes

Social work's documented history does not reflect an official association with the aging population or long-term care settings. Prior to the 1960s, the social work profession adopted scientific approaches, such as those consistent with psychoanalysis, along with prevailing theories on aging. Not unlike many other professions of the day, the social work profession reflected society's values and beliefs on aging, ultimately affecting its future trajectory. Just as these influences set social work on a path away from the field of aging during the first half of the twentieth century, a different set of social values and priorities would result in the profession's entrance into this neglected area, to include the nursing home setting.

In the social work profession, NASW officially acknowledged the field of aging with a 1960 seminar discussing practice methods with the elderly population. This marked a change in focus for the profession, where practice and predominant theories of aging were newly examined (Lowy, 1985). Even though this marked an official recognition of aging and related concerns or issues, textbooks and curricula in aging did not appear in schools of social work until several years later (Luptak, 2004). Also during the 1960s, the nation was soon to experience the unveiling of social issues and problems that were previously unknown by the public on a wide scale. Child abuse, racism, ageism, poverty, and women's issues were only a few of the many areas of concern during this decade. Investigations uncovering the deplorable conditions in

nursing homes and other institutions affirmed the need for reformation and government assistance.

The Ecological Perspective

The unrest of the 1960s, due to social issues and the overall protest of the Vietnam War, greatly influenced the social work profession, as the focus shifted to the injustice of institutional systems on various groups, including elders. The environment was being assessed not just contextually, but as a causative agent for social ills. Individuals were beginning to be viewed not so much as being defective or pathological, but as disadvantaged or innocent victims of their environments. Strategies for social justice included attempts to provide adequate housing, or to implement programs specifically designed to impact the environments of low socioeconomic areas.

Concepts about environments became evident through Ecology, a science concerned with the interaction of organisms with their environments and each other. The scientific approach of ecology served as a metaphoric exemplar for social work theory and practice. Germain (1973) introduced the ecological perspective in social work. Even though Germain was not the first, what sets her ecological perspective apart from similar modes of thinking is that she noted the reciprocal transactions that occurred between a person and the environment, involving mutual and influential exchanges.

The ecological perspective in a nursing home setting is an appropriate lens through which to view not just individual residents, but mezzo and macro interactions as well. With Germain's development of the life model, a practice approach was derived from the ecological perspective, allowing social workers to view residents in their nursing home environments. Concepts in the life model emphasize relationship-building, adaptation, and personal client strengths (Germain &

Gitterman, 1996). Hallmarks of the ecological perspective are congruent with the culture change movement and its emphasis on the easing of power differentials, the formation of mutuality in relationships, and the adaptation of residents and staff to the nursing home environment.

Nursing Home Social Workers Today

The plight of social workers within the NH environment has gained attention, reiterating problems and needs that are challenging and difficult to ameliorate. More specifically, within the nursing home setting, social workers are not required to possess a social work degree and subsequently suffer from inadequate training and preparation (Allen, Nelson, & Netting, 2007; Hooyman & Thompkins, 2005; Liley, 2002), are overburdened due to excessive tasks and responsibilities (*Department of Health and Human Services* [DHHS], 2003; O'Neill, 2002; Tirrito, 1996; Vourlekis, Zlotnik, Simons, & Toni, 2005), and not held to the same standard as other NH staff in regard to certification and/or licensure, as noted by the *National Association of Social Workers* (NASW) in 2009. All these factors ultimately impact the quality of services provided to nursing home residents, and the job satisfaction and retention of social workers within this setting.

Measurable outcomes for social work practice in nursing homes are virtually nonexistent, with facilities often neglecting social worker professional services for the sake of cost containment (Rizzo, 2006; Vourlekis, Zlotnik, & Simons, 2005). Underutilization of social worker professional skills is rampant, and other departments often "dump" inappropriate tasks on social workers. This might include putting labels on resident clothing, shopping for residents, searching for dentures or eyeglasses, tidying rooms, picking up laundry, or distributing mail. These tasks often prevent social workers from fulfilling their federal mandate to attend to the psychosocial needs of nursing home residents (Allen, Nelson, & Netting, 2007).

The role ambiguity that ensues from these issues often results in lower levels of job satisfaction for social workers, leading to burnout, frustration, stress, turnover, and deficits in service delivery (Ammon, 2005; Lloyd, King, & Chenoweth, 2002; Solomon, 2004). It also emphasizes the lack of respect for social workers in this environment, further exacerbated by the power differentials that proliferate in the NH setting (Jervis, 2002; Koren & Doron, 2005). This is further evidenced by the "topdown" hierarchical management style of the traditional medical model nursing home, placing social workers as subordinate to administrators, nurses, and other staff members (Allen, Nelson, & Netting, 2007). One speculates that the lack of licensure or certification of social workers, or the lack of a professional degree in those who are not trained as social workers, may leave trained social workers vulnerable to these abuses. What may also result is a lack of self-esteem, as social workers internalize the lack of respect owed to them as individuals and their professional knowledge and skills.

The Need for Nursing Home Social Workers

In many respects, the social work profession is still developing its presence in nursing homes. In fact, throughout social work's history, the profession has all but ignored the field of aging, with a shortage of literature or documentation substantiating its involvement in the nursing home setting (Cox & Parsons, 1994; Luptak, 2004). With the aging of America, and especially the aging of the baby boom generation, there will be an expanded need for NH social workers in the future. By the year 2050, the number of elders requiring nursing home placement will quadruple, reaching 6.6 million (*U. S. House of Representatives*, 2001), challenging the resources of communities across the nation (*Institute for the Future of Aging Services* [IFAS], 2007). Many NHs are facing bankruptcy, lowered occupancy rates, and a loss of personnel. In fact, the nationwide cost of turnover in the NH industry is over $4 billion annually (*American*

Association of Homes and Services for the Aging [AAHSA], 2008). During the last decade, a NH with a high turnover rate might spend as much as $240,000 annually on recruiting and training new frontline workers alone (Hegeman, 2003). With over 16,000 nursing homes in the country, housing approximately 1.4 million residents (*AAHSA*, 2008), staff turnover, lack of training, and the medical model's hierarchical organizational style have already emerged as crucial dilemmas for the NH industry, society, and the social work profession. The need for a full panoply of SW knowledge and skills in NHs is crucial, making the current status of social workers an imperative issue both now and for the future.

Many consider the approaches of the culture change movement as a "best practices" model for nursing home reform. Best practices in a nursing home setting may generally be defined as any practice or technique that is widely accepted as providing an optimal, effective result (Armenakis & Harris, 2002; Baird, Hu, & Reeve, 2011; Farkas, 2013). In the context of the nursing home setting, the intended result is an increase in the quality of care, and especially the quality of life, of residents through the transformation of the medical model. Though there is strong anecdotal evidence that approaches in the culture change movement have a positive influence on the quality of care and quality of life of nursing home residents, it is obvious that more research into the culture change movement needs to be conducted (Rahman & Schnelle, 2008), especially in regard to social workers (Lubetkin, Annunziato, Downs, & Burak, 2005). According to the Bureau of Labor Statistics (BLS), there are approximately 12,000 social workers employed in nursing homes nationwide, with a need for an additional 2000 projected for the year 2016 (BLS, 2009), for a total of 14,000. This highlights the importance of social workers in the NH environment, especially if humanistic organizational approaches or culture change models are to be predominantly employed in the future.

Research Questions and Job Satisfaction

This research study explored two fundamental questions in regard to the job satisfaction of nursing home social workers. One relates to the organizational and/or managerial trends of current nursing homes, by specifically exploring the traditional, humanistic, or combination nursing home types. In effect: (1) Does a specific type of nursing home have any relationship with the job satisfaction of nursing home social workers?

The second question relates to the models included in the culture change movement. Specifically: (2) Do social workers who identify themselves as practicing in a culture change nursing home have a different level of job satisfaction than those not practicing in a culture change facility?

The answer to these two questions sets the stage for further examination. Some would argue that the humanistic nursing home type of the organizational approach and the models of the culture change movement are virtually the same. If that is true, then the social workers identifying themselves as practicing in a culture change nursing home should be represented by the humanistic nursing home type. To determine if they are the same (or distinct from each other), a third question emerges: (3) Do the number of social workers in culture change nursing homes coincide with the number of social workers in humanistic types of nursing homes?

In order to explore these questions, this study utilized a mailed, self-administered questionnaire to analyze the job satisfaction of social workers in the nursing home environment. The survey consisted of 39 items, adapted from a job satisfaction instrument developed by Lubetkin, Annunziato, Downes, & Barak (2005). In 2010, the survey was sent to 700 nursing homes in 12 mid-western states. These states were selected to better ensure homogeneity. Nursing homes were selected from an online compilation of nursing homes from *Nursing Home*

Compare, developed by the Centers for Medicare and Medicaid Services (CMS).

Job satisfaction was specifically explored for several reasons. First, empirical research has suggested that satisfaction may be related to quality service delivery, job motivation, organizational commitment, as well as stress, burnout, and turnover. Although there are a multitude of job satisfaction components one might research, this study specifically utilized an instrument that explored domains that social workers have identified in past studies as being essential to their practice and job satisfaction in the nursing home setting. These include empowerment, collaborative teamwork, supportive supervision, shared organizational values, available resources, and resident-centered care (Deutschmann, 2001; Gleason-Wynn & Mindel, 1999; Jeong & Keatinge, 2004; Morley & Herarty, 1995; Moyle, Skinner, Rowe, & Gork, 2003; Proenca, 2007; Reinardy, 1999; Seibert, Silver, & Randolph, 2004).

CHAPTER 2

THEORETICAL FRAMEWORKS

The entrenched and inflexible tenets of the medical model have often been touted as a primary impediment to a nursing home resident's personal freedoms and quality of life. The predominant example given by nursing home reformers is the existence of resident abuse and neglect, a problem that has plagued traditional medical model facilities since at least the 1950s and beyond. At the current time, resident abuse in nursing homes is still a rampant problem, as cited by the media, the government, and in academic journals (Choi, Wyllie, & Ransom, 2009; Harris & Benson, 2006; Lyons, 2010; Ulsperger, 2009).

Nursing Homes and Resident Abuse

Abuse is a complex issue, but many reformers believe that NH abuse is often the result of stringent medical protocols that focus more on efficiency and task completion, rather than the quality of life of resident elders. This is not a new phenomenon. In fact, the enactment of NHRA in 1987 was initiated in great part due to reports of abuse and neglect of resident elders in nursing home facilities. Although OBRA set quality of life standards as commensurate with quality of care dimensions, residents in today's traditional, medical model nursing homes are still " . . . denied their privacy, dignity, and basic humanity" (Olson, 2006, p. 292).

When NH residents experience physical pain, harmful injuries, or psychological distress due to intimidation, punishment, or the infliction of personal injury, this falls under the definition of abuse (Muehlbauer & Crane, 2006). It can also include the direct withholding of needed resources or services that are required to maintain an individual's psychological or physical health (*American Psychological Association*, 2006). There are several different types of abuse

that seem to be evident in the NH setting, to include physical harm, neglect, psychological distress, and sexual abuse (Muehlbauer & Crane, 2006).

Clearly, there are a multitude of risks for NH residents in terms of abuse, and it would be far too simplistic to identify the medical model as the primary agent in a cause and effect dissection of the problem. However, it might be fair to say that the medical model sets the stage for opportunity, due primarily to its focus on clinical protocols and efficiency. This extends to the timed delivery of medications, completion of ADLs, mealtimes, and other scheduled services that are deemed necessary components of physical care, but often evoke feelings of being "imprisoned" by resident elders (Goffman, 1961; Vladick, 1980/2003). The emphasis on the completion of duties that may include quotas and excessive achievement levels is inevitable under the medical model. This often results in high levels of staff frustration, stress, and the inability to focus on the personal needs and desires of residents. This creates a nursing home environment that is vulnerable to resident abuse.

Culture Change and Quality of Life

By contrast, the culture change movement places residents at the forefront, with all services designed to meet their specific needs. This approach does not forego the clinical or medical requirements of residents, but places these protocols in a more flexible context. There is a purposeful reduction of restrictive protocols in regard to residents' self-determination, and especially in their ability to make choices and control their "home" environment. Included in the culture change movement is a "neighborhood" concept, where CNAs and other staff are given consistent assignments with the same residents. This approach establishes everyday opportunities to build meaningful relationships and personal knowledge of the resident's needs and desires. The medical model's emphasis on the efficient delivery of clinical services, narrowly focused on

the physical aspects of an individual's care, is considered obsolete and antithetical to a resident's quality of life. The culture change movement promotes an agenda that counteracts resident abuse with relationship-building, trust, and active listening, all purposely designed to enhance each resident's full participation in life. The following table compares the medical model with the culture change approach:

Comparison of Medical and Culture Change Models

Medical Model	Culture Change Model
Organizational Style: Hierarchical "topdown" management style; emphasis on medical protocols/efficiency.	*Organizational Style:* Interactive management style; humanistic; focus on the worth and dignity of residents.
Staffing Parameters: Multidisciplinary staff work with limited collaboration; decisions made by superiors.	*Staffing Parameters:* Multidisciplinary staff work collaboratively as teams; autonomous decision-making.
Resident Choices: Resident services determined by staff; decision-making not encouraged.	*Resident Choices:* Resident-centered care. Residents determine care/services; decision-making encouraged.
Resident and Staff Interactions Efficiency over relationship-building; residents viewed pathologically.	*Resident and Staff Interactions:* Relationship-building crucial; residents seen as evolving, with skills, talents, capacities.
Capacity for Organizational Change: Often resistant to adopting new trends, concepts or alternative models of care.	*Capacity for Organizational Change:* Embraces change, and adopts new models of care; progressive; QOL drives change.

Table compiled from Weiner & Ronch (2003).

In order to understand the importance of these two different models on staff performance and job satisfaction in the nursing home setting, it is necessary to understand the development of these two different perspectives.

Theories in Organizational Management

Max Weber's Bureaucracy

Although the table above demonstrates that the two models for nursing homes are very divergent, it can be argued that the culture change model grew out of the problems created by the medical model, the latter derived from the bureaucratic model of organization developed by Max Weber, a classical organizational theorist. Weber is renowned for his theories of bureaucracy and the hierarchy of authority. In his view, the concept of bureaucracy was basically a matter of administrative control, built on a strong foundation of acquired knowledge. Administrative control was the means by which organizational power was acquired in organizations, carried out by various types of authority (Bennet, 2006; Collyer, 2008; Hinings & Greenwood, 2002). In this context, he believed there was a difference between authority and power. In organizational power relationships, an individual could utilize a dominant stance over another by personal whim or arbitrary mandate. Power used in this way made no attempt to understand or give credence to the opinions, wants, or needs of any member of the organization, especially below the power rank. In essence, no resistance was tolerated, in any form. Authority was established when organizational members legitimized the existing power, and accepted it as the ultimate purveyor of an organization's mission, culture, rules and/or regulations (Di Padova, 1996; Hopfl, 2006).

Weber discussed the classification of different types of organizational authority, to include: (1) charismatic authority, derived from the personal characteristics of an individual in a leadership role, especially if that authority is "inherited" or somehow bestowed; (2) traditional

authority, coming from the belief in entrenched customs or modes of thinking; and (3) rational legal authority, based on rules, codes, or other regulatory features (Di Padova, 1996; Hinings & Greenwood, 2002; Hopfl, 2006).

Since the rise of capitalism, rational legal authority has been the primary vanguard of organizations, a substitute for eminent "raw" power, or authority based on practices from the past. In Weber's estimation, a bureaucracy, which he considered the most efficient form of organization, is the primary means by which rational legal authority is realized. Imparted in this view is the notion that a formal set of rules or regulations should be enacted that affect all in the organization, that are dispassionately enforced, and requiring obedience from all organizational members (Collyer, 2008; Di Padova, 1996; Hopfl, 2006).

Weber's bureaucratic approach establishes divisions within an organization based on clear hierarchies, each with a specific level of authority. The top level of the hierarchy sets the agenda or production goals, which is relayed to the next lower hierarchy, further processed or sent to the hierarchy below that, and so forth, creating an efficient "topdown" managerial style that is driven by a strict adherence to the rules or regulations of the organization. Concerns or complaints of employees are mediated through the office or "bureau" of a specific hierarchical level, where the chain of command is respected, and the rules governing the office are obeyed (Balle, 1999; Di Padova, 1999; Warner, 2007).

It should be noted that Weber did not believe in the more modern and often stereotypical belief that bureaucracies are slow to respond, inflexible, inefficient, and abounding with "red tape" or redundancies. In fact, Weber was concerned with developing management theories to eliminate the dysfunctional nature of 19th century organizations, characterized by excessive despotism, bribery to attain office, inequities in treatment, and other corrupting influences or

behaviors (Collyer, 2008; Trattner, 1999). To Weber, a bureaucracy was a rational approach to administrating organizations, where hierarchies were essential for success. Bureaucracies therefore consisted of specific characteristics, commonly seen in many organizations today: (1) Rules and regulations that are known by all members of the organization, serving as a foundation for continuous management in the workplace; (2) hierarchies with very specific functions, where all members are aware of organizational expectations and the scope of their authority; (3) impersonal enforcement of the rules across the board, promoting equitable treatment; (4) selection of individuals to specific posts or offices made on the basis of their qualifications through the attainment of a diploma or by passing an examination, thereby eliminating favoritism and selection bias; (5) stipends determined by the organization's hierarchy, where members receive remuneration according to their ascendant position in the hierarchy, with higher ranks receiving higher salaries; (6) promotions within the organization determined by seniority or individual merit, the latter assessed by supervisors or those with a higher level of authority; (7) strict separation between private life and the working life of each organizational member. Individuals should be emotionally detached and fixated on work responsibilities, with no outside interference (Hopfl, 2006). Although Weber believed that a bureaucratic form of management was the only rational approach to the rise of capitalism and the formation of organizations, he also voiced a fear of the bureaucratic system. In particular, Weber noted a dichotomy between individual freedom and the bureaucratic need to control (Bartels, 2009; Di Padova, 1999). Individual freedom touches on worker self-determination and humanistic regard, while hierarchical control diminishes creative thought, requiring obedience through the adherence to rules and regulations. Weber believed that there was purposeful rationality in the realm of capitalism, but noted that the inevitability of bureaucracy in a

capitalistic system would place individuals in an “iron cage” from which they could not escape (Du Guy, 2000; Hopfl, 2006; Weber, 1922/1978). Weber therefore believed that the fallout of a bureaucratic system was a loss of fundamental freedoms and personal values.

Weber did not live to see the world’s embrace of the bureaucratic hierarchies that he idealistically described. However, there is no doubt that Weber would agree that while hospitals, nursing homes, and other organizations have incorporated bureaucratic, hierarchical management approaches, they have also suffered the various sociological and humanistic problems he envisioned in a bureaucratic system. Hierarchical bureaucracies that exist in nursing homes and other institutional settings have been characterized as promoting marginalization, alienation, and loneliness (Warner, 2007). In this respect, bureaucracies in these systems are fundamentally about constraint and overall domination, as articulated in the writings of Goffman (1961).

In regard to the entire health care complex, the bureaucratic, hierarchical approach does create a particular culture and climate that promulgates and legitimizes medical expertise and professional control (Collyer, 2008; Redfoot, 2003). In the NH environment, this extends to the everyday life of resident elders, to include inflexible scheduling for mealtimes, social activities, getting up or going to bed, the administration of medications, and the like. The medical model, strengthened by regulatory mandates, creates a dynamic that impacts not just a resident’s quality of life, but the job satisfaction of nursing home staff as well (Weiner & Ronch, 2003).

The power of the medical model in nursing homes is derived from medical knowledge and technological innovations throughout the profession’s history, with an emphasis on the human body as a series of mechanical functions. From the medical viewpoint, illness or disease was believed to be the direct result of mechanical malfunction, breakdown, or failure. The mechanistic paradigm was in contrast with the more general view that human beings were part

of the world's "natural" order, a combination of body and mind. As medical information and technology increased, however, a separation occurred between the body/mind paradigm, a notion historically expressed by philosophers such as Rene Descartes (Descartes, 1662/1985). With Descartes' cartesian dualism, the human body was metaphorically depicted as separate parts of a machine that combined for functionality (Figlio, 1977; Hillier, 1987).

The mechanistic view in medicine continued to grow, with a belief that all illness and disease could be eradicated through new medical insight and technology. As a result of the dominance of the mechanistic viewpoint, what has emerged is a "medical industrial complex" (Starr, 1982) that emphasizes diagnosis and treatment, and often ignores the emotional, cultural, psychological, spiritual, or social aspects of individual patients.

Weber's prediction that bureaucracies and rationalization would inevitably create an erosion of society's human values is seen quite clearly in the medical model throughout the health care system. In nursing homes in particular, the fallout from bureaucratic organization and a hierarchical "topdown" management style has compromised humanistic values and created the need for reformist efforts. As Weber might acknowledge in regard to the nursing home system, the values of self-determination, autonomy, and the dignity of residents have been sacrificed for the efficiency of the medical model. Weber's "iron cage" not only impacts and restrains the individual freedoms of nursing home residents, but their families, staff members, and the surrounding community (Du Guy, 2000; Hopfl, 2006).

