When we first began researching the concept of “culture change” within long-term care facilities, we assumed we would find an already-established set of “best practices,” adapt the material for Florida’s Ombudsman Program and begin implementation with ease. However, after many volumes and long hours of research and discussion, we discovered that Culture Change, by its very nature, is a process. The process can vary vastly from facility to facility in the same way that any change varies from one individual to another. There is no “one-size-fits-all” solution to the issues that arise in long-term care facilities and, as we began to see the principles and practices of real Culture Change come into focus, we similarly watched the ombudsman’s role in that process take shape. Because there are no standard “best practices” for Culture Change, we see the ombudsman’s role in process as a trained facilitator. By focusing on the principles and practices of Culture Change while resolving complaints, he or she will have the opportunity to educate facility staff members and facilitate person-directed care within a particular facility.

Fall 2010
Culture Change Workgroup
Long-Term Care Ombudsman Program
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INTRODUCTION

“There are a number of forces converging that make it clear that the current way of doing business in nursing homes is not sustainable. In recent years, [the Centers for Medicare and Medicaid Services] has expanded the definition of quality measures and quality indicators. In addition, we have to understand what customers really want. When residents and family members are asked about quality of care, they don’t talk about regulatory survey deficiencies. They talk about the relationships they have with staff, the quality of nursing care, whether aides treat residents with respect. We’re beginning to pay much more attention to the voice of the customer—residents, family members, and staff. As baby boomers begin to approach retirement, their expectations are different. Facilities that are able to transform successfully will have a huge competitive advantage, compared with those stuck in the old model.”

Culture Change in For-Profit Nursing Homes
Leslie Grant, Ph.D.
Chapter 1

What is Culture Change?

Culture Change is often cited as having begun in 1986 with the Institute of Medicine’s publication, *Improving the Quality of Care in Nursing Homes*, followed by the 1987 passage of the Nursing Home Reform Act incorporated in the Omnibus Budget Reconciliation Action of that same year. The material in this section draws mostly from the principles of the Pioneer Network and concepts of person-directed care.

Florida’s Pioneer Network describes Culture Change as “the common name given to the national movement for the transformation of older adult services, based on person-directed values, principles and practices where the voices of elders and those working with them are considered and respected. Core person-directed values are choice, dignity, respect, self-determination and purposeful living.”

“A nursing home is a place residents call ‘home,’” wrote Consumer Voice in reference to Culture Change this year. “A place where someone lives and calls home should nurture the human spirit as well as meet medical needs. Culture change is a movement that seeks to create an environment for residents which follows the residents' routines rather than those imposed by the facility; encourages appropriate assignments of staff with a team focus to make deep culture change possible; allows residents to make their own decisions; allows spontaneous activity opportunities; and encourages and allows residents to be treated as individuals.

Deep culture change is an important component of the right of residents to ‘the care and services to attain or maintain the highest practicable physical, mental and psychosocial wellbeing;’ as promised in the 1987 Nursing Home Reform Law. It is the role of the Ombudsman to advocate for residents and their right to make choices to direct their care and life in long-term care facilities.”

According to a paper published in January 2010 entitled *Person-Centered Care for Nursing Home Residents*, among Culture Change researchers, there was initially little agreement as to how actual changes would manifest themselves in long-term care facilities. A 2006 meeting of consumers, policy holders and providers.

The “ideal facility” would feature

- Resident direction – Care to be directed as much as possible by the resident
- Homelike atmosphere – Practices and structures less institutionalized, more like home
- Close relationships between residents, family members and staff (consistent assignment)
- Staff empowerment – work organized to support and empower staff to respond to residents’ needs
- Collaborative decision-making – flattening of the typical hierarchy
- Quality improvement processes – systematic processes for continuous quality improvements
**Basic Culture Change Principles** (NCCNHR Consumer fact sheet #19)