Alternative Theories in Organizational Management

Weber's theories were considered an important part of the classical organizational management style, prominent during the late 19th and 20th centuries. While Weber developed his "rational-legal-authority" model (or bureaucratic management), other perspectives were

articulated during this time. Scientific management, influenced by the thinking of Frederick Winslow Taylor, emphasized the use of empirical research to develop comprehensive solutions in management, and saw the scientific approach as the primary means by which to increase worker productivity (Heames & Breland, 2010; Nelson, 1980; Schachter, 2010). Another perspective was developed by Henri Fayol, who emphasized administrative management approaches, based on his personal management experiences. Fayol believed that managers should involve themselves in the following five management techniques: (1) planning, using a thorough and precise action plan; (2) organizing, to include stepwise preparation and execution; (3) commanding, by extracting the best from personnel; (4) coordinating, by making sure that adequate resources are available to meet goals; and (5) controlling, by identifying weaknesses and eliminating them (Fells, 2000; Wren, Bedeian, & Breeze, 2002).

The classical school's tendency to ignore co-worker interactions, as well as personal behavior and motivation, was considered by many to be a serious flaw in classical thinking. In addition, the Hawthorne experiments, two empirical studies that applied classical management theory, resulted in showing the shortcomings of classicism. The first experiment, conducted in 1924 by a group of engineers, showed that worker productivity increased despite lower and lower levels of lighting in the workplace. The lower the illumination, the higher the production level of employees. The results indicated that production increased because workers were aware of being scrutinized and watched by researchers. The second experiment was conducted in 1928 by two Harvard researchers, Elton Mayo and Fritz Roethlisberger, involving two separate groups. One group was given special privileges in the workplace, such as freedom to leave their workstations, free lunches, rest periods, and increases in pay. The second group did not receive these special privileges. Instead, the only change to their workday was a replacement of their

usual supervisors with the experimenters, who stepped in to supervise their work. Contrary to expectation, the results showed an increase in productivity of the second group who were supervised by the experimenters. It was determined that the attention that workers received by the experimenters was more motivating (in terms of production) than special privileges or other personal benefits. Both of these experiments highlight what has been termed the *Hawthorne Effect*, when workers react to the attention given to them by researchers, consequently influencing the results (Levitt & List, 2011; Macefield, 2007).

The Hawthorne experiments, along with the inability of classical management theory to address personnel challenges, was the impetus for the rise of the behavioral school. Mary Parker Follett, a social worker, was an early pioneer in the behavioral movement, with a special focus on management and the workplace. Follett believed that people had an inherent ability to solve problems in collaboration with each other. In regard to the hierarchical organizational power that characterized the classical school of management, she asserted that the resolution of differences or conflicts in the workplace should not be based on domination, but involve the collaborative sharing of power. In this regard, Follett became renowned for her integrated methods of conflict resolution (Graham, 1995; Tonn, 2003).

Based on the work of Follett and the criticism of the classical school, many theorists began to focus on the role of management, and the fulfillment of worker needs. This gave rise to the human relations movement, best exemplified by the work of Abraham Maslow and Douglas McGregor. Maslow, a psychologist, studied the phenomenon of human needs, a foundation for his theory of motivation. According to this theory, three assumptions are delineated. First, human needs are never fully addressed or satisfied. Second, human beings are essentially motivated by need satisfaction. Third, human needs can be arranged hierarchically according to their

importance. In explicating his theory, Maslow classified his hierarchy of needs into five distinct groups, noting that each level of need must be satisfied before moving to the next higher level. These include physiological needs, safety needs, belongingness and/or love needs, esteem needs, and the need for self-actualization (Daniels, 1982; Hall, Lindzey, & Campbell, 1998; Hoffman, 1999).

The human relations school was also associated with Douglas McGregor, who believed there were two types of organizational managers. The first type of manager, which he called Theory X, was more characteristic of managers in bureaucratic, hierarchical arrangements. Theory X argues that workers are basically lazy, irresponsible, adverse to working, and will attempt to avoid work if possible. Due to these traits, employees need direction, and must be coerced, threatened with punishment, and controlled by management in order to instill motivation and productivity. On the other hand, Theory Y posits that employees want to work, are responsible, trustworthy, innovative, and with high levels of motivation. Theory X and Y enabled organizations to understand different perspectives in management, and what motivates employees to obtain higher levels of productivity (Bobic & Davis, 2003; Sorensen & Minahan, 2011).

Weber's ideal type became the predominant management style of corporations and organizations throughout the twentieth century, and still persists in the United States and around the world. However, a number of contemporary theorists have offered alternative modes of management thinking that address what many perceive as the dysfunctional nature of traditional, bureaucratic organizations that employ hierarchical modes of management.

Organizational Change Theorists

Probably one of the most notable organizational change theorists in the twentieth century

was W. Edwards Deming. He viewed the bureaucratic organizational style of the corporate world as both disabling and existing in a crisis mode. Deming saw bureaucratic hierarchies as redundant, separated by a lack of information, little communication, and an overall focus on profit above the needs and desires of consumers. From his perspective, the result was poor service delivery and lower attainments in quality. In his book *Out of the Crisis* (1986), Deming developed specific management principles that he felt addressed the dysfunctional nature of organizational management. His solution has been deemed Total Quality Management (TQM), with a primary focus on corporate interrelationships, quality service delivery, and customer needs. In order to transform a traditional hierarchical organization, Deming notes that instead of managing through power levels, employees and management should communicate openly with each other for solutions. Employee involvement is considered crucial in preventing problems in quality prior to their manifestation. Corporations should also implement innovative processes or programming based on the best practices of other organizations, by benchmarking and noting superior approaches. This involves a standard of continuous quality improvement (CQI), where the company is committed to perpetual change and transformation. Finally, TQM places customer needs and desires at the forefront, and provides products and services that fulfill customer expectations. Deming's approach has been adopted by a number of corporations and organizations throughout the world. In fact, Wellspring, a culture change model for nursing homes, is considered by many to be a true TQM approach (Deming, 1982; Stone et al., 2002).

Another organizational change theorist is Peter Senge, who maintains that organizations must adapt to the many technological and environmental changes in society. To be competitive and profitable, corporations must serve their customer base by adopting a framework of learning and problem-solving, involving all employees. In order for organizations to grow, learn, and to

transform themselves, emphasis should not be placed on efficiency through bureaucratic and hierarchical structures, but in detecting and then addressing problems on a continual basis. Senge notes three major aspects of learning organizations. First, administrative efforts for change must be collaborative and focused on teamwork. Second, employees must be given the opportunity to make independent decisions and be empowered by management to freely adopt creative approaches. Third, it is essential that all employees share information on a continuous basis, establishing open lines of communication (Senge, 1990; Senge et al., 1999).

Transforming bureaucratic and hierarchical organizations into more competitive and humanistic environments is a serious challenge. John P. Kotter, a scholar and writer on organizational innovations and transformation, has developed an eight-step stage model for successful corporate change: (1) *Establish a sense of urgency*. Inspire employees to move ahead by developing relevant goals and objectives; (2) *Form a powerful guiding coalition*. Build strong associations of employees who can serve as leaders and mentors in the change; (3) *Create a vision*. Allow employee coalitions to establish a simple vision, then execute that vision by forming creative strategies to improve service delivery; (4) *Communicate the vision*. Encourage information-sharing, and attempt to involve all stakeholders in the new vision for organizational change; (5) *Empower others to act on the vision*. Remove any obstacles for change. Encourage reciprocal feedback and praise achievements for change; (6) *Plan for and create short-term wins*. Establish goals and objectives that are easily achieved. Complete goals before tackling new ones; (7*) Consolidate improvements and produce still more change*. If possible, link improvements together. Encourage determination and place a spotlight on achievements and personal progress. Keep future milestones in sight; and (8) *Institutionalize new approaches*. Anchor changes with

values and beliefs that are shared and embedded in the new culture (Kotter, 1996; Kotter & Cohen, 2002).

Transforming Nursing Homes

Since the 1990s, attempts to modify the traditional culture of NH facilities went beyond piecemeal programs with the introduction of "culture change" models. Some examples include the Wellspring model, the Eden Alternative, the Green House model, and what many consider the ultimate exemplar of culture change, the Live Oak Regenerative Community. Although these programs are considered exemplars, little empirical research has been conducted to evaluate the impact of culture change on residents and staff.

Culture Change Models

The Wellspring model of nursing homes, located in Eastern Wisconsin, consists of 11 organizationally-linked, but independent not-for-profit facilities. What makes Wellspring particularly noteworthy is the importance it attaches to its mission and who will carry it out, believing that potential employees are not motivated by financial compensation, but in making a difference in the lives of residents (Kehoe & Heesch, 2003). When seeking an individual to fill an employment position, for example, a NH in the organization will leave a position unfilled if they believe a prospective employee does not share their core values. Although policies that set quality standards are put into play by top management in the Wellspring model, there is an emphasis on the services provided by frontline workers, in collaboration with supportive supervisors (Reinhard & Stone, 2001). An additional feature essential to the model is its alliance with other nursing homes, part of Wellspring's quest for true quality assurance (Kehoe & Heesch, 2003). Wellspring's organizational success relies heavily on the interrelationship of the

coalition, and the willingness of allied nursing homes to cooperate and collaborate with each other. The alliance identifies best practices, assures accountability, and minimizes competition.

Stone, Reinhard, Bowers, Zimmerman, Phillips, Hawes, et al. (2002) evaluated the Wellspring model and compared it to traditional medical model nursing homes. A mixed methods approach was utilized, to include focus group interviews, site visits, participant observation, and analyses of secondary data. The study found that during the evaluation period, staff turnover was lowered, and federal survey performance improved. The implementation of Wellspring required no additional costs or outlay of resources. Results showed that staff were more vigilant in identifying resident problems or concerns, and were generally more proactive in providing care to residents. Participant observation and interviews indicated that there was an improvement in the quality of life of residents, and in positive reactions from family members. The interactions between residents and staff also increased in a positive way. Even though Wellspring held up well when evaluated, it is considered quite a complex set of reforms, and not easily implemented.

The Eden Alternative (EA) is a human habitat model, developed to combat what the founder, William Thomas, believes are the three plagues of NHs: loneliness, boredom, and helplessness (Thomas, 1996). When the model is successful, Eden has made inroads into enhancing both quality of care and quality of life domains. An important component of the model is a focus on the physical environment, where efforts are made to create a more homelike atmosphere that includes softer lighting, comfortable furniture, outdoor gardens, the addition of pets, and other personally enhancing amenities. Medicalized, institutional, and inflexible routines are minimized, such as set meal times or bathing that follows efficiency schedules. Instead, residents are given choices about such matters, with a strong emphasis on their autonomy and

personal wants and needs. In addition, the model advocates a flattening of organizational hierarchies, flexibility in staff scheduling, and a strong collaboration with all stakeholders.

Although the Eden Alternative is undoubtedly the most renowned humanistic model in a number of culture change approaches, few empirical evaluations in this area have been conducted. Coleman, Looney, O'Brien, Ziegler, Pastorino, and Turner (2001) examined the quality of care (QOC) and quality of life (QOL) of NH residents in a single facility one year following the implementation of the Eden Alternative (EA) in November of 1998. The EA nursing home was compared to a traditional medical model nursing facility, using resident data from the Minimum Data Set (MDS), version 2.0, as well as reports from staff. While EA had no beneficial effects on residents' cognitive abilities, infection rates, functional status, survival rates, or cost of care, anecdotal reports indicated that EA was enhancing for both the residents and members of the staff. For example, the introduction of animals in the nursing home did have a positive effect on some of the residents and caregivers. Reportedly, it relieved the depression in a few residents and created a positive atmosphere within the facility. Researchers suggested that positive results of the Eden Alternative might be further actualized beyond one year following implementation. However, no longitudinal follow-up research has been conducted on this EA facility.

The Green House (GH) model, also developed by William Thomas, is often considered the second generation of the Eden Alternative. It advances the idea that the essential environment of any nursing home should be warm, smart, and green (Thomas, 2003). In this context, Green Houses are small, intimate domiciles (warm), with high-tech features (smart), in a setting that incorporates gardens (green) and other elements providing a humanistic, resident-centered environment. The first Green House was constructed in 2002 in Tupelo, Mississippi, and at the

current time, Green Houses have been constructed in limited numbers across the nation. The Green House dwellings accommodate 8-10 residents, are located in family neighborhoods, and provide skilled nursing services to resident elders.

Kane, Lum, Cutler, Degenholtz, and Yu (2007) evaluated the effectiveness of the Green House (GH) model on resident quality of life and quality of care measures in a two-year longitudinal study. The GH model consisted of four small-house dwellings, each housing approximately 10 resident elders. Two traditional nursing home facilities (Cedars and Trinity) were utilized as comparison sites. Minimum Data Set (MDS) assessments were utilized to measure the effectiveness of the GH intervention on residents' quality of care. Quality of life was measured by 11 domains: physical comfort, functional competence, privacy, dignity, meaningful activities, relationships, autonomy, food enjoyment, spiritual well-being, security, and individuality. Researchers found that compared to the Cedars NH, the GH dwellings measured higher on seven of the 11 quality of life domains: privacy, dignity, meaningful activity, relationships, autonomy, food enjoyment, and individuality. Compared to the Trinity facility, the GH dwellings measured higher on four of the 11 quality of life domains: privacy, dignity, autonomy, and food enjoyment. On all domains, the GH models did not rate lower on any of the eleven quality of life domains when compared to the Cedars or Trinity facilities.

Most NH reformers agree that CC is best exemplified by the Live Oak Regenerative Community in El Sobrante, California, established in 1977 by Barry Barkan. Unlike more recent culture change models, Live Oak has become the vanguard of humanistic, resident-centered transformation. It demonstrates a fully functioning environment that communicates and actualizes the personal growth of all members of the community. Also unlike other culture change models, this facility is ". . . distinguished by its focus on building a healthy culture for

aging rather than on mitigating the negative effects of aging" (Barkan, 2003, p. 197).

The notion of mitigating problems, rather than creating real communities that actively incorporate humanistic and resident-centered values and beliefs into their everyday existence, is the failure of many nursing homes that attempt to "replicate" or adopt culture change models. The Eden Alternative, as well as other CC models, were developed to combat or ameliorate specific problems such as staff turnover, poor clinical outcomes, and a host of other issues. Conversely, Live Oak has developed an aging community that continuously regenerates itself through the evolution and transformation of both resident elders and those who work in this environment (Barkan, 2003). Live Oak is an exemplar for the NH industry, and in direct alignment with the intent of the CC movement, providing a fluid, growing, and interactive community that supports the unique nature of each stakeholder. The reality of embracing and assimilating humanistic values and beliefs is not only evident in its vision, but in the translation of CC values into action. In this respect, Live Oak is a highly interactional and living system, cultivated by the interplay between all members and the surrounding community.

The Wellspring model, the Eden Alternative, the Green House model, along with Live Oak, are just four examples of a number of culture change models or initiatives that have been developed as best practices to transform the traditional culture of the nursing home. Although social workers have been variously involved in the culture change movement since its inception, only two studies have examined nursing home social workers in facilities undergoing culture change (e.g., Lubetkin, Annunziato, Downes, & Barak, 2005; Neuman, 2003).

Empirical evaluations of CC have not only been limited, but there is no available information to determine how many NHs have adopted the CC approach. In an attempt to

discover this information, Doty, Koren, and Sturla (2008) mailed questionnaires to directors of nursing (DONs) in 1,435 NHs between February and June of 2007. The study examined three domains of culture change: (1) If NHs practiced resident-centered care; (2) if the workplace encouraged staff autonomy and decision-making; and (3) if the NH had a "homelike" physical environment. Based on the results of the survey, researchers determined if nursing homes were traditional, had adopted culture change, or were striving to be culture change facilities. It was found that 31% had adopted culture change, showing a reduction in turnover, higher occupancy rates, decreased operational costs, and a more competitive edge. Overall, CC adopters supported a team approach, a flatter hierarchical style of management, resident-centered choices and decisions, staff empowerment, and a more homelike environment.

Job Satisfaction in Organizational Settings

The Hawthorne studies of the 1920s were pivotal in questioning the dominance of the bureaucratic organization and management styles and their effect on worker performance and job satisfaction. Current humanistic efforts often cite the traditional or medical model as the primary impediment to resident-centered care in nursing homes across the country. To be sure, there are a number of organizational constraints that appear to exist in the nursing home industry, most evident in the hierarchical tiers of employment, as well as other related facets. The nursing home industry is not the only organization to adapt a "topdown" management style, representing a common historical model in the business world, and still flourishing today. However, those that persist in adopting these models all share a notable disadvantage in regard to an employee's job satisfaction. During the 1980s and early 1990s, a number of researchers attempted to delineate organizational constraint areas that impacted employee job performance and job satisfaction. The findings of many of these studies are just as relevant today as they were decades earlier.

Elements of Job Satisfaction

A good example of a study that examined constraints in the workplace was conducted by by Peters, O'Connor, and Rudolf (1980). By conversing with employees who had experienced organizational constraints, they developed a taxonomy of eight constraint areas that influence job satisfaction and performance: (1) job-related information (needed to complete tasks on the job); (2) necessary tools and equipment; (3) adequate materials and supplies; (4) budgetary support (enough money to purchase necessary resources); (5) assistance from other people (in terms of services); (6) task preparedness (adequate skills or training to complete the job); (7) time availability (to complete tasks); and (8) physical environments that promote task completion.

Although most organizational constraint studies are related to job performance, many show a correlation between constraints and job satisfaction (Jex & Gudanowski, 1992; Keenan & Newton, 1984; O'Connor et al., 1984; Spector et al., 1988). As one might expect, employees with a high level of organizational constraints also experience dissatisfaction with their jobs. In one study by O'Connor, Peters, Rudolf, and Pooyan (1982), higher levels of job satisfaction were correlated with specific "situational" constraints, such as having job-related information; access to tools and equipment; adequate materials and supplies; opportunity to prepare for job tasks; budgetary support; assistance from other workers; enough time to complete tasks, and a work environment that is open and supportive.

Another correlate with job satisfaction is role ambiguity and role conflict. A role is generally interpreted as a pattern of behavior required of an employee in an organization. Role ambiguity occurs when a person's role in the company is not clearly defined, and that lack of certainty often creates a sense of doubt as to what comprises an employee's responsibilities and duties. Role conflict may occur when work demands are incompatible with job functions and

overall responsibilities. Studies of role ambiguity and role conflict have shown a correlation with job satisfaction (Jackson and Schuler, 1985), where satisfaction with one's supervisor emerged as an important facet. In fact, studies examining both organizational constraints as well as role ambiguity and conflict have shown supervision to be an important element in job satisfaction, possibly reflecting the importance of supervisors in setting the stage for how an employee interprets and experiences their roles. In the NH setting, job satisfaction studies often note the existence of uncertainty and conflict in social workers, particularly when individuals are expected to perform duties they consider outside their mandated roles, resulting in ambiguous and conflicting roles. This might include running errands for residents, looking for lost items, or assisting them in performing tasks for daily living (Luptak, 2004).

Job stress is another variable that emerges in job satisfaction research, requiring a person to respond or adapt to a specific event or situation in the workplace. Although these can at times be construed as transitory or temporary "bumps in the road", job stressors that are consistently experienced can have a long-term influence on job satisfaction (Cooper and Cartwright, 1994; Warr and Payne, 1983). The nursing home environment presents a number of these stressors. For example, many social workers testify they experience excessive workloads, particularly in regard to the overwhelming amounts of paperwork and documentation they must complete on a daily basis (Cox & Parsons, 1994; Luptak, 2006).

Job stress can also be experienced when employees experience a loss of control in their environment, particularly as it relates to decision-making and overall empowerment. The ability to exercise autonomy over tasks and responsibilities has a correlation with job satisfaction (Jex and Beehr, 1991). Some researchers have postulated that control mitigates job stress, where an increase in autonomous decision-making can reduce the negative effects of excessive demands

(Dwyer and Ganster, 1991; Karasek, 1979). Spector (1986) conducted a meta-analysis examining job satisfaction with perceived control, and found that intrinsic elements of work were more highly correlated with job satisfaction than were more extrinsic ones. For example, despite excessive work demands experienced in many social work settings, the intrinsic rewards of assisting clients may lead to more job satisfaction than salary or other extrinsic rewards.

Job satisfaction is the most frequently studied factor in organizational research, for a number of reasons. Job satisfaction can be a proxy for an organization's ability to function, highlight areas that need improvement, or indicate what strategies are effective. It can also assess if employees are treated equitably, with respect, and whether they consider specific protocols and organizational goals as fair and in keeping with the overall mission statement of the company. In the social services arena, job satisfaction may also be related to the quality of services, and the extent to which employee responsibilities are carried out to fulfill the needs and desires of customers.

Job satisfaction itself is a variable concerned with the attitudes of people as they relate to their employment. It can be defined as a worker's evaluation of how an organization fulfills his/her employment needs (Dawis and Lofquist, 1984), or how people personally feel about their jobs and the tasks they perform (Spector, 1997). Butler (1990) noted that the concept of job satisfaction has less to do with the personal characteristics of a worker, and more to do with organizational practices. In short, job satisfaction is how individuals personally feel about their overall interaction with the workplace, which includes their assessment of how an organization fulfills their needs from a physical and psychological point of view.