- Know each person – recognition and honor of each individual, resident or staff member
- Each person can and does make a difference
- Relationships are the fundamental building block of a transformed culture
- Respond to the spirit, as well as mind and body
- Risk-taking is a normal part of life
- Put the person before the task
- All individuals are entitled to self-determination, independence, dignity, respect and choice wherever they live
- Community is the antidote for institutionalization
- Promote the growth and development of everyone in the facility
- Shape and use the potential of the environment in all its aspects: physical, organizational, psycho/social/spiritual
- The practice of self-examination, searching for new creativity and opportunities for improvement
- Recognition that culture change and transformation are not destinations but journeys; always works in progress

**Artifacts of Culture Change**

“Culture is comprised of beliefs and values, basic underlying assumptions, and behaviors and artifacts. In any culture, artifacts are the physical evidence that can be readily seen by an observer: structures for living and working, objects for daily use, rituals and activities, dress, and ways in which people interact (Shein, Edgar H. *Organizational Culture and Leadership*, 2nd ed. San Francisco: Jossey-Bass Publications, 1992.)

When we think of culture changes, we can view ‘artifacts’ as evidence of the culture change journey. The artifacts will serve as a way for us to assess the extent of the culture change that has taken place.

The artifacts are organized by type (referred to as “domains” in the literature):

- Care Practice
- Environmental
- Family and Community
- Leadership
- Workplace Practice
Care Practice Artifacts

- Dining
  - Restaurant-style dining: orders taken by staff, residents are served by staff
  - Buffet-style dining: residents select their food or staff assist
  - Family-style dining
  - Open dining: time window for each meal when residents can decide when to eat
  - 24-hour kitchen: residents can dine any time
  - Open Pantry concept – snacks available anytime
  - Baking – aroma of baking stimulates appetite

- Celebrations of individual residents’ birthdays
- Aromatherapy available
- Massage therapy available
- Pet therapy available : visits arranged, staff bring pets, pets reside at facility
- Waking/bedtimes selected by residents
- Residents’ bathroom care and assistance: based on individual resident needs
- Residents choose bathing times and levels of assistance
- Hospice approach for dying resident
- Community mourning: Memorials held for deceased residents
- Care planning – move from medical focus to resident-focused, such as using “I-format” care plans

Environmental Artifacts

- Neighborhood/community environment
  - Resident-focused layout of facility building - organized into neighborhoods or small communities rather than hospital-style facility
  - Neighborhoods that include dining options, library, activity areas, barber shop, beauty shop and laundry facilities
  - Private rooms rather than shared rooms
  - If shared rooms, each resident can access their living space privately – no curtains
  - Windows in living spaces – private, not through another resident’s living space
  - Wheelchair-accessible living space including mirrors, kitchen appliances, etc.
  - Closets with movable shelves, rods that can adjust to residents’ needs
  - Residents free to decorate living space without restrictions, using nails, screws, paint, etc.
  - Individual heating/AC controls in resident living area
  - Outdoor spaces, gardens and activity areas
  - Removal of nurses’ stations
  - Computer/internet availability
  - Workout areas or gym
  - Removal of call bells, replace with phones or cell phones
  - Overhead paging only used for emergencies
Family and Community Artifacts

- Private areas for meeting with guests
- Private guestroom to allow guest to stay overnight
- Private dining rooms
- Areas for intergenerational activities

Leadership Artifacts

- Involve Certified Nursing Assistants (CNAs) in care planning
- Focus on quality and measurement of satisfaction of residents/families with facility, staff and practices
- Match each staff member with resident as a ‘buddy’
- Community meetings - resident council meetings
- Learning circles: involve residents, families and staff to encourage communication

Workplace Practice Artifacts

- Consistent work assignments for staff
- Staff self-scheduling
- Non-managerial staff allowed to attend outside training paid for by facility
- Staff clothing is personal and professional, not scrubs or uniforms
- Cross-training of all staff members
- Awards given to recognize staff involved in culture change
- Career ladder for CNAs
- Job development: CNA to Licensed Practical Nurse (LPN), LPN to Registered Nurse (RN)
- Onsite day-care for children of staff members
- Paid volunteer coordinator on staff in addition to activity director
- Employee evaluations include measures of a staff member’s support of residents
- Lower turn-over rates of CNAs, LPNs, RNs
- Longevity of Director of Nursing (DON)
- Longevity of administrator
- Lower percentage of CNA, LPN, RN shifts covered by agency staff
- Lower overall resident occupancy rate