In many ways, the humanistic approach currently advocated in the NH industry touches

on job motivation and advocates changes in the nature and content (characteristics) of the many tasks that employees perform. Hackman & Oldham (1976; 1980) have noted the existence of five core characteristics that influence an employee's psychological state, ultimately leading to job satisfaction, motivation, performance on the job, and turnover. These include skill variety, task identity, task significance, autonomy, and job feedback. The first three combine to influence the meaningfulness of work as experienced by the employee. Autonomy is associated with an individual's sense of responsibility, and feedback promotes knowledge acquisition or a perception of the outcomes related to the work one performs. In job characteristics theory, researchers maintain that these core characteristics are related to the overall job satisfaction of employees, and how motivated they will be in the workplace. In addition, the foundation of this theory, like Spector's (1986) findings, shows that many people find an intrinsic satisfaction in performing the tasks and duties related to their jobs, not because of an extrinsic reward system.

A Review of Literature Relevant to this Study

There are only two studies pertaining to the job satisfaction of social workers before and after a humanistic culture change intervention, both taking place in hospital settings. One was conducted by Lubetkin, Annunziato, Downes, and Burak (2005) in a nursing home facility affiliated with a large hospital system. The research team administered a survey questionnaire to 5,300 staff (including 19 social workers) prior to a culture change intervention in 2002, and again to 4,700 staff members (including 22 social workers) two years later. Research findings showed that while medical staff increased their job satisfaction following the hospital's organizational culture change, social workers remained neutral on the majority of the job satisfaction domains. The only area where social workers showed a slightly higher rate of job satisfaction was in the area of resource availability.

The second study was conducted by Neuman (2003), who surveyed 44 medical social workers in five (5) hospitals that were undergoing organizational reengineering, with one serving as a comparison hospital. Utilizing a mixed method approach (survey questionnaires and focused group interviews), the effects of organizational reengineering on the job satisfaction of social workers was explored. Constructs included social worker morale, overall job satisfaction, opinions regarding organizational change, identification of new responsibilities or tasks, and educational training. The study found that organizational reengineering negatively altered social worker roles, increased their tasks, and left them with less supervisory support. It also had a negative effect on social workers in terms of job satisfaction, professional identity, and attitudes toward organizational reengineering in a hospital setting. It did, however, show that the job satisfaction of social workers was heightened related to discharge planning tasks and the counseling of patients.

With a lack of research on the job satisfaction of social workers in CC nursing homes, a review of the literature additionally highlights job satisfaction research that is relevant to the six domains of the job satisfaction survey. In past research studies, nursing home social workers have identified a number of areas contributing to their well-being and job satisfaction. These include: (1) Empowerment in the workplace, to include autonomy, decision-making, and respect in the NH environment; (2) collaborative relationships with staff and management, and the development of a team concept; (3) active support from supervisors, involving personalized interactions and open communication; (4) a NH environment that shares similar values and beliefs; (5) available resources that are adequate and assist in providing quality psychosocial care; and (6) fulfillment of the needs and desires expressed by residents, to include opportunities for self-determining choices and decisions related to their care.

In terms of empowerment, Gleason-Wynn and Mindel (1999) found that autonomous decision-making and ability to independently complete tasks are elements that contribute to a social worker's sense of empowerment and job satisfaction. In this study, 326 NH social workers responded to a mailed, self-administered job satisfaction questionnaire with 110 items. It was found that four distinct environmental factors were predictive of job satisfaction: autonomy, supervisory support, co-worker support, and satisfaction with clients. Seibert, Silver, and Randolph (2004) also found that administrative efforts to promote an empowering agenda in the workplace resulted in the empowerment of staff.

Studies have also demonstrated a positive correlation between job satisfaction and teamwork. For example, Moyle, Skinner, Rowe, and Gork (2003) used focus group interviews to investigate elements necessary for job satisfaction, and found that teamwork was an important feature, where all staff shared common workplace values regarding the quality care of resident elders. In a study by Proenca (2007), 180 employees who worked as part of a team were surveyed in four medical centers with a self-administered questionnaire. Among other results, it was found that perceptions of a team's context and atmosphere were empowering elements that heightened a worker's commitment and job satisfaction. In another study, it was shown that work teams which were trained for optimal performance proved more flexible and responsive in the workplace, especially when goals were clearly explained, and communication heightened. In addition, when workers were given feedback on their performance, there was an increase in work variety, autonomy, and job satisfaction (Morley and Herarty, 1995). Schofield and Amodeo (1999), in their analysis of 224 articles related to interdisciplinary teams, showed that working as a team can create a positive climate of cooperation through communication, teaching, and the mutual sharing of ideas and information.

Some researchers have explored the correlation between the sharing of organizational values and job satisfaction. Deutschmann (2001) showed this relationship when direct care workers and administrators in three nursing homes were interviewed. These nursing homes were specifically chosen due to their demonstration of successful workforce practices. It was found that sharing and internalizing the NH's set of organizational values was essential to the job satisfaction of employees.

Having available resources to complete one's work is also positively correlated to job satisfaction. For a period of 15 weeks, Jeong and Keatinge (2004) conducted semi-structured interviews with eight staff members in a single nursing home undergoing organizational change. Among other results, the researchers found that job satisfaction was strongly related to the provision of the following by supervisors or administrators: (1) material resources, such as monetary incentives to attend in-service educational workshops, as well as the necessary equipment to complete nursing home tasks; (2) environmental resources, to ensure that the general physical environment was homelike and comfortable; (3) psychosocial resources were provided to create a familial type of bond between administrators, staff members, and the residents; and (4) psychological resources, such as the support of staff from administrators, was fundamental to job satisfaction. For example, each staff member was treated as equally important to the mission of the facility, by soliciting their opinions, and inviting their participation through team meetings and one-on-one exchanges with other staff or supervisors.

When decision-making is brought closer to the resident or client (resident-centered care), there is an increase in the job satisfaction of social workers. Reinardy (1999) demonstrated this connection after conducting open-ended interviews with 17 social workers in rural and urban

nursing homes. It was found that advocating for a resident's needs, and respecting individual resident choices, enhanced the job satisfaction of social workers.

Job satisfaction may also be a proxy for how thoroughly CC nursing homes or specific nursing home types have assimilated the culture *and* climate of humanistic trends. Glisson (2007) has defined the social context as including the " . . . norms, values, expectations, perceptions, and attitudes of the members of an organization, all of which effect how services are delivered" (p. 787). While culture " . . . captures the way things are done in an organization . . . climate captures the way people perceive their work environment" (p. 739). This was demonstrated in a study by Glisson and James (2002), where 283 case managers from 33 child welfare and juvenile justice teams were surveyed, utilizing both an Organizational Culture Inventory (OCI) and a Psychological Climate Questionnaire (PCQ). The analysis showed that while culture and climate were distinct elements, they were both essential to job satisfaction and perceptions of quality service delivery.

In a study of organizational climate, Glisson and Hemmelgarn (1998) conducted a study of 32 public service offices for children in 24 Tennessee counties, to explore both the quality and outcomes of service providers. A longitudinal, quasi-experimental design was used to collect qualitative and quantitative data over a 3-year period. Results indicated that an organizational climate characterized by few conflicts, clear worker roles, personalization, and collaboration were all necessary for the delivery of quality services.

Glisson, Dukes, and Green (2006) studied the effects of an organizational intervention referred to as ARC (Availability, Responsiveness, and Continuity) on the climate and culture in 26 case management teams from 10 urban and 16 rural organizations. Case managers were randomly assigned to either the ARC or the control group. Researchers utilized a pre-test and

post-test classical experimental design. It was found that the ARC intervention improved the climate of the case management teams by reducing role conflict, overload, and emotional exhaustion.

Glisson's work is an important contribution to this study, as humanistic trends such as culture change are intent on altering not just the culture and climate of nursing homes, but essentially transforming the social context as well. For example, Glisson (2007) notes that both culture and climate are constructs embedded in the social context of an organization. As such, reformist efforts to transform the social context of the NH environment must understand the importance of both elements in making that transition.

In order to determine the identified barriers and enablers to culture change, Scalzi, Evans, and Hostvedt (2006) evaluated three NHs that implemented culture change initiatives. The mixed-method approach utilized a sample of 67 NH staff and 14 family members. Participants were assessed through survey instruments, semi-structured interviews, and an observational tool. It was found that barriers to CC were the exclusion of some staff in culture change activities, as well as management's over-emphasis on compliance with regulations and operational costs. Further barriers included the turnover of NH administrators and frontline workers. Enablers to CC included facility-wide empowerment, shared values and goals in service delivery, and a strong coalition of CC advocates.

Another barrier to the successful implementation of models in the culture change movement is an inability to fully assimilate the values and beliefs of the culture change paradigm by forgoing in-depth, pervasive inculcation and preliminary assessment. Robinson and Rosher (2008) evaluated a single NH that had undergone culture change to determine barriers to implementation. Research was conducted on a 151-bed NH in the mid-west that began CC

programming in 2002 for a period of two years. Quantitative data was collected on resident depression, job satisfaction of staff members, and the satisfaction of resident families. Measurements were taken at baseline and during continual phases of culture change. A qualitative component included ongoing interviews of staff to ascertain the impact of CC on resident elders. Among other results, it was found that the NH continued to practice under the hierarchical management style of the medical model, preventing staff from being empowered in regard to resident care. In addition, preliminary assessment of the NH's readiness for CC initiatives was not adequately addressed at the outset. It was therefore suggested that CC initiatives should be delayed if collaborative teamwork concepts cannot be operationalized and subsequently embedded in the culture and climate of the facility. The study highlighted the need for intense preparation for CC, and in rectifying any barriers identified upon initial assessment. Although clinical indicators did not show any positive correlations between CC and quality of care, anecdotal reports noted improvements in the quality of life for resident elders.

Job Satisfaction of Nursing Home Social Workers

Despite the strong recommendation by the federal government and reformers to adopt culture change into nursing homes across the country, empirical evidence to support both the implementation and effectiveness of CC has been quite limited. Job satisfaction studies of employees in the culture change environment have been few and predominantly anecdotal, with only the Neuman (2003) and Lubetkin et al. (2005) studies highlighting social workers in these settings. The latter were conducted by researchers in nursing homes affiliated with major hospitals, finding that social workers overall experienced no change or a lower level of job satisfaction following the implementation of culture change initiatives.

To ascertain if these results persisted in non-hospital settings, this study mailed 700 job satisfaction questionnaires to social workers practicing in separate and independent nursing homes in 12 mid-western states. In regard to job satisfaction, the study looked at nursing home type (traditional, combination, humanistic) and culture change affiliation. The first question explored in this study was whether social workers practicing in a humanistic type of nursing home had a higher level of job satisfaction than those in a combination or traditional type of facility. The second question in this study examined whether social workers practicing in a culture change nursing home had a higher level of job satisfaction than those not practicing in a non-culture change facility. The third and final question examined whether social workers in culture change nursing homes were equally represented in humanistic types of nursing homes.

Based on the preceding review of literature the following hypotheses will be examined:

H1: *Social workers in a humanistic type of nursing home will have a higher level of job satisfaction than social workers practicing in a combination or traditional type of facility.*

H2: *Social workers identifying themselves as practicing in a culture change nursing home will have a higher level of job satisfaction than will social workers who do not practice in a culture change facility.*

H3: *Social workers who identify themselves as practicing in a culture change nursing home will also identify themselves as practicing in a humanistic type of nursing home.*

CHAPTER 3

METHODOLOGY

Despite its formal introduction in 1997 by nursing home reformers and a large coalition of progressive thinkers, culture change has not been widely or empirically studied. Most results from culture change research have been anecdotal, and although valuable, do not have the rigor of a quantitative study. The most renowned culture change models, like the Eden Alternative (EA), Wellspring, or the Green House (GH) model, are devoid of the multitude of empirical studies one might expect from innovations so highly advocated. The few that are studied examine culture change utilizing a pre-test/post-test design, with mixed results.

The Impetus for this Study

In searching for relevant studies that highlighted social workers in culture change nursing homes, it soon became apparent that only two studies qualified: Lubetkin et al. (2005) and the Neuman (2003) study. Although it was initially disappointing to find only two studies that pertained to culture change and social workers, the results were unexpected and intriguing. In both studies, the findings showed a rather startling "disconnect" between the implementation of culture change in hospital affiliated nursing homes and the job satisfaction of social workers. This was considered a curious set of findings, due to the fact that the ideology, values, and beliefs underpinning humanistic culture change are in direct alignment with those of the social work profession.

Almost immediately, one wondered if the same results would be obtained if the job satisfaction of social workers were examined in nursing homes not affiliated with a hospital. Towards this end, several criteria were considered. First, examining social workers in separate, independent nursing homes with no affiliations with a hospital was essential. Second, since

federal legislation mandates that nursing homes with 120 or more beds must hire a social worker (or someone with an allied degree), it seemed necessary to only include nursing homes with 120 or more beds. Third, rather than examining private pay nursing homes, or those that are only certified by Medicare, it seemed important to be inclusive, both in diversity and socioeconomic terms, by sampling nursing homes that were certified by both Medicare and Medicaid. Finally, it was decided that nursing homes would be chosen in a 12-state area in the mid-west, to form a more geographic, consistent grouping, and to better ensure a timely and expedient return of surveys by respondents.

Rationale for a Quantitative Study

This study utilized a cross-sectional survey design, specifically to examine the job satisfaction of social workers in regard to nursing home type and culture change affiliation. Quantitative methods were chosen because they are often more robust, allowing results to be generalized to a larger population (Weisberg, Krosnick, & Bowen, 1996). Also, a quantitative method can more aptly convey the validity and reliability of measures through analyses, providing future researchers with the knowledge and confidence required to utilize the same instrument to replicate a study (Rubin & Babbie, 2008).

Another reason for using a quantitative approach concerns the ability to more stringently control extraneous variables, as well as filling in the gaps found in other studies. In regard to the latter, for example, culture change research has not explored the “type” of nursing home (traditional, humanistic, or combination) and its relationship to the job satisfaction of social workers. Further, no research has been done in culture change that specifies non-hospital settings, nursing homes with 120 beds or more beds, and certified by Medicare and Medicaid. This study attempted to close some of these gaps by identifying a nursing home’s type, sampling

only those nursing homes that were in a non-hospital setting, with 120 or more beds, and certified by both Medicare and Medicaid.

Advantages of a Mailed Survey

A mailed, self-administered questionnaire survey was chosen, as it is far more feasible than one-on-one interviews in terms of cost, and less difficult to implement (Fink, 2009). In this study, for example, travel to urban and rural areas of 12 states, food and lodging, the cost of recording equipment, the procurement of a quiet and accessible space for interviewing, as well as possible transcription fees, would be prohibitive, due primarily to limited funding.

While there is no doubt that a mailed survey can be labor intensive as well, the cost of postage (to and from), labels, copies of the survey, cover letter/consent forms, and follow-up procedures for non-responders, is the primary financial outlay for the design. In addition to this, mailed, self-administered surveys also allow respondents anonymity, where questionnaires can be completed in privacy. By comparison, qualitative face-to-face interviews may create an uncomfortable environment for respondents, especially if they consider some questions to be too personal or intrusive (Bourque & Fielder, 2003).

Disadvantages of Mailed Surveys

The primary disadvantage of a mailed survey questionnaire is a poor response rate. Mailed surveys are often limited by a non-return rate that is higher than most other research methods (Salant & Dillman, 1994). Care needs to be taken in developing strategies to prompt respondents to complete and return questionnaires. In the current study, this first included an attempt to construct a 2-page information statement soliciting both participation and support. The first page was primarily introductory (Appendix A), and the second page highlighted the confidentiality of the survey and other parameters (Appendix B). A second strategy used to

increase the response rate was the use of a cover page with a cartoon drawn by the researcher, incorporating a NH social work theme. A third strategy to compel a higher response rate was the utilization of a follow-up postcard reminder (Appendix C), mailed to non-responders two weeks following the mailing of the survey to prompt the completion of the questionnaire (Buckingham & Saunders, 2004). These postcard reminders were generically addressed to the "Social Work Department" of each non-responder's nursing home address, as was done with the original survey questionnaire.

Another disadvantage of a quantitative survey approach as compared to a qualitative method is that quantitative methods often do not capture the rich narratives of respondents. This includes in-depth information provided by interviewing one-to-one, and the opportunity to probe a participant's responses for further information or to clarify the narrative. Although the current study did include an open-ended question on the final page of the survey, the ability to relate to the participant in a personal way, or to gain further information, was severely limited by the use of a mailed survey. Even so, the open-ended question did allow participants to freely express themselves outside the confines of a limited response range.

Key Concepts

Independent variables (IVs) in this study were type of nursing home and culture change affiliation. The independent variable of nursing home type was measured by designating whether each respondent practiced in a traditional, combination, or humanistic type of nursing home. Culture change affiliation was measured by asking if respondents practiced in a culture change nursing home, to which they replied either yes or no.

The dependent variable (DV) in the study was job satisfaction, measured with a 39-item job satisfaction scale. The job satisfaction scale included six domains, to include empowerment,

teamwork, supportive supervision, identification with values, available resources, along with resident-centered care. Due to the insertion of 14 additional questions, the job satisfaction survey contained a total of 53 items. However, these 14 questions were considered redundant, and not utilized for analysis. Therefore, only the 39-item job satisfaction questionnaire was analyzed, listed in the enclosed Codebook (see Appendix E, Section E).

Job Satisfaction Survey and Operationalization

The job satisfaction survey had six sections, to include the following: (1) Section A focused on respondents' demographic information (seven items); (2) Section B focused on respondents' work in the nursing home (two items); (3) Section C focused on nursing home type (five items); (4) Section D focused on Culture Change Identification (three items); (5) Section E focused on Job Satisfaction (39 items); and (6) Section F offered respondents an opportunity to express their opinions via an open-ended question (see Appendix D)

Section A: Demographic Background of Respondents

This included socio-demographic variables, some of which were open-ended questions while others were closed-ended fixed response items. Gender was operationalized as male (1) and female (2). Age was measured as follows: below 20 years (1), 20-29 years (2), 30-39 years (3), 40-49 years (4), 50-59 years (5), 60-69 years (6), and over 69 years (7).

Race categories included White (1), Black or African American (2), American Indian or Alaska Native (3), Asian (4), Native Hawaiian or Other Pacific Islander (5), and Other (6). If *Other*, and you feel your race is not represented by these choices, please enter that information here (6a, with a blank line for a response).

Highest educational level was operationalized as follows: BSW (1), MSW (2), Other (3). If *Other*, include type of degree (3a, with a blank line for a response). If *Other*, include degree

area (3b, with a blank line for a response). Employment status in the Nursing Home was operationalized as Full-Time (1) or Part-Time (2).

Gross (pre-tax) salary in 2009 was operationalized as follows: $20,000 or Below (1), $20,001 to 25,000 (2), $25,001 to $30,000 (3), $30,001 to 35,000 (4), $35,001 to 40,000 (5), $40,001 to 45,000 (6), $45,001 to 50,000 (7), $50,001 to 55,000 (8), $55,001 to 60,000 (9), $60,001 to 65,000 (10), and Over $65,000 (11).

The total experience of respondents as nursing home social workers (in years and months) was operationalized as follows: 11 months or less (1), 1 year to 5 years, 11 months (2), 6 years to 10 years, 11 months (3), 11 years to 15 years, 11 months (4), 16 years to 20 years, 11 months (5), 21 years to 25 years, 11 months (6), 26 years to 30 years, 11 months (7), 31 years to 35 years, 11 months (8), 36 years to 40 years, 11 months (9), and 41 years or over (10).

Section B: Work in the Nursing Home

This section included two items, each exploring the social worker's job in the nursing home. Item one was operationalized by instructing respondents to "Please check the top <u>five</u> activities you perform in the nursing home". This included the following: Counseling/Mental Health (1), Discharge Planning (2), Resource Allocation (3), Assessments (4), Documentation (5), Explaining Medicare/Medicaid (6), Advocacy (7), Mediation (8), Care Planning (9), Admissions (10), Communicating with Families (11), and Other (12), please list (with a blank line for a response).

Item two was operationalized by instructing respondents to "Please check up to <u>five</u> activities you often perform for residents outside of your job description as a social worker", to include the following: Running Errands for Residents (1), Driving Residents to Appointments (2), Buying Items for Residents (3), Assisting Residents with Dressing (4), Feeding Residents at

Mealtimes (5), Facilitating Resident Activities (6), Assisting Residents with Hygiene (7), Moving Residents to Another Room (8), Other (9), please list (with a blank line for a response), and Does Not Apply (10).

Section C: Nursing Home Type

This section was operationalized by utilizing a response range of 1-9, running across the page from left to right. Each respondent was instructed to read a defining statement about a NH type, then to choose the statement that was the closest to describing the NH type in which they practiced. If they agreed with the statement on the left side of the page (a traditional nursing home), they assigned it a number of 1, 2, or 3. If they agreed with the statement on the right side of the page (a humanistic nursing home), they assigned it a number of 7, 8, or 9. If they felt they practiced in a nursing home sharing characteristics from both the traditional and humanistic statements, they assigned it a number of 4, 5, or 6. A series of five statements were provided to respondents, and included Organizational Style (1), Staff Interactions (2), Resident Choices (3), Resident and Staff Interactions (4), and Capacity for Organizational Change.

Nursing home type (traditional, combination, and humanistic) was overall determined for this section by combining all the scores from each category of statements. By doing this, a range of 5 to 45 determined the lowest to highest scores possible in this section. In keeping with the instructions for this section, it was determined that 5-15 would be traditional, 16-30 would be combination, and 31-45 would be humanistic.

Section D: Culture Change Identification

This was operationalized by instructing respondents to read a statement defining culture change, then asking the respondents (based on that statement), if they practiced in a culture change nursing home (check yes or no). If the respondent answered yes, two other questions

were asked. The first question: “If yes, did you have an active role in developing or implementing culture change?” (check yes or no). The second question: “If yes, how many years has your nursing home been a culture change facility?” (two blanks were included, one for years, the other for months).

Section E: Job Satisfaction

A response scale with a range of 1-6 was utilized in the job satisfaction survey, with the following choices offered: 1 = Strongly Disagree, 2 = Disagree, 3 = Somewhat Disagree, 4 = Somewhat Agree, 5 = Agree, and 6 = Strongly Agree. The six job satisfaction domains in the 39-question survey questionnaire included empowerment (9 items), teamwork (6 items), supportive supervision (10 items), identification with values (5 items), available resources (5 items), and resident-centered care (4 items).

Job satisfaction was operationalized by adapting the Employee Satisfaction Scale utilized by Lubetkin, Annunziato, Downes, and Burak (2005). The original measurement scale contained 43 items, divided into six domains. A few questions from the original questionnaire were slightly altered, and several eliminated as not being appropriate for the present study, leaving a total of 39 items. Questions that were altered were basically in wording or reference to their hospital setting or name, losing none of the content. For example, the item *We are thoughtful about how to save money at the Jewish Home and Hospital* was changed to *We are thoughtful about how to save money at this facility*. In another example, the original item read *We put residents’ needs first here* and was changed to *We put the needs of residents first here.* The following items were deleted: *I believe this survey will lead to changes within the organization; There has been information and communication about the Jewish Home and Hospital’s culture change initiative; I think that culture change at the Jewish Home and Hospital is a good idea.* The first

item was deleted because their survey was purposeful and designed to be shared with all hospital staff as part of a pre/post-test survey in regard to their culture change initiative. The other two items were deleted for basically the same reason, that it referred to their implementation of culture change, and therefore not relevant to this study.

It should be noted that the survey contained a total of 53 items, due to the insertion of 14 additional questions. The latter were considered redundant, and not utilized in the final analysis. Therefore, only the 39-item job satisfaction questionnaire was analyzed. Items corresponding to the 39 items are listed in the Codebook for this study (see Appendix E, Section E).

Section F: Personal Opinion

This open-ended item was operationalized by including the following instructions and blank lines for a response: “Please take an opportunity to express your viewpoint as it relates to your job satisfaction as a nursing home social worker. You may want to discuss your role, the nursing home’s organizational style, ethics and values, the culture change movement, needed improvements, or any area you feel is important or essential to your job satisfaction as a social worker in this environment”.

Methodology for Data Collection

The study was conducted in 12 mid-western states, to include the following: Arkansas, Colorado, Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, Oklahoma, South Dakota, and Wisconsin. These states were chosen for their commonality in cultural “midwest” values, in an attempt to better ensure homogeneity.

To determine the sample size most appropriate for the study, probability assessment (statistical power analysis) was utilized, with a 0.05 margin of error (see Table 1). The effect size (ES) was approximated by estimating the correlational strength between the independent variable

(type of NH) and the dependent variable (job satisfaction). A medium ES (r = .30; r^2 = .09) was chosen. In order to decrease the probability of a Type II error, a maximal statistical power of 0.99 was also used (with .05 level of significance), yielding a minimal sample size of 200, obtained from a statistical power table (Rubin & Babbie, 2008). Since difficulties can arise due to low response rates, a typical response rate of 30 percent (0.30) would only yield a return of 60 surveys. To ensure that at least 200 surveys would be returned, the number of NHs was therefore increased. Assuming a 30 percent response rate, a sample size of 700 was needed to garner close to the 200 samples needed (210 to be exact). In the 12 states chosen for the study, there were 4,047 nursing homes initially identified, with a total of 934 that met the criteria established for eligibility in this study. Random selection of 720 from the 934 that met eligibility requirements were selected, using a random numbers table (Rubin and Babbie, 2008). Twenty of these were utilized for the pilot study, and the rest (n = 700) for the actual survey.

The sampling frame for this study was Medicare's Nursing Home Compare (NHC), an online list of all nursing homes in the United States that participate in Medicare and/or Medicaid (CMS, 2009). In addition to listing contact information (name of NH, address, and telephone number), NHC also listed the characteristics of each facility by state. Nursing Home Compare provided the information used to determine criteria for inclusion in this study: (1) facilities with 120 or more beds; (2) nursing homes that were Medicare and Medicaid participants; and (3) nursing homes not affiliated with a hospital. Criteria sampling was therefore utilized to select nursing homes that matched the profile established. Once this group was determined, nursing homes were randomly selected for the study.

Prior to the pilot study, an application for project approval was made to the University of Kansas Human Subjects Committee Lawrence (HSCL) on February 28, 2010. The application

was approved on March 10, 2010, which prompted the further development of the pilot study. The latter consisted of 20 surveys, divided into two groups. Pilot study A had a font size of 12, and contained 10 pages. Pilot study B had a font size of 10, with a total of 8 pages. The latter also contained a section that defined culture change, followed by three questions based on that definition.

On April 7, 2010, these survey questionnaires, along with a cover letter/information statement, and a self-addressed, stamped envelope, were sent to 20 nursing homes and two expert reviewers. Follow-up reminder postcards were mailed on April 19, 2010 to eleven non-responders. A week following this mailing, an attempt was made to contact (by telephone) those who completed a survey, to follow-up with a verbal questionnaire regarding their experiences completing the questionnaire. An attempt was also made to contact (by telephone) those who did not respond to the pilot study questionnaire, to discuss their non-participation and to solicit suggestions. Based on the feedback from these telephone calls, as well as written critiques from the two reviewers, the survey was altered in format and content.

On May 26, 2010, 700 survey questionnaires, each with a cover page cartoon, a cover letter, an information sheet, and a self-addressed stamped envelope, were mailed to nursing home social work departments in a 12-state area. It should be noted that the cover letter was specific in explaining that responses to the survey questionnaire would be confidential, coded, and entered into a software program. It was further explained that the primary researcher would be the only person to know the contact address of the nursing homes, which might be used in the event that any questionnaires were returned with missing data.

Representativeness in sampling from all 12 states was additionally considered, especially due to differences in population size. For example, North and South Dakota had fewer total

nursing homes, and therefore fewer facilities that met the study's criteria. However, it was determined that this would not have an influence on the overall results of the study due to homogeneity between the states and consistent government regulations. In regard to the latter, federal mandates specified by OBRA, to include protocols for psychosocial service delivery, are consistent throughout the United States, including the 12 states in this study.

To ensure that the study produced accurate results, attention was paid to the possible sampling errors that might occur. Salant and Dillman (1994) delineated four sources of error in survey sampling that were taken into consideration: (1) sampling error; (2) coverage error; (3) measurement error; and (4) non-response error.

A sampling error occurs when a researcher inadvertently measures some characteristic of the respondents when random sampling is utilized. Invariably, some error in sampling will always be present, but the predominant method that reduces this threat is to increase the sample size. By using a sample size of 700, this particular type of sampling error was reduced in this study.

A coverage error typically occurs when the sampling frame does not include all the members of an intended group. One common strategy that reduces this threat is to select a sample with specific criteria. In this study, NH criteria included a non-hospital setting, having 120 or more beds, and being certified by both Medicare and Medicaid. These criteria narrowed down the sample from 4,047 NHs to 934 in a 12-state area. Random selection reduced this number further to a total of 720. While this leaves 214 potential social workers that were not chosen, each of the social workers in the sample of 934 had an equal chance of being included in either the pilot or final study when random selection was utilized.

The potential for a measurement error was addressed by examining the reliability and validity of the measures in this study. Reliability was good, and the study possessed good face and content validity. In addition, this study attempted to diminish measurement errors by making sure the questionnaire had a font size that was readable, content which was free of jargon, clear printing, with easy to understand instructions and/or directions.

To reduce the possibility of a non-response error, follow-up reminder postcards were mailed to non-responders two weeks after surveys were mailed. The postcards solicited the return of completed surveys, with an offer to send another survey questionnaire if desired. Contact information was included on the postcard, with an address, telephone number, and email address.

The date the survey was mailed was recorded on a spreadsheet. Returned surveys were checked in by recording the date of return, and then examined to make sure there was no missing data. If any data was missing, the respondent in the social work department of his/her specific nursing home was contacted to complete the questionnaire. Names of respondents were not solicited or recorded, maintaining anonymity. Once all the data had been collected and cleaned, data entry was used to transfer the data into the 2010 Statistical Package for the Social Sciences (SPSS Grad Pack, Version 18) for data analysis. A computer was utilized to develop the questionnaire packet, cover/information letters, and to address mailing labels. Basic computer software programs (Microsoft Office; Excel spreadsheets) were used to generate lists and other documentation forms to record information.

Methodology for Data Analysis

Prior to data analysis, all response items on the survey questionnaire were coded and entered into SPSS-18 Grad Pack (see Appendix E for SPSS Codebook). The level of significance

for data analysis was set at 0.05, a standard probability level for quantitative research studies (Rubin & Babbie, 2008). Data analysis consisted of (1) descriptive information, including frequency distributions and percentages; and (2) inferential statistics, to include statistical tests for comparison and analysis.

Initially, large amounts of data were examined by noting essential data features. Frequency and percentage distributions were calculated on all variables, measures of central tendency and variability were conducted on continuous level variables. Correlational analyses were conducted on all the 39 job satisfaction items as a whole, and each of the six domains of the job satisfaction survey and their items (Cronbach's alpha). These are listed in the Results section of this study.

Hypothesis testing was accomplished by examining the mean scores of social workers on all indicators of job satisfaction, specifically any differences between social workers in terms of their nursing home type (Hypothesis 1) and culture change affiliation (Hypothesis 2). Hypothesis 3 was tested utilizing a chi-square test.

The first hypothesis was analyzed using an analysis of variance test, looking specifically at the descriptive statistics and parameter estimates. A Tukey's HSD post-hoc test was used to examine the mean differences between the humanistic-combination, humanistic-traditional, and combination-traditional groups. Analysis was therefore used to check if mean differences were statistically significant.

An independent samples t-test was utilized to analyze the second hypothesis. The mean differences between those in a culture change nursing home, and those not in a culture change environment, were analyzed in regard to job satisfaction (39 questions) to check for statistical

significance. When variances were shown to be unequal using a Levine's test, a Satterthwaite approximation (which produces a fractional number in the degrees of freedom) was utilized.

A chi-square (X^2) was utilized to analyze the third hypothesis, to see if a statistically significant relationship existed between nursing home type and culture change identification. Specifically, an estimation was made to determine whether or not any relationship between the two occurred by chance.

An analysis of variance test was also utilized to examine nursing home type with each of the six domains of job satisfaction: empowerment, teamwork, supportive supervision, identification with values, available resources, and resident-centered care. A Tukey's HSD post-hoc test was also used to examine the mean differences between the humanistic and combination types, humanistic and traditional types, and the combination and traditional nursing home types.

An independent samples t-test was also utilized to analyze the means of social workers practicing in a culture change nursing home, and those not practicing in a culture change nursing home, with each of the six domains of job satisfaction: empowerment, teamwork, supportive supervision, identification with values, available resources, and resident-centered care. When unequal variances were shown through a Levine's test, a Satterthwaite approximation was used, producing a fractional number in the degrees of freedom.

The open-ended question in the survey was analyzed using procedures consistent with qualitative methods. An assistant was utilized in the process, serving as an external auditor/rater. Initially, the comments were transcribed into a computer, keeping survey numbers intact. The content was thoroughly read, looking for general patterns. Overall, open coding was utilized to uncover the variety and expansiveness of the comments. To keep this activity more organized, an

adapted “cut and paste” method was utilized. This entailed coding sentences from the transcript and them, with their corresponding numbers, into a framework for analysis. The coding scheme was constantly shifting and re-ordered by the researcher and the external rater until both were satisfied with the coding and the placement of each sentence into specific categories or themes.

CHAPTER 4

RESULTS OF THE SURVEY

Section A: Demographic Information

In 2010, 700 questionnaires were mailed out to nursing home social workers in a 12-state area. The response rate was 46%, or 321 surveys, with 94% of the respondents being female. Age was classified into five categories, and it was found that 21% of respondents were between the ages of 20 to 29; 28% of respondents were between the ages 30 to 39; 20% of respondents were between the ages of 40 to 49 years; 23% of respondents were between the ages of 50 to 59 years; and 8% of the respondents were between the ages of 60 to 69 years (see Table 2 for gender and age).

In terms of race, 93% of the respondents self-identified as White, 5% of respondents self-identified as Black or African American, 1% of respondents self-identified as American Indian or Alaska Native, and another 1% of respondents self-identified as Asian American. It should be noted that although the survey did not query ethnicity, seven of the respondents noted they were Hispanic, with another individual indicating a mixed race background (see Table 3).

The majority of respondents (66%) were trained as social workers. Of these, 45% had BSW degrees, and 21% had an MSW degree. In regard to the rest, 22% of respondents had a BA or BS degree; 9% of the respondents had a MA or MS degree; 2% of the respondents had an AA degree; and 1% of the respondents had a high school diploma or GED (see Table 4).

The top five academic degree types, or major areas of study, included the following: 66% of respondents had degrees in social work; 10% of respondents had degrees in psychology; 7% of respondents had degrees in gerontology; 5% of respondents had degrees in sociology; and 3% of respondents had degrees in business (see Table 5).

Employment status in the nursing homes reflected that 98% of respondents worked full-time, and 2% worked part-time. In regard to salary, 2% made $20,000 or less. The other salary ranges and percentages included $20,001 to 30,000 (12%); $30,001 to 40,000 (35%); $40,001 to 50,000 (36%); and $50,001 to 60,000 (11%). The remaining 4% reported a salary over $60,000 (see Table 6).

The total experience of respondents as nursing home social workers reflected that 6% had less than 1 year of experience; 59% of respondents had 1-10 years of experience; 25% of respondents had 11-20 years of experience; 8% of respondents had 21-30 years of experience; and 2% of respondents had 31-40 years of experience (see Table 7).

Section B: Work in the Nursing Home

The top five activities performed by respondents included documentation (80%); assessments (78%); communicating with families (73%); care planning (65%); and discharge planning at 59% (see Table 8).

The top five activities performed outside of a respondent's job description included moving residents to another room (79%); buying items for residents (65%); running errands for residents (61%); facilitating resident activities (29%), with another 21% involved in feeding residents at mealtimes (see Table 9).

Section C: Nursing Home Type

This section of the questionnaire was divided into five items, with each item offering a statement that described a traditional and a humanistic nursing home type. Respondents then rated their nursing home as being either traditional, humanistic, or a combination facility. The five items included statements about organizational style; staff interactions; resident choice; resident/staff interactions; and organizational change. Overall nursing home type was determined

by cutting the total number of scores possible (5-45) by following the directions for this section. Therefore, 5-15 was deemed a traditional type of nursing home, 16-30 a combination type, and 31-45 a humanistic type of nursing home. Based on this division, the survey showed that overall, 9% (n = 29) were traditional; 44% (n = 141) fell into the combination type, and 47% (n =151) were humanistic (see Table 10).

The frequency results for each statement item in this section included the following: organizational style (25% traditional, 45% combination, 30% humanistic); staff interactions (16% traditional, 33% combination, 51% humanistic); resident choices (12% traditional, 41% combination, 47% humanistic); resident and staff interactions (17% traditional, 38% combination, 44% humanistic); and organizational change (20% traditional, 39% combination, 41% humanistic) (see Table 11).

Section D: Culture Change Identification

When respondents were asked if they practiced in a culture change nursing home, 61% said yes, and 39% said no. For those respondents who answered yes (n = 197), they were asked if they had an active role in developing or implementing culture change. The results showed that 82% of the 197 respondents said yes, and 18% said no. Finally, respondents who answered yes (n = 197) were asked how many years and/or months they had been a culture change facility. The results showed that 7% of the respondents reported themselves being a culture change nursing home for 12 months or less; 35% for 1-2 years; 22% for 3-4 years; 11% for 5-6 years; 5% for 7-8 years; 4% for 9-10 years; and 1% for 11 years or longer. Another 15% (n = 30) did not have this information (see Table 12).

Hypothesis Testing: Results

For both hypothesis 1 and 2, job satisfaction was measured with the job satisfaction

questionnaire (39 questions). Analysis of variance and t-tests were utilized for comparison and analyses. The instrument adapted for this study has good reliability. Job satisfaction measured by the 39-item scale was analyzed for its internal consistency, with a Cronbach's alpha level of .96, demonstrating good reliability of the questionnaire as a whole. A chi-square (X^2) test was used for hypothesis 3.

Hypothesis 1: *Social workers in a humanistic type of nursing home will have a higher level of job satisfaction than social workers practicing in a combination or traditional type of facility.*

An ANOVA was conducted to compare job satisfaction with nursing home type. There was a statistically significant difference at the $p < .05$ level between the humanistic, combination, and traditional nursing home types ($F = 107.59$, $df = 2, 318$, $p = .001$). Post-hoc comparisons using the Tukey HSD test indicated that the humanistic nursing home type showed a statistically significantly difference from the combination and traditional types. There was a smaller difference between the humanistic and combination types, and a larger difference between the humanistic and traditional nursing home types. There was also a statistically significant difference between a combination type and a traditional type of nursing home (see Tables 13 and 14).These results suggest that social workers practicing in a humanistic type of nursing home experience a higher level of job satisfaction than do those in a combination or traditional type of facility.

Hypothesis 2: *Social workers identifying themselves as practicing in a culture change nursing home will have a higher level of job satisfaction than will social workers who do not practice in a culture change facility.*

An independent-samples t-test was conducted to compare the job satisfaction of social workers in culture change and non-culture change nursing homes. There was a statistically significant difference between those in a culture change nursing home and those not in a culture change facility ($t = -7.34$, $df = 204.04$, $p = .001$). If variances were shown to be unequal using a Levine's test, a Satterthwaite approximation was used, which produces fractional numbers in the degrees of freedom. These results suggest that social workers who practice in culture change nursing homes experience higher levels of job satisfaction than social workers practicing in non-culture change facilities (see Table 15).

Hypothesis 3: *Social workers who identify themselves as practicing in a culture change nursing home will also identify themselves as practicing in a humanistic type of nursing home.*

A chi-square test was performed to determine if social workers who identified themselves as practicing in a culture change nursing home would also identify themselves as practicing in a humanistic type of nursing home. The results of the analysis showed there was a statistically significant relationship between a humanistic type of nursing home and practicing in a culture change nursing home: X^2 (2, N = 321) = 82.35, $p < .05$ (see Table 34). However, frequency results also show that not all of the social workers in a culture change nursing home (n = 197) identified themselves as being in a humanistic nursing home type. Of the 197, 131 or 66% said they practiced in a humanistic nursing home type; 60 or 31% identified themselves as being in a combination type, and 6 or 3% identified themselves as being in a traditional type of nursing home.

Job Satisfaction Domains

The job satisfaction questionnaire, consisting of 39 questions, was divided into six different domains, each reflecting a different aspect of job satisfaction. These included:

(1) empowerment; (2) teamwork; (3) supportive supervision; (4) identification with nursing home values/beliefs; (5) available resources; and (6) resident-centered care. The six domains were analyzed separately by looking at each domain's scores in regard to nursing home type, and separately with culture change affiliation. The six domains of the scale were analyzed for internal consistency, with Cronbach's alpha levels ranging from a low of .77 to a high of .91, indicating general reliability of the scale. Specifically, alpha levels in each of the six domains were as follows: empowerment (.87), teamwork (.84), supervisory support (.91), identification with NH Values (.79), available resources (.82), and resident-centered care (.77).

Empowerment

An ANOVA was conducted to compare empowerment with nursing home type. There was a statistically significant difference at the $p < .05$ level between the humanistic, combination, and traditional nursing home types ($F = 83.07$, $df = 2, 318$, $p = .001$). Post hoc comparisons using the Tukey HSD test indicated that the humanistic nursing home type showed a statistically significant difference from the combination and traditional types. The differences were smaller between the humanistic and combination types, and larger between the humanistic and traditional facilities; the combination nursing home type showed a larger difference than the traditional type. These results suggest that social workers practicing in a humanistic type of nursing home experience higher levels of empowerment than do those practicing in either a combination or traditional facility. In turn, social workers in combination types have a higher level of empowerment than those in traditional types of facilities (see Tables 16 and 17).

An independent-samples t-test was conducted to compare the empowerment of social workers in culture change and non-culture change nursing homes. There was a significant difference between social workers in a culture change nursing home and those not in a culture

change facility (t = -6.21, df = 200.03, p = .001). If variances were shown to be unequal using a Levine's test, a Satterthwaite approximation was used, which often produces fractional numbers in the degrees of freedom. These results suggest that social workers who practice in a culture change nursing homes have a higher level of empowerment than do those social workers practicing in a non-culture change facility (see Table 18).

Teamwork

An ANOVA was conducted to compare teamwork with nursing home type. There was a statistically significant difference at the $p < .05$ level between the humanistic, combination, and traditional nursing home types ($F = 82.71$, df = 2, 318, $p = .001$). Post-hoc comparisons using the Tukey HSD test indicated that the humanistic nursing home type showed a statistically significant difference from the combination and traditional types. The differences were smaller between the humanistic and combination types, and larger between the humanistic and traditional facilities. The combination nursing home type showed a larger difference than the traditional type. These results suggest that social worker who practice in a humanistic type of nursing home experience higher levels of teamwork than do those practicing in either a combination or traditional facility. In turn, social workers in combination nursing home types have a higher level of teamwork than those in traditional types of facilities (see Tables 19 and 20).

An independent-samples t-test was conducted to compare the teamwork of social workers in culture change and non-culture change nursing homes. There was a significant difference between social workers in a culture change nursing home and those not in a culture change facility (t = -6.03, df = 201.19, p = .001). If variances were shown to be unequal using the Levine's test, a Satterthwaite approximation was used, which can produce a fractional number

in the degrees of freedom. These results suggest that social workers who practice in a culture change nursing homes experience a higher level of collaborative teamwork than do those social workers practicing in a non-culture change facility (see Table 21).

Supportive Supervision

An ANOVA was conducted to compare supportive supervision with nursing home type. There was a statistically significant difference at the $p < .05$ level between the humanistic, combination, and traditional NH types ($F = 90.43$, $df = 2, 318$, $p = .001$). Post-hoc comparisons using the Tukey HSD test indicated that the humanistic nursing home type showed a statistically significant difference from the combination and traditional types. The differences were smaller between the humanistic and combination types, and larger between the humanistic and traditional facilities. The combination nursing home type showed a larger difference than the traditional type (see Tables 22 and 23).These results suggest that social workers practicing in a humanistic type of nursing home experience higher levels of supportive supervision than do those practicing in either a combination or traditional facility. In turn, social workers in combination types have a higher level of supportive supervision than those in traditional types of facilities.

An independent-samples t-test was conducted to compare the supportive supervision of social workers in culture change and non-culture change nursing homes. There was a significant difference between social workers in a culture change nursing home and those not in a culture change facility ($t = -6.42$, $df = 231.93$, $p = .001$). If the variances were shown to be unequal using a Levine's test, a Satterthwaite approximation was used, which produces a fractional number in the degrees of freedom. Results suggest that social workers who practice in a culture change

nursing homes have a higher level of supportive supervision than do those social workers practicing in a non-culture change facility (see Table 24).

Identification with Nursing Home Values

An ANOVA was conducted to compare nursing home values with nursing home type. There was a statistically significant difference at the $p < .05$ level between the humanistic, combination, and traditional NH types ($F = 75.89$, $df = 2, 318$, $p = .001$). Post-hoc comparisons using the Tukey HSD test indicated that the humanistic nursing home type showed a statistically significant difference from the combination and traditional types. The differences were smaller between the humanistic and combination types, and larger between the humanistic and traditional facilities. The combination nursing home type showed a larger difference than the traditional type (see Tables 25 and 26).These results suggest that social workers practicing in a humanistic type of nursing home identify more with nursing home values than do those practicing in either a combination or traditional facility. In turn, social workers in combination types identify more with NH values than those in traditional types of facilities.

An independent-samples t-test was conducted to compare the NH values of social workers in culture change and non-culture change nursing homes. There was a significant difference between social workers in a culture change nursing home and those not in a culture change facility ($t = -7.13$, $df = 203.61$, $p = .001$). If the variances were shown to be unequal using a Levine's test, a Satterthwaite approximation was used, which can produce a fractional number in the degrees of freedom. These results suggest that social workers who practice in a culture change nursing homes identify more with NH values than do social workers practicing in a non-culture change facility (see Table 27).

Available Resources

An ANOVA was conducted to compare available resources with nursing home type. There was a statistically significant difference at the $p < .05$ level between the humanistic, combination, and traditional nursing home types ($F = 67.80$, $df = 2, 318$, $p = .001$). Post-hoc comparisons using the Tukey HSD test indicated that the humanistic nursing home type showed a statistically significant difference from the combination and traditional types. The differences were smaller between the humanistic and combination types, and larger between the humanistic and traditional facilities. The combination nursing home type showed a larger difference than the traditional type (see Tables 28 and 29).These results suggest that social workers practicing in a humanistic type of nursing home have more available resources than do those practicing in either a combination or traditional facility. In turn, social workers in combination types have more available resources than those in traditional types of facilities.

An independent-samples t-test was conducted to compare the available resources of social workers in culture change and non-culture change nursing homes. There was a significant difference between social workers in a culture change nursing home and those not in a culture change facility ($t = -6.81$, $df = 215.44$, $p = .001$). If variances were shown to be unequal using a Levine's test, a Satterthwaite approximation was used, which produces a fractional number in the degrees of freedom. These results suggest that social workers who practice in a culture change nursing homes have a higher level of available resources than do those social workers practicing in a non-culture change facility (see Table 30).

Resident-Centered Care

An ANOVA was conducted to compare resident-centered care with nursing home type. There was a statistically significant difference at the $p < .05$ level between the humanistic,

combination, and traditional NH types (F = 87.27, df = 2, 318, p = .001). Post-hoc comparisons using the Tukey HSD test indicated that the humanistic nursing home type showed a statistically significant difference from the combination and traditional types. The differences were smaller between the humanistic and combination types, and larger between the humanistic and traditional facilities. The combination nursing home type showed a larger difference than the traditional type (see Tables 31 and 32). These results suggest that social workers practicing in a humanistic type of NH experience higher levels of resident-centered care than do those practicing in either a combination or traditional facility. In turn, social workers in combination types have a higher level of resident-centered care than those in traditional types of facilities.

An independent-samples t-test was conducted to compare the resident-centered care of social workers in culture change and non-culture change nursing homes. There was a significant difference between social workers in a culture change nursing home and those not in a culture change facility (t = -8.25, df = 201.70, p = .001). If variances were shown to be unequal using a Levine's test, a Satterthwaite approximation was used, which can produce a fractional number in the degrees of freedom. These results suggest that social workers who practice in a culture change nursing homes have a higher level of resident-centered care than do those social workers practicing in a non-culture change facility (see Table 33).

Open-Ended Question

The open-ended question located on the last page of the survey was analyzed using qualitative methods. Out of the 321 social work participants in the study, 191 (or 60%) responded to this item. The instructions for this section were as follows: Please take an opportunity to express your viewpoint as it relates to your job satisfaction as a nursing home

social worker. You may want to discuss your role, the nursing home's organizational style, ethics and values, the culture change movement, needed improvements, or any area you feel is important or essential to your satisfaction as a social worker in this environment.

Emergent Themes

Five themes emerged in the open-ended question, to include the following: (1) Job Satisfaction; (2) Workload; (3) Administration and Supervision; (4) Residents; and (5) Culture Change. The following are comments made from each major theme as written by social work respondents, but the examples are not exhaustive. They represent typical comments that relate to the emergent themes identified.

Job Satisfaction

Many social workers wrote about their job satisfaction in positive terms, even if they experienced some difficulties in practice: "Although I have many challenging days, I really enjoy my work"; The situation of being over-burdened but satisfied with the job was often part of the commentary: "Overall, I am very satisfied with my job"; "I enjoy my position . . . ."; "I love it here"; "I like what I do . . ."; "Every day is different, but I enjoy my job".

Others discussed teamwork in regard to job satisfaction, many in a positive tone: "We have high standards we all work together to meet"; "Support and teamwork are essential"; "Multidisciplinary team approach is key to my satisfaction". However, teamwork was frustrating for other social workers: "…other disciplines . . . want your help in almost every area . . . but do not want to recognize the job"; ". . . my department struggles with the inefficiencies of the nursing department . . . lack of responsibility, lack of initiative, lack of leadership, and . . . lack of good common sense"; "People get defensive and . . . teamwork diminishes".

Respect, as an element of job satisfaction, was also discussed in the narratives. There were some positive comments: ". . . I feel like my job is respected . . ."; "My facility . . . values the social work profession . . ."; "In general, I feel social workers are respected"; "I feel valued by family, staff, and the residents . . . ." More often, the narrative commented on the lack of respect of nursing home social workers: "Social Services Dept. is not respected"; "We are not valued"; "I don't feel social workers get the respect they deserve or credit for our expertise"; ". . . my opinion doesn't matter"; ". . . social workers are not as respected as nurses".

Being underpaid was another area of frustration: "My hours and pay have been cut recently. . ."; "My biggest concern is that I feel social workers are underpaid for the jobs they do"; "My general opinion about nursing home social workers is that we are underpaid . . .".

Social workers commented about their roles being stressful: ". . . I'm worn out by the increasing complexity and stress"; "Harried days . . . leave you feeling tired/stressed"; ". . . the biggest stressor is finding ways to do more . . . w/ less . . .".

Workload

In regard to workload, more comments were made about paperwork and documentation than any other single topic, framed in a negative tone: "Paperwork is endless"; "They expect you to do loads of paperwork including admissions"; "It would be nice if I could spend less time on documentation"; ". . . there is way too much paperwork . . ."; "The increase in paperwork to stay in compliance has been unbelievable over the last 14 years"; "There is a lot of documentation"; "The paperwork required has been all consuming sometimes . . ."; "As a social worker I get buried under paperwork . . ."; "Regulatory paperwork often frustrates me as I feel it takes time away from relationship building with residents". These general ideas were expressed throughout the written narratives about paperwork and documentation.

Performing tasks outside of one's job description as a social worker also seemed to be quite problematic in the nursing home: ". . . admissions, discharges, room moves, talking to families about insurance . . . picking up res from hospital, taking glasses/dentures to be fixed, etc, etc, etc. . . ."; ". . . yard work (planting flowers, weeding, watering), and basically anything any other dept/staff doesn't want to deal with . . ."; "My role is everything!"; ". . . doing all the tasks that do not fit neatly into other department's [sic] job descriptions"; ". . . no one to advocate on behalf of the social worker when 'dumped' upon".

The overall volume of work required by nursing home social workers was also expressed in written narratives: "I hardly have time to go to the bathroom . . ."; "The duties assigned to me are unrealistic for just one person . . ."; " We are impossibly overwhelmed . . ."; ". . . my workload has increased tremendously . . ."; "I . . . am left with little time to actually meet with residents . . ."; ". . . nursing home social workers . . . are underpaid and overworked"; ". . . I often feel . . . overwhelmed by the large work load"; ". . . we are . . . drowning . . . ."

Lack of time to complete necessary tasks also emerged in the written narratives: "Trying to find the time for all the duties I have . . . is challenging"; "Extremely busy, not enough hours in the day"; "Weekly work has averaged 70 hours/wk. . . ."; "We'd like to take the time for 'social work' but it's just not possible!"; "Obviously I enjoy what I do, but the hours can be extremely long".

For some social workers, excessive meetings seemed to prevent task completion or interfere with the building of relationships with residents: "The majority of my time is spent attending meetings in which I serve no definable purpose"; "I spend 2-3 hours of my 6 hour day in meetings!"; ". . . meetings leave little time to complete paper work"; "I spend so much time in

meetings throughout the day . . . I don't even have time to counsel or do any type of therapy with residents"; "[We have] meetings to schedule meetings".

Administration/Supervision

Social workers had a number of comments about administrators or supervisors, some of which were positive, and some negative. On the positive side: "We have . . . a very smart and compassionate administrator . . ."; "I personally feel that I have a good supervisor"; "The facility owner and administrator are excellent quality people with high ethical and moral values". Negative comments were more often expressed by social workers: ". . . administrators . . . do not seem to be knowledgeable about team building . . . are more fiscally driven than placing the priorities of the residents first"; "I do not feel that I have backing from the administrator"; "Topdown management decisions are based solely on money . . ."; "We have an administrator who is controlling"; ". . . the role of the social worker is not valued by administration".

Residents

Although time constraints were often cited in regard to job satisfaction and workload, many social workers wrote about not having enough "time" to spend with residents: "There is far too little time for direct services with residents"; "I do wish I had more time to visit with the residents"; "What I miss the most, I am at the desk more than I am with residents"; "I wish I had more time to do more counseling"; "I wish there were more time to spend individually with each resident . . ."; "I cannot give as much one-on-one time to the residents and families as I would like to . . . ."

Advocating for residents was an important element to social workers. Some felt a sense of fulfillment by doing so: "Very satisfying to assist res and advocate for them and families", while some found this an ongoing endeavor: "I am constantly advocating for the residents".

Still, other social workers found that advocating for residents was difficult or frustrating: “I feel unable to advocate fully for my residents, and feel the medical model used is psychosocially harmful to my residents”; “Trying to find the time . . . [to] be my residents’ advocate is challenging”.

Overall, many social workers noted a strong emotional attachment to residents: “I love my residents”; “ I love serving elders . . .”; “. . . my heart [is] with this age group”; “I love residents and wouldn’t want to leave”; “. . . I love the residents. . . .”

Culture Change

Virtually all comments related to culture change noted experiences of implementation, partial implementation, or difficulties related to culture change initiatives: “We did put in snack cabinets for residents to access 24/7, but then the company got rid of the lady (hired to implement culture change) . . .”; “We have implemented different aspects of CC that have allowed residents to have choices (meal choice, rising and bedtime choice, remodeling, pets, landscaping) . . .”; “We’re struggling with CC. I feel medical + Dr. orders often trump resident satisfaction and self-determination”; “As far as CC, we give some credence to it as we offer residents some choices, but not complete choices on whatever they want and times they want to do things”; “We talk about CC and are making little steps toward person-centered care”.

Summary

The primary purpose of this study was to examine whether nursing home type, and practicing in a culture change facility, were related to the job satisfaction of social workers in nursing homes not affiliated with a hospital. Statistically significant findings showed that being in a culture change and humanistic type of nursing home were positively related to job satisfaction. It was further shown that culture change and nursing home type were positively

related to the six domains of job satisfaction: empowerment, teamwork, supervisory support, identification with NH values, available resources, and resident-centered care.

The results of this study were in clear contrast to the findings of the Lubetkin et al. (2005) and Neuman (2003) studies, where the implementation of culture change had a neutral or negative influence on the job satisfaction of social workers in hospital affiliated nursing homes. In this study, the findings suggest that social workers are positively affected by culture change in terms of satisfaction, at least in facilities that are separate and independent, with 120 or more beds, certified by Medicare and Medicaid, and in the 12 mid-western states in the study.

In a cross-sectional survey design, one cannot ascribe a causal relationship, but one can say with a high degree of certainty that differences exist between the culture change and non-culture change group, as well as the humanistic, combination, and traditional nursing home group in regard to job satisfaction.

This study is important in forming an empirical baseline for the study of social workers in both humanistic and culture change nursing homes. It also touches on the complexities of being a social worker in an organizational climate that teems with dysfunction on many levels, often derived from the unyielding and inflexible tenets of the medical model. The culture change movement is not an independent entity, but an ideological part of the reformation efforts that belong to organizational change theorists from the past. Culture change initiatives enhance the quality of life of residents in nursing homes across the nation, addressing abuse, neglect, and resident choice. It is purposeful and designed to transform the entire complex of nursing home facilities, ultimately creating individual atmospheres that are creative, motivating, and homelike.

CHAPTER 5

DISCUSSION

The results of this study demonstrate that nursing home types that are humanistic, and those facilities that have implemented a culture change initiative, are positively related to the job satisfaction of social workers who practice in these environments. The results therefore create an important baseline for research, as no other study has focused on the job satisfaction of social workers in culture change nursing homes that are independent of a hospital setting. In addition, unlike the Neuman (2003) and Lubetkin et al. (2005) studies, this study showed that social work satisfaction was impacted by culture change. This is an important finding, as many might believe that nursing home social workers are negatively influenced by culture change, based entirely on the results of the Neuman and Lubetkin et al. research. Further, many novice researchers might not know that hospital affiliated nursing homes only comprise approximately 13% of all total facilities in the country, versus the majority that are not affiliated with a hospital (*Centers for Medicare and Medicaid Services*, 2012). Having culture change information that reflects the reality in nursing homes is essential to making decisions important for research, policy development, funding, the social work profession, and overall reformation efforts in regard to nursing homes in this country.

Survey Demographics

Gender and Race

In terms of demographic information, it was no surprise that 94% of the social workers were female, especially in light of the fact that social work is a female-driven profession, and especially true in the nursing home industry. In addition, with the possible exception of administrators, most of the staff of any given nursing home consists primarily of females. In this

study, it was also expected that the majority of social workers would be White (93%), with a low percentage of African Americans (5%), American Indians/Alaska Natives (1%), or Asian Americans (1%). This seems to follow a racial pattern seen in other nursing homes in regard to social workers, physical/recreational therapists, directors of nursing, and administrators are White. However, this pattern seems to be reversed when it comes to many frontline workers, employees in food services, or nursing home maintenance, where people of color are commonly represented (Squillace, 2011).

Age of Respondents

In terms of age, the majority of social workers were between the ages of 20 to 49 (69%). It was interesting to find that 31% were between the ages of 50 to 69, as the physical and psychological demands of the job are quite overwhelming, and one might expect fewer social workers in this age range. This percentage may also reflect the advantages of experience and tenure in the role of social worker.

Educational Level

Information garnered from nursing home legislation, books, articles, and academic research note that many nursing home social workers often do not have actual degrees in social work, so it was gratifying to see that 66% of social workers in this study had either a BSW (45%) or MSW (21%) degree. Another 22% had allied degrees. However, the remaining 12% represented a variety of degree areas, rendering these social workers as being out-of-compliance with OBRA mandates related to academic degree requirements for nursing homes with 120 or more beds.

Salary of Respondents

In terms of salary, 71% of social workers in this study fell into an overall range of

$30,000 to $50,000. Looking at that range more closely, 16% had a salary of $30,000 to 35,000; 19% $35,001 to 40,000; 22% $40,001 to 45,000; and 14% $45,001 to 50,000. In 2010, the national median annual income of social workers employed in nursing homes was $41,860 (Bureau of Labor Statistics, 2012). When the median was calculated for salary in this study, the result was a range of $40,001 to 45,000, consistent with the BLS report. However, does the salary of nursing home social workers offer a living wage? That certainly depends on personal family size, cost of living in specific states, if the social worker is a single parent or otherwise dealing with a multitude of conditions and economic situations. Salaries for social workers are said to be 11% less than other professional occupations (Linsley, 2003). In the current recession, the salary of social workers in nursing homes has undoubtedly been affected by the economic downturn, a situation which may continue for some time.

Nursing Home Experience

Total nursing home experience in this study was somewhat expected, with 37% having 1 to 5 years of experience. The second highest was 6 to 10 years at 21%, followed by a range of 11 to 15 years at 13%, with 12% falling into a range of 16 to 20 years. Despite pervasive turnover in nursing homes across the nation, it is interesting that social workers in this study have stayed in the nursing home setting long enough for it to be considered a more permanent career choice, especially reflected in the 25% that have 11 to 20 years of nursing home experience in a social worker position.

Top Five Activities Performed

There was no particular surprise in regard to the activities performed by nursing home social workers, with documentation (at 80%) leading the list. Academic studies often note the excessive amount of paperwork in nursing homes, assessed by social workers as problematic and

preventing them from building relationships with residents and attending to their psychosocial needs. However necessary documentation is to the position of social workers in a nursing home setting, it is nonetheless burdensome. One speculates if the introduction of technology, such as wireless components, feeding into a central data bank, might be a beneficial aid in decreasing the time spent completing documentation, and especially in the reduction of paper files, charts, and so forth.

Top Five Activities Outside of Job Description

This is further exacerbated by the extraneous activities social workers perform outside of their job descriptions. In this study, 73% of social workers spent time moving a resident to another room, buying items for residents (65%), running errands (61%), facilitating activities (29%), and feeding residents (21%). The expansiveness of the situation was exemplified in this study, where another 34% of social workers stated they were pulled away from required duties to attend to an exhaustive list of errands for residents. This is consistent with narratives from social workers in this and other studies that often express the feeling they are being "dumped" on by other departments when it involves activities deemed inconsequential to their role as social worker. This obviously points to a lack of respect for social workers in this setting, and more seriously highlights role ambiguity.

Nursing Home Type

There were some interesting results in regard to nursing home type. The nursing home types in this study were traditional (9%), combination (44%), and humanistic (47%). It was somewhat expected that the largest type would be humanistic, with smaller percentages reflected in the combination and traditional types. Although this was reflected in the frequency results, the large number of combination types was not expected.

One possible explanation for the large number of combination nursing homes may be that these facilities are “striving” to be humanistic environments. This notion is reflected in a study by Doty, Koren, and Sturla (2008) in their attempt to assess the extent to which concepts related to the culture change movement had penetrated nursing homes nationwide. The researchers divided nursing homes into three groups: culture change adopters, culture change strivers, or traditional nursing homes. It was found that 31% were culture change adopters, 25% culture change strivers, and 43% traditional. The study first defined culture change and placed nursing homes into one of the three groups depending on how they incorporated culture change.

Culture change adopters were nursing homes that completely or predominantly adhered to the definition. Culture change strivers partially adhered to the definition of culture change (or not at all), but had administrators or other leaders who were very committed to adopting this approach. Traditional nursing homes only partially adhered to this definition (or not at all), with administrators who were not committed to adopting culture change.

Although one cannot be sure if the combination type in the current study reflects the same tendency to strive for a humanistic type category described by Doty et al., it might be a plausible assessment, and would explain the large number of combination types. The notion that the combination type may be striving to adopt a humanistic organizational structure may indicate that more humanistic administrations are being inculcated in some fashion, and slowly becoming a norm in the industry.

Culture Change Identification

Culture change identification in this study was accomplished by offering a definition of culture change, condensed from the humanistic categories under nursing home type. Based on this definition, social workers in the study were asked if they practiced in a culture change

nursing home. The results showed that 197 or 61% practiced in a culture change facility, with 82% of this group having an active role in developing or implementing culture change. Social workers were additionally asked how long their nursing homes had been a culture change facility. The results were somewhat unexpected, as 35% indicated a range of 1 to 2 years, with 22% indicating a range of 3 to 4 years, and another 11% reflecting 5 to 6 years. It was expected that the number of years as a culture change facility would be much higher, since culture change has been on the scene for over15 years, and well known throughout the nursing home industry. The overall lack of time as a culture change facility is a critical finding, as reformation of this magnitude requires a slow but steady evolution. Changing the culture of an institutional setting requires an alteration in mindset, forming a new paradigm through struggle, assimilation, and further growth and evolution. This type of transformation takes many years or decades to realize, and requires personal and professional adaptations (Koren, 2010; Misiorski & Kahn, 2005; Thomas, 2003).

Job Satisfaction

The job satisfaction variable in this study has important ramifications. Multiple factors can be studied in organizations to explore overall effectiveness, and job satisfaction of employees is considered one of the most essential. It should therefore come as no surprise to learn that job satisfaction is the most frequently studied factor in organizational research, for a number of reasons. Job satisfaction can be a proxy for an organization’s ability to function, highlights areas that need improvement, or indicate what strategies are effective. It can also assess if employees are treated equitably, with respect, and whether they consider specific protocols and organizational goals as fair and in keeping with the overall mission statement of

the organization. In the social services arena, job satisfaction may also be related to the quality of services, and the extent to which employee responsibilities are carried out to fulfill the needs and desires of clients.

In many ways, the humanistic approach currently advocated in the NH industry touches on job motivation and advocates changes in the nature and content (characteristics) of the many tasks that employees perform. Despite a historical lack of empirical study in this specific area, there are some characteristics that purportedly relate to job satisfaction. Hackman & Oldham (1976; 1980), for example, have been quite influential in noting the existence of five core characteristics that influence an employee's psychological state, ultimately leading to job satisfaction, motivation, performance on the job, and turnover. These include skill variety, task identity, task significance, autonomy, and job feedback. The first three combine to influence the meaningfulness of work as experienced by the employee. Autonomy is associated with an individual's sense of responsibility, and feedback promotes knowledge acquisition or a perception of the outcomes related to the work one performs. In job characteristics theory, researchers maintain that these core characteristics are related to the overall job satisfaction of employees, and how motivated they will be in the workplace. In addition, the foundation of this theory is that many people find an intrinsic satisfaction in performing the tasks and duties related to their jobs, not because of an extrinsic reward system.

The job satisfaction questionnaire in this study was comprised of six domains that were related to job satisfaction, to include empowerment, teamwork, supportive supervision, an identification with nursing home values, available resources, and resident-centered care. The humanistic nursing home type as well as culture change did show a statistically significant relationship with these six domains.

Empowerment

Respondents showed that being in a humanistic nursing home, as well as practicing in a culture change facility was related to a sense of empowerment, ultimately leading to a higher level of job satisfaction. Empowerment in the nursing home involves autonomy, and being able to make practice decisions. While the medical model may constrain or prohibit personal talents or strengths, being empowered in the workplace often generates creativity and resident-centered innovations. The ability to make choices and utilize one's professional knowledge and skills is an important piece of being empowered in the workplace. When Weber and others note that a bureaucratic, hierarchical system erodes essential freedoms, empowerment is one domain that is affected. Researchers have reported this connection, with a realization that empowerment is an important part of job satisfaction (Acker, 2004; Flesner & Rantz, 2004; Seibert, Silver, & Randolph, 2004).

Teamwork

Living or working in a vacuum is seldom a successful endeavor in regard to meeting the needs of nursing home elders. Results of this study showed that when social workers in a humanistic or culture change environment are actively involved with others in meeting a common goal, they have a higher level of job satisfaction. This involves communication that is effective throughout the nursing home, especially in regard to residents and fellow workers. Collaborative teamwork therefore creates a positive working environment for all staff members. The sharing of information is another positive, keeping all members of the team aware of new policies or ways to solve eminent problems or concerns. Teamwork is therefore a domain that is associated with job satisfaction in the nursing home setting (Morley & Herarty, 1995; Moyle, Skinner, Rowe, & Gork, 2003; Proenca, 2007).

Supportive Supervision

It seems intuitive that having a supportive supervisor increases an individual's job satisfaction. Therefore, it was no surprise that in this study, social workers practicing in a humanistic type of nursing home or in a culture change facility had a higher level of job satisfaction when they had a positive and supportive relationship with their supervisors. Supervisors who are supportive have a respect for their co-workers, and offer guidance that is focused on continual progress. At the same time, an effective supervisor is cognizant of a worker's efforts, and willing to recognize or offer praise for work. Social workers in a humanistic or culture change environment also showed that strong and reliable supervision involves a clear presentation of job performance goals, and the willingness to share knowledge and information. Accessibility is another characteristic of a supportive supervisor, and the ability to create an environment of trust and open communication. When these elements are present, workers have a higher level of job satisfaction (Hackman & Oldham, 1976; 1980; Jackson & Schuler, 1985; Luptak, 2006).

Identification with Nursing Home Values

In this study, the results showed that social workers in a humanistic or culture change nursing home identified more with the values of the nursing home, ultimately contributing to higher levels of job satisfaction. Included in this is the feeling that one's work contributes in a meaningful way to the nursing home's mission, with actions and decisions that support the underpinning values. In nursing homes that abide by the medical model, this can cause some concern for social workers who believe in a resident's self-determination. The medical model is often structured by inflexible rules and regulations, diminishing personal freedom and resident choice. The frustration and confusion that occurs when a nursing home's values are not

assimilated by workers may lead to role ambiguity. If social workers feel they are not practicing in an environment that shares their professional ethics and values, then residents will not receive the full panoply of a social worker's knowledge and skills. The sharing of common values is an essential element leading to job satisfaction (Cox & Parsons, 1994; Deuschmann, 2001; Vladeck, 2003; Weiner & Ronch, 2003).

Available Resources

Having available resources that contribute to the completion of tasks is directly related to job satisfaction. In this study, social workers in a humanistic type of nursing home or a culture change facility showed that when resources were available to them in the service of residents, it contributed to a higher level of job satisfaction. The availability of resources not only includes tangible materials, but environmental, psychosocial, and psychological resources. Resources may also include training and educational components, as well as having a work environment that provides comfort and safety. If workers have personal or professional problems, there should be resources in the workplace that can offer therapeutic support. Overall, the availability of resources essential to the care of residents is associated with higher levels of job satisfaction (Jeong & Keatinge, 2004; Jex & Gudanowski, 1992; Peters, O'Connor, & Rudolf, 1980).

Resident-Centered Care

When social workers provide resident-centered care in the nursing home environment, this leads to higher levels of job satisfaction. In this study, social workers practicing in a humanistic type of nursing home, and those in a culture change facility, displayed higher levels of job satisfaction when they could provide services that directly addressed a resident's needs and desires. The resident-centered approach is pivotal to the humanistic, culture change perspective, where resident needs are central and drive service delivery. Needs are fulfilled with

respect, in keeping with resident self-determination. An essential piece of this approach is the resident-staff relationship, where residents are perceived on an equal par with all members of the nursing home facility, and are treated from that set of values and beliefs. As staff members view residents as independent, capable, resilient, and valued as individuals, it restores an elder's sense of self-worth, dignity, self-efficacy, and instills a sense of belonging. When nursing home social workers can respond to the needs and desires of residents, they experience higher levels of job satisfaction (Gilbert & Bridgees, 2003; Koren, 2010; Lehning & Austin, 2010; Stevenson & Gifford, 2009; Talerico, O'Brien, & Swafford, 2003; Wolverson, 2003).

Culture Change and Humanistic NH Type

Although many social workers practicing in a culture change nursing home were also identified as being in a humanistic nursing home type (66%), another 31% were combination, and 3% were traditional. This appears to suggest that even though humanistic organizational nursing home types and culture change do share a large percentage of similar characteristics, they are not totally the same. If they were, all of the culture change social workers would have identified themselves as also being in a humanistic type of nursing home. The 31% of culture change social workers that fell into the combination type of nursing home may be identified as having characteristics from both the traditional and humanistic nursing home types due to length of time in the culture change movement, or a trajectory towards either of the polar extremes. It is impossible to further clarify the data (based on this particular analysis) beyond what has been submitted here.

Open-Ended Question

The emergent themes in the open-ended question reflected the literature on nursing home social workers. These five themes include job satisfaction, workload, administration or supervision, residents, and culture change. respondents made the case for the many barriers and/or obstacles encountered by nursing home social workers. Lack of respect, excessive paperwork and documentation, deficiencies in supervision, severe time constraints, and frustrations with culture change. Yet, it also became apparent that while these obstacles were real and often overwhelming, social workers felt a strong kinship and affection for the residents they served (Cox & Parson, 1994; Olson, 2006; Misiorski & Kahn, 2005; Weiner & Ronch, 2003).

Further Discussion

Social workers encounter many barriers in nursing homes as they attempt to provide quality psychosocial services. The values driving practice in the medical model often clash with social work values related to quality of life and social justice. Issues especially related to resident self-determination are additionally at odds with the medical model's concern with protocols, scheduled routines, and other standards to ensure regulatory compliance and efficiency. Social workers are often given mundane tasks that prevent them from responsibly attending to the psychosocial needs of residents. Social workers are also encumbered by rapid turnover of essential staff, lowered professional status, poor stipends, and excessive bureaucratic reporting (Cox & Parsons, 1994; Luptak, 2004). Again, the barriers or restraints to social work practice are often attributed to the restrictive bureaucracy of the medical model (Thomas, 1996; Vladeck, 2003; Weiner & Ronch, 2003). As might be expected, this often makes it difficult to enhance quality of life domains of resident elders.

The social work profession itself has been touted as devaluing the role of nursing home social workers, with the pervasive notion that practicing in this environment demands "…less skill than presumably more psychodynamic treatment settings…" (Kane, 2006, p. 595). This assessment is part of what Jervis (2002) describes as "…the stigma of the nursing home setting" (p. 15), historically aligned as it is with society's conception of institutional care. The notion that the nursing home is a "…medicalized quasi-asylum…" (Allen, Nelson, & Netting, 2007, p. 12) is a commonly shared belief that stigmatizes both the residents as well as the individuals who work in this environment. Lack of public education in regard to the inner workings of nursing homes is a giant obstacle to overcome, as the public may simply believe that anyone who works in such an environment is involved in the mistreatment of elderly residents. The social work profession must endeavor to properly define the role of nursing home social workers, making sure they are prepared in establishing themselves as leaders and collaborators in humanistic endeavors. In order to accomplish this, NASW must continue to acknowledge that social workers are inadequately trained for their roles in the nursing home arena (Allen, Nelson, & Netting, 2007; Vourlekis, Zlotnik, & Simons, 2005; Sehrawat, 2010). This includes a continued push for licensure, and educational training specific to mental health, especially in regard to depression, anxiety, and other psychiatric issues in residents that are common and often neglected in nursing homes (Harrington & Carrillo, 1999; Linkins, Lucca, Housman, & Smith, 2006).

Culture Change Does Not Mean Replication

Despite their success in some nursing homes, a review of the literature suggests that culture change models have not always been successfully implemented. Many nursing homes have become frustrated that culture change has not occurred when they have "replicated" a specific model or approach. However, mere replication does little to achieve the transformative

features of culture change, without first assuring all participants assimilate the values and overall beliefs underpinning the approach. In this regard, there is a tendency for some NHs to become slaves to the exact replication of culture change models, without understanding that paradigmatic change is a journey, not a specific destination. In essence, the culture change movement encompasses an evolutionary transformation, focused on the personal growth of all individuals. In this context, forming an intellectual agreement with CC values does not necessarily result in behaviors and standards that are truly humanistic and centered on the needs of residents and staff. Values are meaningless unless they are translated into action. In this respect, values and "values in action" form a dichotomy in many NHs attempting to implement a CC approach. In the complexity of the culture change paradigm, the transformation goes beyond shifts in the structure of the facility. It involves organizational changes in the underlying values and beliefs of each NH environment (Gibson & Barsade, 2003).

The Strengths Perspective

Both the humanistic nursing home type and culture change are in alignment with the strengths perspective, to include each stakeholder within the nursing home, and the surrounding community. The intent of the strengths perspective is to uncover knowledge, accumulated wisdom, as well as assets and untapped resources. The strengths perspective would then be concerned with ". . . discerning those resources, and respecting them and the potential they may have for reversing misfortune, countering illness, easing pain, and reaching goals" (Saleebey, 1997, p. 12). Not only would this perspective be concerned with uncovering nursing home resources, but in harnessing or mobilizing them to address resident and staffing needs, or other areas that require enhancement or alteration.

In regard to nursing homes, the antithesis to the strengths perspective is the medical model. The traditional nature of this model highlights symptomology, diagnoses, and treatment. Nursing home residents are viewed from a position of illness and chronicity, and the workforce is subjected to medical hierarchies and policies that are highly structured and often deemed punitive. In short, the medical model typically emphasizes the efficiency of clinical services over the humanity of nursing home residents. The difference between these two sets of values and beliefs are considered the essential impediment to any sort of change, a situation known only too well by nursing home reformers.

Limitations of the Study

If funding had allowed, a second mailing of a survey to non-responders might have solicited a higher response rate. Likewise, sending surveys on a nationwide basis may have increased the external validity of the study, and allowed for a stronger position in regard to generalization. Speculating beyond the 12 mid-western states used in this study might be cautiously applied in terms of generalizability, but only for those nursing homes that also meet the initial criteria set forth by this study: nursing homes with 120 or more beds, not affiliated with a hospital, and certified by both Medicare and Medicaid. These particular nursing homes (across the nation) that conform to the criteria may be more alike than one might initially believe. Each of these facilities must adhere to strenuous rules and regulations of the federal government if they are certified by Medicare and/or Medicaid, part of this study's criteria. Logically, the similarities come from the same regulations, imposed nationwide. Homogeneity in terms of regulations may enable findings of this study to be generalized to social workers across the United States.

Findings in This Study

The Neuman (2003) and the Lubetkin et al. (2005) studies showed that social workers were either neutral or negatively impacted by the introduction of culture change initiatives in hospital affiliated nursing homes. However, in this study, conducted in nursing homes that were not affiliated with a hospital, being in a humanistic and culture change facility was related to the job satisfaction of social workers. The differences between the humanistic and combination types were small, indicating that social workers in a combination nursing home type were close to the job satisfaction levels attained by the humanistic group. The six domains of the job satisfaction questionnaire used in this study also showed that being in a humanistic nursing home type or a culture change facility was related to a social worker's empowerment, teamwork, supportive supervision, identification with values, available resources, and resident-centered care.

This study was the first to examine culture change and social workers practicing in separate, independent nursing homes. This is important, as independent facilities make up the majority of all nursing homes in the United States. Therefore, these findings have widespread appeal. Since there are few empirical studies on culture change in nursing homes, this study adds to the lack of research in this area, particularly in regard to the job satisfaction of social workers practicing in these settings.

Implications for Social Workers

Humanistic trends and the culture change movement have important implications for social workers in the NH industry. First, both are in alignment with social work's core values and ethical ideology, an ecological perspective, the life model, as well as the strengths perspective. Second, through their roles as advocate, mediator, educator, and broker, social workers can bring all stakeholders together around humanistic, resident-centered values and beliefs. Third, social

workers can redefine the medical model through education and relationship-building with staff members who are entrenched in the protocols of this approach. All of these efforts increase the understanding and communication between service providers, ultimately leading to mutual respect and a higher level of quality services for resident elders (Martin & Bonder, 2003). Perhaps most importantly, given their historic absence from the field of aging, and NH settings in particular, social workers can more actively involve themselves with reform efforts. This is especially crucial in the current social and political climate, where legislators, consumers and their families, administrators, regulators, ombudsmen, and other stakeholders have displayed a strong interest in changing the culture in nursing home settings.

Concluding Remarks

Researchers and experts in organizational change note it can take 17 years or longer for an innovation to evolve into common practice and become the norm (Balas & Boren, 2000). In this regard, the culture change movement has barely taken hold. On the other hand, the approach following the bureaucratic hierarchies that eventually evolved into the medical model, have been around since the industrial era. As such, the medical model has become deeply entrenched, and will no doubt continue in some fashion for many years to come. Nursing home reformists have long endorsed the altering or modification of the medical model, to be replaced by a more humanistic and/or resident-centered management style. Current reformation efforts in the NH industry are focused on the development of approaches that specifically enhance the quality of care, and especially the quality of life, of nursing home residents. Whether interchangeably referred to by nursing home reformists as total quality management (TQM), continuous quality improvement (CQI), or reengineering, all have generally been placed under the umbrella of "culture change" in the nursing home industry.

If the SW profession is to continue to advocate and involve itself in humanistic efforts, social workers must have a strong empirical base, and extract knowledge and skills from these endeavors. This research study is an attempt to address the lack of scholarship in culture change, to specifically explore the relationship between type of nursing home, culture change affiliation, and the job satisfaction of social workers.

The role that social workers play in humanistic endeavors or culture change initiatives have barely been defined by the profession, the federal government, or in the nursing home industry. Again, the lack of empirical research in this area limits professional credibility, and fails to document social work's current and potential contributions to the culture change movement. In this respect, knowing how satisfied nursing home social workers are about their jobs in different types of facilities or while practicing under a new paradigm (such as culture change), is essential to the development of best practices in this setting. Job satisfaction results in this study not only build the necessary foundation required for further research and study, but highlights how the knowledge and skills of nursing home social workers and the profession can strategically and actively promote reformation.

Research studies have often shown that higher levels of job satisfaction are related to an increase in relationship-building, better employee performance, motivation, and quality service delivery. In the nursing home setting, it has been associated with less absenteeism and turnover, thereby promoting a sense of stability, safety, and the formation of trusting interpersonal relationships with residents. Consequently, a higher level of job satisfaction in nursing home employees, including social workers, generally translates into more regard for the needs and desires of resident elders. It therefore addresses the quality of life deficits cited by researchers,

the direct result of being mired in the bureaucratic, hierarchical approach of the medical model (Ammon, 2005; Cox & Parson, 1994; Olson, 2006; Weiner & Ronch, 2003). .

Without doubt, the nursing home system is unwieldy, complex, and utterly perplexing to those who attempt to understand its failure to provide quality of care and quality of life to NH residents. The system is entangled with capitalism, politics, economics, social values, racism, poverty, diversity, ageism, patriarchy, and other conditions. No singular improvement or enhancement will dramatically alter this environment unless society agrees that change is urgent and necessary. The current status quo in NHs reflects a societal fear of aging that places elders in peril. Society's obsession with youth, and the common belief that only the young have the capacity for personal growth and fulfillment, has created a condition where elders are infantilized, diminished, and undervalued.

No matter how deeply embedded the myths and beliefs surround the concept of aging, they cannot prevent the inevitable from occurring for each member of society. Barring premature death from illness, an accident, or other events, each of us will grow older. In that reality, the desire to live a long, meaningful, and worthwhile existence is offset for many individuals by the current condition of nursing home facilities. For many of these people, being marginalized in a nursing home setting denies them a full participation in life. If the public desires a different reality for themselves as they age in society, today's elders must be given the opportunity for self-direction in their lives, to actualize their existence, and to engage with community for the purpose of personal growth and fulfillment. The culture change movement, with its emphasis on a resident-centered approach, has articulated these ideals, and is determined to transform and deinstitutionalize nursing homes across the nation. This reform, put into motion by social

workers and other stakeholders, will form the foundation for future policies, and enable elders to create, inspire, endeavor, and grow to their full potential.

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APPENDIX A

Cover Letter

Alice L. Dye, MSW, LCSW, ACSW
12417 Cambridge Avenue
Grandview, Missouri 64030-1831
Telephone: (816) 761-1687
Email: aldye@kc.rr.com

Dear Nursing Home Social Worker:

My name is Alice Dye, and I am a doctoral student at the University of Kansas School of Social Welfare (KUSSW). At the present time, I am seeking your participation in a research study I am conducting towards the completion of my doctoral degree, with a focus on nursing home social workers. Your nursing home was randomly selected using the latest online version of *Nursing Home Compare*, derived from the Centers for Medicare and Medicaid Services (CMS).

I have a personal reason for examining this area because of my own background as a social worker in nursing home settings. Due to this experience, I am profoundly aware of the many challenges that exist in providing psychosocial services to resident elders.

For a number of years now, I have studied the organizational styles of nursing homes, and wondered if nursing home social workers are somehow influenced by the "type" of nursing homes in which they practice. Specifically, would a social worker's job satisfaction be affected by being in a traditional nursing home, a humanistic environment, or one that incorporates both approaches?

This is the primary focus of exploration in my research study. It has important implications for nursing home social workers in terms of initial training, continuing education, service delivery, along with other outcomes. In addition, this study may highlight whether or not nursing homes should make organizational changes to coincide with a specific type of nursing home, especially if it seems to impact service delivery, addresses the needs and desires of residents, and is financially feasible.

The enclosed survey questionnaire will take approximately 15 minutes to complete. In order to understand and clarify your rights as a participant, please take the time to read the attached Information Statement. It provides important contact information in the event that you have questions or wish to further discuss my research study.

Thank you for your time. Although your participation is voluntary, your interest, support, and participation would be greatly appreciated.

Sincerely,

Alice L. Dye

Enclosure(s): Information Statement
Job Satisfaction Questionnaire
Postage Paid Return Envelope

APPENDIX B

Information Letter

Alice L. Dye, MSW, LCSW, ACSW
12417 Cambridge Avenue
Grandview, Missouri 64030-1831
Telephone: (816) 761-1687
Email: aldye@kc.rr.com

Information Statement

You should know that the School of Social Welfare at the University of Kansas supports the practice of protection for human subjects participating in research. The following information is provided for you to decide if you would like to participate in the present study. Your participation is solicited, but strictly voluntary. The survey questionnaire enclosed is self-administered, and will take approximately 15 minutes to complete. Your responses to the questionnaire will be coded and entered into a computer software program. Consequently, your name will not be associated with the research findings.

As previously discussed, my research is examining the job satisfaction of nursing home social workers, and whether it is related to type of nursing home. Although participation may not benefit you directly, I believe that the information obtained through this research will help address the overall lack of scholarship in the field of nursing home social work, particularly as it relates to the current emphasis on organizational change and other related trends.

In addition, the study will give you an opportunity to contribute to the clarification of the social worker role in nursing home facilities, to highlight needed changes or enhancements, and to provide information about what is essential to the delivery of quality psychosocial services to residents.

The Human Subjects Committee Lawrence (HSCL) at the University of Kansas has given approval for this research (approval number: 18585). If you have further questions about your rights as a participant, you may contact Mary Denning, Coordinator of HSCL at (785) 864-7429 or mdenning@ku.edu. The mailing address is HSCL, University of Kansas, 2385 Irving Hill Road, Lawrence, Kansas 66045-7563.

If you would like to verify my current status as a doctoral student or my affiliation with the School of Social Welfare at the University of Kansas, please contact my research methodologist, Dr. Mahasweta Banerjee, at (785) 864-4720 or mahaswetab@ku.edu. Dr. Banerjee's mailing address is KUSSW, 121 Twente Hall, 1545 Lilac Lane, Lawrence, Kansas 66044-3184.

Completion of the survey indicates your willingness to participate in this research project and that you are over the age of eighteen. If you would like further information concerning my study before or after it is completed, please contact me using my address, telephone number, or Email information listed at the top of this page.

Again, thank you for your time and attention.

Sincerely,

Alice L. Dye

APPENDIX C

Reminder Postcard

stamp

Social Work Department
Delmar Gardens
12100 West 109th Street
Overland Park, KS 66210

Dear Nursing Home Social Worker:

You may recall that I recently mailed your SW department a Job Satisfaction Survey as part of a study towards the completion of my doctoral degree. If you have already completed and returned the survey, let me take this opportunity to thank you for your participation. If you have not finished the survey, it will only take approximately 15 minutes to complete. For your convenience, you may return it in the stamped envelope I previously enclosed.

Please be reminded that your participation is strictly voluntary. However, your efforts in this regard would be greatly appreciated, as you will be making a contribution to the research and study of nursing home social workers.

Sincerely,

Alice L. Dye, MSW. LCSW, ACSW
Telephone: (816) 761-1687
Email: aldye@kc.rr.com

Mailing Address:
12417 Cambridge Avenue
Grandview, Missouri 64030-1831

APPENDIX D

Job Satisfaction of Nursing Home Social Workers

A. Your Demographic Background

1. Your Gender (check one):

1. _____ Male
2. _____ Female

2. Your Age (check one):

1. _____ Below 20 years
2. _____ 20 – 29 years
3. _____ 30 – 39 years
4. _____ 40 – 49 years
5. _____ 50 – 59 years
6. _____ 60 – 69 years
7. _____ Over 69 years

3. Your Race (check all that apply):

1. _____ White
2. _____ Black or African American
3. _____ American Indian or Alaska Native
4. _____ Asian
5. _____ Native Hawaiian or Other Pacific Islander
6. _____ Other

6a. If *Other,* and you feel your race is not represented by these choices, please enter that information here:

_____

4. Your Highest Educational Qualification (check one):

1. _____ BSW 2. _____ MSW

3. _____ Other

3a. If *Other*, include type of degree:

_____
(ex: BA, BS, MA, MS, PhD, etc.)

3b. If *Other*, include degree area (if applicable):

_____
(ex: Gerontology, Psychology, Sociology, etc.)

5. Your Employment Status in the Nursing Home (check one)

1. _____ Full-Time 2. _____ Part-Time

6. Your Gross (pre-tax) Salary in 2009 (check one):

1. _____ $20,000 or Below
2. _____ $20,001 to 25,000
3. _____ $25,001 to 30,000
4. _____ $30,001 to 35,000
5. _____ $35,001 to 40,000
6. _____ $40,001 to 45,000
7. _____ $45,001 to 50,000
8. _____ $50,001 to 55,000
9. _____ $55,001 to 60,000
10. _____ $60,001 to 65,000
11. _____ Over $65,000

7. Your Total Experience as a Nursing Home Social Worker in Years/Months (check one):

1. _____ 11 months or less
2. _____ 1 year to 5 years, 11 months
3. _____ 6 years to 10 years, 11 months
4. _____ 11 years to 15 years, 11 months
5. _____ 16 years to 20 years, 11 months
6. _____ 21 years to 25 years, 11 months
7. _____ 26 years to 30 years, 11 months
8. _____ 31 years to 35 years, 11 months
9. _____ 36 years to 40 years, 11 months
10. _____ 41 years or over

B. Your Work in the Nursing Home:

1. Please Check the Top Five Activities You Perform in the Nursing Home:

1. _____ Counseling/Mental Health
2. _____ Discharge Planning
3. _____ Resource Allocation
4. _____ Assessments
5. _____ Documentation
6. _____ Explaining Medicare/Medicaid
7. _____ Advocacy
8. _____ Mediation
9. _____ Care Planning
10. _____ Admissions
11. _____ Communicating with Family
12. _____ Other (please list): _____

2. Please Check Up to Five Activities You Often Perform for Residents Outside of Your Job Description as a Social Worker:

1. _____ Running Errands for Residents
2. _____ Driving Residents to Appointments
3. _____ Buying Items for Residents
4. _____ Assisting Residents with Dressing
5. _____ Feeding Residents at Mealtimes
6. _____ Facilitating Resident Activities
7. _____ Assisting Residents with Hygiene
8. _____ Moving Residents to Another Room
9. _____ Other (please list): _____
10. _____ Does Not Apply

C. Your Nursing Home Type

The following five statements are numbered from 1 to 9 in an effort to identify the type of nursing home setting in which you are currently employed. If you feel that the statement on the left more accurately reflects the environment in your nursing home, you may assign it a number of 1, 2, or 3. If the statement on the right more accurately depicts your nursing home, you may choose to assign it a number of 7, 8, or 9. If your nursing home facility shares characteristics from both statements, you may assign it a number of 4, 5, or 6. In all cases, circle just <u>one</u> number in each statement:

1. Organizational Style (circle the number that best characterizes your nursing home):

1	2	3	4	5	6	7	8	9
Organization characterized by a hierarchical or "topdown" management style; emphasis on medical procedures as well as efficiency.								Organization characterized by an interactive, humanistic, and resident-centered management style; focus is on the needs of both staff and residents.

2. Staff Interactions (circle the number that best characterizes your nursing home):

1	2	3	4	5	6	7	8	9
Departmental staff work on an independent level; collaboration is limited. Supervision focused on task completion, with little interaction and support.								Multidisciplinary staff members work collaboratively; autonomous decision-making is encouraged; supervision is interactive and fully supportive.

3. Resident Choices (circle the number that best characterizes your nursing home):

1	2	3	4	5	6	7	8	9
Resident services, schedules, and activities generally chosen by staff; limitations in resident self-determination and making decisions; resident choice is not typically encouraged.								Residents choose their own services, schedules, and activities. Self-determination, decision-making, and resident choice predominates; focus is on resident needs and desires.

4. Resident and Staff Interactions (circle the number that best characterizes your nursing home):

1	2	3	4	5	6	7	8	9

Efficiency and the completion of tasks valued over the building of relationships with the residents; residents are viewed from a dependency perspective, with limitations in capacities, skills, and capabilities.

Relationship-building with the residents is essential; residents are viewed from a strengths perspective, with capabilities, talents, and capacities; all residents are seen as growing and evolving as individuals.

5. Capacity for Organizational Change (circle the number that best characterizes your nursing home):

1	2	3	4	5	6	7	8	9

Organization is often resistant to adopting new trends, concepts or alternative models of care; the administrative approach is most often traditional, emphasizing the continuance of the current mode of operation.

Organization embraces change and has actively adopted new models of care; administrative approach is progressive, and continually seeks alternative ways to improve the quality of services given to residents.

D. Culture Change Identification

One organizational style that has been recommended by the government, nursing home reformers, and some states is culture change. Generally, it is defined as a humanistic and resident-centered approach that places the needs and desires of residents first. It gives residents decision-making power over their own services, activities, schedules, and medical care. Service delivery by staff is collaborative, focused on multidisciplinary work teams, and fully supported by both supervisors and administrators. Residents are encouraged to grow and develop as individuals, viewed overall as possessing talents, skills, capabilities, and personal strengths.

1. Based on this definition, do you practice in a culture change nursing home? (check one):

_____ Yes _____ No

2. If *yes*, did you have an active role in developing or implementing culture change? (check one):

_____ Yes _____ No

3. If *yes,* how many years has your nursing home been a culture change facility?

_____ Years _____ Mos.

E. Your Job Satisfaction

The following questions explore your job satisfaction in the nursing home in which you are currently employed. The questions have a response range of 1 to 6, to include the following: 1 = Strongly Disagree, 2 = Disagree, 3 = Somewhat Disagree, 4 = Somewhat Agree, 5 = Agree, and 6 = Strongly Agree. Please circle the number that best corresponds to your choice.

	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
1. I have the necessary authority to do my job well.	1	2	3	4	5	6
2. I have the proper tools and equipment to complete my tasks.	1	2	3	4	5	6
3. Cooperation between departments in getting the job done.	1	2	3	4	5	6
4. Overall, I'm satisfied focusing on needs/desires of residents.	1	2	3	4	5	6
5. At work my opinions seem to count.	1	2	3	4	5	6
6. My supervisor helps me to improve my work performance.	1	2	3	4	5	6
7. I'm provided with the necessary training to do a good job.	1	2	3	4	5	6
8. The work I do makes a difference in the lives of residents.	1	2	3	4	5	6
9. I am involved in making decisions about how work gets done.	1	2	3	4	5	6
10. My evaluation helps me improve my job performance.	1	2	3	4	5	6
11. My work contributes in a meaningful way to our mission.	1	2	3	4	5	6
12. Overall, I am satisfied with the level of empowerment I have in my job.	1	2	3	4	5	6

	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
13. We are thoughtful about how to save money at this facility.	1	2	3	4	5	6
14. I feel comfortable in reporting medical or health care errors.	1	2	3	4	5	6
15. Overall, I'm satisfied with staff and our mutual collaboration.	1	2	3	4	5	6
16. My knowledge/skills are used by the nursing home.	1	2	3	4	5	6
17. I would recommend our nursing home services to others.	1	2	3	4	5	6
18. Overall, I am satisfied with my supervisor.	1	2	3	4	5	6
19. I am routinely consulted by the administration when organizational changes or new policies are developed.	1	2	3	4	5	6
20. My work environment makes me feel positive about my job.	1	2	3	4	5	6
21. We put the needs of residents first here.	1	2	3	4	5	6
22. There is opportunity for advancement within the organization.	1	2	3	4	5	6
23. Overall, I am satisfied with the nursing home's values/beliefs.	1	2	3	4	5	6
24. Supervisors are accessible and knowledgeable.	1	2	3	4	5	6
25. I am able to respond to the needs and desires of residents.	1	2	3	4	5	6
26. I can count on other staff members for help and cooperation.	1	2	3	4	5	6

	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
27. We welcome family and friends in the care/life of residents.	1	2	3	4	5	6
28. Communication throughout the organization is effective.	1	2	3	4	5	6
29. I understand the mission and values of our organization.	1	2	3	4	5	6
30. I am comfortable seeking the help I need from my supervisor.	1	2	3	4	5	6
31. I am able to solve problems I am faced with at work.	1	2	3	4	5	6
32. Overall, I am satisfied with all the available resources needed to complete tasks.	1	2	3	4	5	6
33. I feel valued as an employee.	1	2	3	4	5	6
34. Other multidisciplinary staff members and I function as a team.	1	2	3	4	5	6
35. My supervisor treats me with respect.	1	2	3	4	5	6
36. When I have personal problems, there are resources available at work that can help me.	1	2	3	4	5	6
37. The facility is a physically secure/safe place for me to work.	1	2	3	4	5	6
38. I often perform tasks outside of my job description.	1	2	3	4	5	6
39. My suggestions are encouraged and welcomed.	1	2	3	4	5	6
40. My cultural background is respected here.	1	2	3	4	5	6

	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
41. I'm willing to pitch in and work outside of my assignment.	1	2	3	4	5	6
42. I am required to be licensed to work here.	1	2	3	4	5	6
43. In the last month, I've had recognition/praise for my work.	1	2	3	4	5	6
44. Residents have a safe environment in the NH.	1	2	3	4	5	6
45. Communication with my direct supervisor is usually good.	1	2	3	4	5	6
46. My delivery of services is consistently high in quality.	1	2	3	4	5	6
47. The actions and decisions within our organization support our mission and values.	1	2	3	4	5	6
48. In the last six months, I've talked to someone about my progress.	1	2	3	4	5	6
49. There have been discussions about the last inspection results and how to improve things.	1	2	3	4	5	6
50. Within the next year, I intend to leave the nursing home.	1	2	3	4	5	6
51. My job performance goals and standards have been clearly presented to me.	1	2	3	4	5	6
52. I have an excessive amount of paperwork and documentation.	1	2	3	4	5	6
53. Overall, I am satisfied with my job at the nursing home.	1	2	3	4	5	6

E. Your Personal Opinion

Please take an opportunity to express your viewpoint as it relates to your job satisfaction as a nursing home social worker. You may want to discuss your role, the nursing home's organizational style, ethics and values, the culture change movement, needed improvements, or any area you feel is important or essential to your satisfaction as a social worker in this environment:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Your participation in my research is greatly appreciated! Please take a moment to look over the survey to make sure you have responded to every item. After you have completed the questionnaire, fold it in half, and return it in the stamped envelope provided.

THANKS!

JSS: 00-____

Appendix E

Codebook for SPSS

A. Your Demographic Information

1. Your Gender	GENDER1 = Male GENDER2 = Female
2. Your Age	AGE1 = Below 20 Years AGE2 = 20 – 29 Years AGE3 = 30 – 39 Years AGE4 = 40 – 49 Years AGE5 = 50 – 59 Years AGE6 = 60 – 69 Years AGE7 = Over 69 Years
3. Your Race	RACE1 = White RACE2 = Black or African American RACE3 = American Indian or Alaska Native RACE4 = Asian RACE5 = Native Hawaiian or Pacific Islander RACE6 = Other
4. Your Highest Educational Qualification	EDUC1 = BSW EDUC2 = MSW EDUC3 = Other EDUC4 = Degree EDUC5 = Major
5. Your Employment Status In the Nursing Home	STATUS1 = Full-Time STATUS2 = Part-Time
6. Your Gross (pre-tax) Salary in 2009	SALARY1 = $20,000 or Below SALARY2 = $20,000 – 25,000 SALARY3 = $25,001 – 30,000 SALARY4 = $30,001 – 35,000 SALARY5 = $35,001 – 40,000 SALARY6 = $40,001 – 45,000 SALARY7 = $45,001 – 50,000 SALARY8 = $50,001 – 55,000 SALARY9 = $55,001 – 60,000 SALARY10 = $60,001 – 65,000 SALARY11 = Over $65,000

7. Your Total Experience as a Nursing Home Social Worker in Years/Months	EXPER1 = 11 months or less EXPER2 = 1 year to 5 years, 11 months EXPER3 = 6 years to 10 years, 11 months EXPER4 = 11 years to 15 years, 11 months EXPER5 = 16 years to 20 years, 11 months EXPER6 = 21 years to 25 years, 11 months EXPER7 = 26 years to 30 years, 11 months EXPER8 = 31 years to 35 years, 11 months EXPER9 = 36 years to 40 years, 11 months EXPER10 = 41 years or over

B. Your Work in the Nursing Home

1. Please Check the Top Five Activities You Perform in the Nursing Home	TOPFIVE1 = Counseling/Mental Health TOPFIVE2 = Discharge Planning TOPFIVE3 = Resource Allocation TOPFIVE4 = Assessments TOPFIVE5 = Documentation TOPFIVE6 = Explaining Medicare/Medicaid TOPFIVE7 = Advocacy TOPFIVE8 = Mediation TOPFIVE9 = Care Planning TOPFIVE10 = Admissions TOPFIVE11 = Communicating with Families TOPFIVE12 = Other
2. Please Check Up to Five Activities You Perform Outside of Your Job Description as a Social Worker	OUTJOB1 = Running Errands for Residents OUTJOB2 = Driving Residents to Appointments OUTJOB3 = Buying Items for Residents OUTJOB4 = Assisting Residents with Dressing OUTJOB5 = Feeding Residents at Mealtimes OUTJOB6 = Facilitating Resident Activities OUTJOB7 = Assisting Residents with Hygiene OUTJOB8 = Moving Residents to Another Room OUTJOB9 = Other (please list)

C. Your Nursing Home Type

1. Organizational Style	ORGSTYLE1 = Traditional ORGSTYLE2 = Combination ORGSTYLE3 = Humanistic
2. Staff Interactions	STAFFINT1 = Traditional STAFFINT2 = Combination

	STAFFINT3 = Humanistic
3. Resident Choices	RESCHOICE1 = Traditional RESCHOICE2 = Combination RESCHOICE3 = Humanistic
4. Resident/Staff Interactions	RESSTAFFINT1 = Traditional RESSTAFFINT2 = Combination RESSTAFFINT3 = Humanistic
5. Organizational Change	ORGCHANGE1 = Traditional ORGCHANGE2 = Combination ORGCHANGE3 = Humanistic
6. Nursing Home Type	NHTYPE1 = Traditional NHTYPE2 = Combination NHTYPE3 = Humanistic

D. Culture Change Identification

1. Do you practice in a culture change nursing home?	D1CCNH1 = Yes D1CCNH2 = No
2. If yes, did you have an active role in developing and/or implementing culture change?	D2CCDEV1 = Yes D2CCDEV2 = No D2CCDEV3 = No Response D2CCDEV4 = Not Applicable
3. If yes, how many years and/or months has your NH been a culture change facility?	D3CCYRS = Years D3CCMOS = Months D3CCUNK = Unknown D3CCNOR = No Response

E. Your Job Satisfaction

Two letter codes followed by the item number indicate a Domain question (item) from the Job Satisfaction Instrument (consisting of 39 questions). Example: EM9 refers to the Empowerment Domain, item number 9 in the survey.

Empowerment

EM1	I have the necessary authority to do my job well.
EM5	At work my opinions seem to count.
EM9	I am involved in making decisions about how work gets done.
EM14	I feel comfortable in reporting medical or health care errors.
EM22	There is opportunity for advancement within the organization.

EM31	I am able to solve problems I am faced with at work.
EM33	I feel valued as an employee.
EM39	My suggestions are encouraged and welcomed.
EM40	My cultural background is respected.

Teamwork

TM3	There is cooperation between departments in getting the job done.
TM26	I can count on other multidisciplinary staff members for help and cooperation.
TM27	We welcome and include family/friends in the care and the life of the residents.
TM28	Communication throughout the organization is effective.
TM34	Other multidisciplinary staff members and I function as a team.
TM41	I am willing to pitch in and do work outside of my job assignment.

Supportive Supervision

SS6	My direct supervisor helps me to improve my work performance.
SS10	The employee performance evaluation helps me improve my job performance.
SS24	Supervisors are accessible and knowledgeable.
SS30	I am comfortable seeking the help I need from my supervisor.
SS35	My supervisor treats me with respect.
SS43	In the last month, I have received recognition or praise for my work.
SS45	Communication with my direct supervisor is usually good.
SS48	In the last six months, I have talked to someone about my progress.
SS49	There have been discussions about inspection results and how to improve things.
SS51	My job performance goals and standards have been clearly presented to me.

Identification/NH Values

ID11	I feel that my work contributes in a meaningful way to our mission.
ID13	We are thoughtful about how to save money at this facility.
ID17	I would recommend our nursing home services to a family or friend.
ID29	I understand the mission and values of our organization.
ID47	The actions and decisions within our organization support our mission and values.

Available Resources

AR2	I am provided with the proper tools and equipment to complete my tasks.
AR7	The organization provides the necessary training to do a good job.
AR20	My physical work environment makes me feel positive about my job.
AR36	When I have personal problems, there are resources at work that can help me.
AR37	The facility is a physically secure and safe place for me to work.

Resident-Centered Care

RC8	The work I do makes a difference in the lives of residents.
RC21	We put the needs of residents first here.
RC25	I am able to respond to the needs and desires of residents.
RC44	I believe that our residents have a safe environment in the nursing home.

F. Your Personal Opinion (COMMENTS)

Question: Please take an opportunity to express your viewpoint as it relates to your job satisfaction as a nursing home social worker. You may want to discuss your role, the nursing home's organizational style, ethics and values, the culture change movement, needed improvements, or any area you feel is important or essential to your satisfaction as a social worker in this environment.

NOTE: The open-ended question did have a code (COMMENTS) in SPSS, but the responses or narratives were not analyzed utilizing this program. However, SPSS did provide the survey number for each individual that did respond:

003	114	201	281	336	426	549	646
004	115	203	282	348	428	555	649
008	118	204	283	350	430	556	652
009	119	205	284	354	431	563	655
015	127	207	288	355	449	567	662
019	130	217	289	359	450	569	663
024	139	219	291	360	453	575	664
033	147	227	292	367	456	580	668
051	155	232	293	368	460	587	669
054	158	234	294	369	465	602	670
057	161	236	298	371	471	608	672
063	167	239	299	379	477	611	675
064	173	241	300	382	490	612	677
065	175	248	303	383	498	618	680
068	176	250	309	384	507	621	681
069	177	253	313	396	509	624	683
076	180	261	314	409	514	625	685
082	181	263	316	411	521	627	687
085	183	267	320	413	522	628	690
092	186	270	322	415	529	629	691
093	192	271	326	416	535	630	692
099	195	273	327	418	540	633	693
102	196	275	328	419	542	634	696
105	197	280	329	420	548	636	

N = 191 out of 321 (60% Response Rate)

Table 1

Power of Test of Significance of Correlation Coefficient by Level of Significance, Effect Size, and Sample Size

.05 Significance Level			
	Effect Size		
	Small	Medium	Large
Sample Size	r = .10 r^2 = .01	r = .30 r^2 = .09	r = .50 r^2 = .25
20	.07	.25	.64
40	.09	.48	.92
60	.12	.65	.99
80	.14	.78	*
100	.17	.86	
200	.29	.99	
300	.41	*	
400	.52		
600	.69		
800	.81		

*Power values below this point exceed .995.
Source: Rubin and Babbie (2008), derived from tables in Cohen (1988).

Table 2

Gender and Age

Gender	Frequency	Percent
Male	20	6
Female	301	94
Total	321	100
Age	**Frequency**	**Percent**
20 – 29 Years	67	21
30 – 39 Years	91	28
40 – 49 Years	65	20
50 – 59 Years	73	23
60 – 69 Years	25	8
Total	321	100

Table 3

Race

Race	Frequency	Percent
White	292	91
Black or African American	17	5
American Indian or Alaska Native	2	1
Asian American	2	1
Other*	8	2
Total	321	100

*Seven of the respondents in this category self-identified as hispanic; One respondent self-identified as being of mixed race.

Table 4

Highest Educational Qualification

Degree	Frequency	Percent
BSW	145	45
MSW	66	21
BA or BS	70	22
MA or MS	29	9
AA Degree	6	2
GED or H.S.	5	1
Total	321	100

Table 5

Type of Degree: Top Five

Degree Area	Frequency	Percent
Social Work	211	65.7
Psychology	33	10.3
Gerontology	24	7.5
Sociology	16	5.0
Business	9	2.9

Table 6

Employment Status and Gross (Pre-Tax) Salary in 2009

Employment Status	Frequency	Percent
Full-Time	315	98
Part-Time	6	2
Total	321	100

Gross (Pre-Tax) Salary in 2009	Frequency	Percent
$19,000 or Below	8	2
$20,000 – 25,000	14	4
$25,001 – 30,000	26	8
$30,001 – 35,000	51	16
$35,001 – 40,000	60	19
$40,001 – 45,000	71	22
$45,001 – 50,000	45	14
$50,001 – 55,000	18	6
$55,001 – 60,000	16	5
$60,001 – 65,000	10	3
Over $65,000	4	1
Total	321	100

Table 7

Total Experience as a Nursing Home Social Worker in Years

Experience	Frequency	Percent
Less than 1 year	19	6
1 year to 10 years	188	59
11 to 20 years	79	25
21 to 30 years	27	8
31 to 40 years	8	2
Total	321	100

Table 8

Top Five Activities Performed in the Nursing Home

Nursing Home Activity	Frequency	Percent
Documentation	256	80
Assessments	252	78
Communicating with Families	230	72
Care Planning	208	65
Discharge Planning	190	59

Table 9

Top Five Activities Performed Outside of Job Description

Activity	Frequency	Percent
Moving Residents to another Room	255	79
Buying Items for Residents	210	65
Running Errands for Residents	197	61
Facilitating Resident Activities	93	29
Feeding Residents at Mealtimes	67	21

Table 10

Nursing Home Type

Nursing Home Type	Frequency	Percent
Traditional	29	9
Combination	141	44
Humanistic	151	47
Total	321	100

Table 11

Nursing Home Type Categories

Categories	NH Type	Frequency	Percent
Organizational Style:	Traditional	81	25
	Combination	145	45
	Humanistic	95	30
	Total	321	100
Staff Interactions:	Traditional	52	16
	Combination	106	33
	Humanistic	163	51
	Total	321	100
Resident Choice:	Traditional	38	12
	Combination	131	41
	Humanistic	152	47
	Total	321	100
Resident/Staff Interactions:	Traditional	56	18
	Combination	123	38
	Humanistic	142	44
	Total	321	100
Organizational Change:	Traditional	64	20
	Combination	124	39
	Humanistic	133	41
	Total	321	100

Table 12

Culture Change Survey Questions

Questions		Frequency	Percent
Do you practice in a Culture Change Nursing Home?	No	124	39
	Yes	197	61
	Total	321	100
If yes, active role in developing or implementing CC?	No	35	18
	Yes	162	82
	Total	197	100
If yes, how many years and/or months as a Culture Change facility?	Less than 12 months	14	7
	1 to 2 years, 11 months	69	35
	3 to 4 years, 11 months	44	22
	5 to 6 years, 11 months	21	11
	7 to 8 years, 11 months	9	5
	9 to 10 years, 11 months	8	4
	11 years and over	2	1
	Unknown years/months	30	15
	Total	197	100

Table 13

Job Satisfaction and Nursing Home Type

Descriptive Statistic

Dependent Variable: Job Satisfaction Mean Score (39 Qs)

Nursing Home Type	Mean	Std. Deviation	n
Traditional	3.39	.82	29
Combination	4.47	.65	141
Humanistic	5.08	.49	151
Total	4.66	.78	321

Tests of Between-Subjects Effects

Dependent Variable: Job Satisfaction Mean Score

Source	Type III Sum of Squares	degrees of freedom	*M* Square	F	p
NH Type	78.39	2, 318	39.19	107.59	.001

Parameter Estimates

Dependent Variable: Job Satisfaction Mean Score (39Qs)

					95% Confidence Interval	
NH Type	*M* Diff.	S.E	t	p	Lower Bound	Upper Bound
Traditional	-1.69	.12	-13.82	.001	-1.93	-1.45
Combination	-.61	.07	-8.57	.001	-.74	-.47
Humanistic*	---	---	---	---	---	---

*Reference Category

Table 14

Job Satisfaction and NH Type: Post-Hoc Test

NH Type Comparisons*

Dependent Variable: Job Satisfaction Mean Score (39 Qs)

Comparison	*M* Diff.	Sig.	95% Confidence Interval	
			Lower Bound	Upper Bound
Humanistic vs. Combination	.61	.001	.44	.77
Humanistic vs. Traditional	1.69	.001	1.40	1.98
Combination vs. Traditional	1.08	.001	.80	1.37

*Tukey HSD

Table 15

Job Satisfaction and Culture Change

Group Statistics

			n	M	SD	SE Mean
Dependent Variable: Job Satisfaction Mean Score (39 Qs)	Do you practice in a culture change nursing home?	No	124	4.27	.85	.08
		Yes	197	4.91	.61	.04

Independent Samples Test

		Levene's Test for Equality of Variances	
		F	Sig.
Job Satisfaction Mean Score (39 Qs)	Equal variances not assumed	18.16	.001

		t-test for Equality of Means				
		t	df	Sig. (2-tailed)	M Diff.	SE Diff.
Job Satisfaction Mean Score	Equal variances not assumed	-7.34	204.04	.001	-.64	.08

Table 16

Empowerment and Nursing Home Type

Descriptive Statistics

Dependent Variable: Empowerment Domain Mean

Nursing Home Type	Mean	Std. Deviation	n
Traditional	3.26	.95	29
Combination	4.48	.77	141
Humanistic	5.03	.57	151
Total	4.63	.86	321

Tests of Between-Subjects Effects

Dependent Variable: Empowerment Domain Mean

Source	Type III Sum of Squares	degrees of freedom	*M* Square	F	p
NH Type	81.77	2, 318	40.89	83.07	.001

Parameter Estimates

Dependent Variable: Empowerment Domain Mean

					95% Confidence Interval	
NH Type	*M* Diff.	S.E.	t	p	Upper Bound	Lower Bound
Traditional	-1.77	.14	-12.43	.001	-2.05	-1.49
Combination	-.55	.08	-6.74	.001	-.71	-.39
Humanistic*	---	---	---	---	---	---

*Reference Category

Table 17

Empowerment and NH Type: Post-Hoc Test

NH Type Comparisons*

Dependent Variable: Empowerment Mean

			95% Confidence Interval	
Comparison	*M* Diff.	Sig.	Lower Bound	Upper Bound
Humanistic vs. Combination	.55	.001	.36	.75
Humanistic vs. Traditional	1.77	.001	1.43	2.10
Combination vs. Traditional	1.21	.001	.88	1.55

*Tukey HSD

Table 18

Empowerment and Culture Change

Group Statistics

			n	M	SD	SE Mean
Dependent Variable: Empowerment Mean	Do you practice in a culture change nursing home?	No	124	4.25	.97	.09
		Yes	107	4.87	.69	.05

Independent Samples Test

		Levene's Test for Equality of Variances	
		F	Sig.
Empowerment Mean	Equal variances not assumed	23.66	.001

		t-test for Equality of Means				
		t	df	Sig. (2-tailed)	M Diff.	SE Diff.
Empowerment Mean	Equal variances not assumed	-6.21	200.03	.001	-.62	.10

Table 19

Teamwork and Nursing Home Type

Descriptive Statistics

Dependent Variable: Teamwork Domain Mean

Nursing Home Type	Mean	Std. Deviation	n
Traditional	3.57	.85	29
Combination	4.51	.69	141
Humanistic	5.06	.46	151
Total	4.69	.75	321

Tests of Between-Subjects Effects

Dependent Variable: Teamwork Domain Mean

Source	Type III Sum of Squares	degrees of freedom	*M* Square	F	p
NH Type	61.86	2, 318	30.93	82.71	.001

Parameter Estimates

Dependent Variable: Teamwork Domain Mean

					95% Confidence Interval	
NH Type	*M* Diff.	S.E.	t	p	Lower Bound	Upper Bound
Traditional	-1.49	.12	-12.05	.001	-1.36	-.98
Combination	-.55	.07	-7.68	.001	-.69	-.41
Humanistic*	---	---	---	---	---	---

*Reference Category

Table 20

Teamwork and NH Type: Post-Hoc Test

NH Type Comparisons*

Dependent Variable: Teamwork Mean

			95% Confidence Interval	
Comparison	*M* Diff.	Sig.	Lower Bound	Upper Bound
Humanistic vs. Combination	.55	.001	.38	.72
Humanistic vs. Traditional	1.50	.001	1.20	1.79
Combination vs. Traditional	.94	.001	.65	1.24

*Tukey HSD

Table 21

Teamwork and Culture Change

Group Statistics

			n	M	SD	SE Mean
Dependent Variable: Teamwork Mean	Do you practice in a culture change nursing home?	No	124	4.36	.85	.08
		Yes	197	4.89	.60	.04

Independent Samples Test

		Levene's Test for Equality of Variances	
		F	Sig.
Teamwork Mean	Equal variances not assumed	18.03	.001

		t-test for Equality of Means				
		t	df	Sig. (2-tailed)	M Diff.	SE Diff.
Teamwork Mean	Equal variances not assumed	-6.03	201.19	.001	-.53	.09

Table 22

Supportive Supervision and Nursing Home Type

Descriptive Statistics

Dependent Variable: Supportive Supervision Mean

Nursing Home Type	Mean	Std. Deviation	n
Traditional	2.97	1.09	29
Combination	4.21	.94	141
Humanistic	4.98	.67	151
Total	4.46	1.03	321

Tests of Between-Subjects Effects

Dependent Variable: Supportive Supervision Mean

Source	Type III Sum of Squares	degrees of freedom	*M* Square	F	p
NH Type	122.91	2, 318	61.46	90.43	.001

Parameter Estimates

Dependent Variable: Supportive Supervision Mean

					95% Confidence Interval	
NH Type	*M* Diff.	S.E.	t	p	Lower Bound	Upper Bound
Traditional	-2.01	.17	-11.78	.001	-2.34	-1.67
Combination	-.62	.10	-6.13	.001	-.83	-.58
Humanistic*	---	---	---	---	---	---

*Reference Category

Table 23

Supportive Supervision and NH Type: Post-Hoc Test

NH Type Comparisons*

Dependent Variable: Supportive Supervision Mean

Comparison	*M* Diff.	Sig.	95% Confidence Interval	
			Lower Bound	Upper Bound
Humanistic vs. Combination	.77	.001	.54	1.00
Humanistic vs. Traditional	2.01	.001	1.61	2.41
Combination vs. Traditional	1.24	.001	.83	1.64

*Tukey HSD

Table 24

Supportive Supervision and Culture Change

Group Statistics

			n	M	SD	SE Mean
Dependent Variable: Supportive Supervision Mean	Do you practice in a culture change nursing home?	No	124	4.01	1.06	.09
		Yes	197	4.74	.90	.06

Independent Samples Test

		Levene's Test for Equality of Variances	
		F	Sig.
Supportive Supervision Mean	Equal variances not assumed	5.91	.016

		t-test for Equality of Means				
		t	df	Sig. (2-tailed)	M Diff.	SE Diff.
Supportive Supervision Mean	Equal variances not assumed	-6.42	231.93	.001	-.74	.11

Table 25

Identification with Nursing Home Values and Nursing Home Type

Descriptive Statistics

Dependent Variable: Identification with NH Values Mean

Nursing Home Type	Mean	Std. Deviation	n
Traditional	3.69	1.05	29
Combination	4.68	.69	141
Humanistic	5.27	.57	151
Total	4.87	.82	321

Tests of Between-Subjects Effects

Dependent Variable: Identification with NH Values Mean

Source	Type III Sum of Squares	degrees of freedom	*M* Square	F	p
NH Type	69.62	2, 318	34.81	75.89	.001

Parameter Estimates

Dependent Variable: Identification with NH Values Mean

					95% Confidence Interval	
NH Type	*M* Diff.	S.E.	t	p	Lower Bound	Upper Bound
Traditional	-1.58	.14	-11.50	.001	-1.85	-1.31
Combination	-.59	.08	-7.45	.001	-.75	-.43
Humanistic*	---	---	---	---	---	---

*Reference Category

Table 26

Identification with NH Values and NH Type: Post-Hoc Test

NH Type Comparisons*

Dependent Variable: Identification with NH Values Mean

Comparison	*M* Diff.	Sig.	95% Confidence Interval	
			Lower Bound	Upper Bound
Humanistic vs. Combination	.60	.001	.40	.78
Humanistic vs. Traditional	1.58	.001	1.26	1.90
Combination vs. Traditional	1.00	.001	.66	1.31

*Tukey HSD

Table 27

Identification with Nursing Home Values and Culture Change

Group Statistics

			n	M	SD	SE Mean
Dependent Variable: Identification with NH Values Mean	Do you practice in a culture change nursing home?	No	124	4.46	.90	.08
		Yes	197	5.12	.65	.05

Independent Samples Test

		Levene's Test for Equality of Variances	
		F	Sig.
Identification with NH Values Mean	Equal variances not assumed	10.97	.001

		t-test for Equality of Means				
		t	df	Sig. (2-tailed)	M Diff.	SE Diff.
Identification with NH Values Mean	Equal variances not assumed	-7.13	203.61	.001	-.66	.09

Table 28

Available Resources and Nursing Home Type

Descriptive Statistics

Dependent Variable: Available Resources Mean

Nursing Home Type	Mean	Std. Deviation	n
Traditional	3.28	1.05	29
Combination	4.28	.94	141
Humanistic	4.92	.68	151
Total	4.49	.97	321

Tests of Between-Subjects Effects

Dependent Variable: Available Resources Mean

Source	Type III Sum of Squares	degrees of freedom	*M* Square	F	p
NH Type	90.07	2, 318	45.03	67.80	.001

Parameter Estimates

Dependent Variable: Available Resources Mean

					95% Confidence Interval	
NH Type	*M* Diff.	S.E.	t	p	Lower Bound	Upper Bound
Traditional	-1.63	.17	-9.57	.001	-1.97	-1.30
Combination	-.64	.10	-6.47	.001	-.83	-.44
Humanistic*	---	---	---	---	---	---

*Reference Category

Table 29

Available Resources and NH Type: Post-Hoc Test

NH Type Comparisons*

Dependent Variable: Available Resources Mean

			95% Confidence Interval	
Comparison	*M* Diff.	Sig.	Lower Bound	Upper Bound
Humanistic vs. Combination	.64	.001	.41	.87
Humanistic vs. Traditional	1.63	.001	1.23	2.03
Combination vs. Traditional	1.00	.001	.59	1.40

*Tukey HSD

Table 30

Available Resources and Culture Change

Group Statistics

			n	M	SD	SE Mean
Dependent Variable: Available Resources Mean	Do you practice in a culture change nursing home?	No	124	4.03	1.03	.09
		Yes	197	4.77	.81	.06

Independent Samples Test

		Levene's Test for Equality of Variances	
		F	Sig.
Available Resources Mean	Equal variances not assumed	9.26	.003

		t-test for Equality of Means				
		t	df	Sig. (2-tailed)	M Diff.	SE Diff.
Available Resources Mean	Equal variances not assumed	-6.80	215.44	.001	-.74	.11

Table 31

Resident-Centered Care and Nursing Home Type

Descriptive Statistics

Dependent Variable: Resident-Centered Care Mean

Nursing Home Type	Mean	Std. Deviation	n
Traditional	4.00	.87	29
Combination	4.87	.54	141
Humanistic	5.41	.46	151
Total	5.05	.68	321

Tests of Between-Subjects Effects

Dependent Variable: Resident-Centered Care Mean

Source	Type III Sum of Squares	degrees of freedom	*M* Square	F	p
NH Type	53.23	2, 318	26.62	87.27	.001

Parameter Estimates

Dependent Variable: Resident-Centered Care Mean

					95% Confidence Interval	
NH Type	*M* Diff.	S.E.	t	p	Lower Bound	Upper Bound
Traditional	-1.41	.11	-12.78	.001	-1.63	-1.19
Combination	-.48	.07	-6.96	.001	-.61	-.41
Humanistic*	---	---	---	---	---	---

*Reference Category

Table 32

Resident-Centered Care and NH Type: Post-Hoc Test

NH Type Comparisons*

Dependent Variable: Resident-Centered Care Mean

Comparison	*M* Diff.	Sig.	95% Confidence Interval	
			Lower Bound	Upper Bound
Humanistic vs. Combination	.54	.001	.39	.69
Humanistic vs. Traditional	1.41	.001	1.15	1.67
Combination vs. Traditional	.87	.001	.61	1.13

*Tukey HSD

Table 33

Resident-Centered Care and Culture Change

Group Statistics

			n	M	SD	SE Mean
Dependent Variable: Resident-Centered Care	Do you practice in a culture change nursing home	No	124	4.66	.73	.06
		Yes	197	5.30	.52	.04

Independent Samples Test

		Levene's Test for Equality of Variances	
		F	Sig.
Resident-Centered Care	Equal variances not assumed	14.62	.001

		t-test for Equality of Means				
		t	df	Sig. (2-tailed)	M Diff.	SE Diff.
Resident-Centered Care	Equal variances not assumed	-8.25	201.70	.001	-.63	.07

Table 34

Culture Change and NH Type

			Nursing Home Type			
			Trad	Comb	Huma	Total
Do you practice in a culture change nursing home?	No	Count	23	81	20	124
		% Within	19%	65%	16%	100%
	Yes	Count	6	60	131	197
		% Within	3%	31%	66%	100%
Total		Count	29	141	151	321
		% Within	9%	44%	47%	100%

Chi-Square Test

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	82.347[a]	2	.001
N of Valid Cases	321	---	---

a. 0 cells (0%) have expected count less than 5. The minimum expected count is 11.20.