The list above was compiled by Carmen S. Bowman, Edu-Catering, LLP, as part of the Quality of Life Proxy Indicators, HHSM-500-2005-0076P between CMS and Edu-catering:

Additional information regarding Culture Change assessment tools is provided in Chapter 4.
The Language of Culture Change (Pioneer Network)

To change the culture of an institution requires a shift in the very building blocks of its foundation, both in the practical, physical ways as well as in the way the residents, staff and general public view that institution. One of the simplest ways to begin moving toward a change in culture is to change the language we use to describe that culture.

Below is a list of current and suggested vocabulary used to describe individuals who live in long-term care facilities.

<table>
<thead>
<tr>
<th>Old</th>
<th>New</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffering from</td>
<td>has or with</td>
</tr>
<tr>
<td>Wing, unit</td>
<td>household, neighborhood</td>
</tr>
<tr>
<td>Allow</td>
<td>encourage, welcome, help, facilitate</td>
</tr>
<tr>
<td>Diaper</td>
<td>brief, pad, brand name</td>
</tr>
<tr>
<td>Admit</td>
<td>move in</td>
</tr>
<tr>
<td>Discharge</td>
<td>move out</td>
</tr>
<tr>
<td>Lobby, common area</td>
<td>living room, parlor</td>
</tr>
<tr>
<td>Feeder</td>
<td>person who needs help eating</td>
</tr>
<tr>
<td>Wanderers</td>
<td>persons who like to walk</td>
</tr>
<tr>
<td>Ambulate</td>
<td>walk</td>
</tr>
<tr>
<td>Toileting</td>
<td>using the bathroom</td>
</tr>
<tr>
<td>Demented</td>
<td>person with cognitive loss</td>
</tr>
<tr>
<td>A diabetic, a quad</td>
<td>a person who has (whatever condition)</td>
</tr>
</tbody>
</table>

Comparisons of Nursing Home Cultures (Consumer Voice website)

Institution-Directed Culture
- Staff provides standardized "treatments" based upon medical diagnosis.
- Schedules and routines are designed by the institution and staff and residents must comply.
- Work is task-oriented and staff rotates assignments.
- As long as staff know how to perform a task, they can perform it "on any patient" in the home.
- Decision-making is centralized.
- There is a hospital-like environment.
- Structured activities are available when the activities director is on duty.
- There may be a sense of isolation and loneliness among residents.

Person-Directed Culture
- Staff enters into a caregiving relationship based upon individualized care needs and personal desires.
- Residents and staff together design schedules that reflect a resident’s personal needs and desires.
- Staff’s work is relationship-centered, and staff have consistent assignments.
- Staff bring their personal knowledge of elders into the caregiving process.
- Decision-making is as close to the resident as possible.
• The environment reflects the comforts of home.
• Spontaneous activities are available around the clock.
• There is a sense of community and belonging.

What will a “culture-changed” facility look like?
(Used with permission from the Pioneer Network)

To paint a clearer picture of what tangible culture change inside a facility is like, the Pioneer Network offered the following example in the area of dining:

**Dining, provider-directed style:**
Nursing home serves meals at 8:00 a.m., noon and 6:00 p.m. Residents who are independent eat in the dining room. Residents requiring assistance eat in lounge areas on their units. Meals are delivered to the main dining room and the nursing units on carts carrying trays. Residents who do not prefer the main meal may choose the alternate.

**Dining, staff-centered style:**
Nursing home serves breakfast from 7:00 a.m. until 9:00 a.m. Lunch is from 11:30 a.m. until 1:30 p.m. and dinner is from 4:30 to 6:30 p.m. Residents have their choice of one or two seatings at each meal. Each meal offers a main dish or an alternate, except for breakfast, which is buffet-style in the dining room. Residents who don’t eat in the dining room receive meals either in their bedrooms or in a lounge area on trays sent to the units.

**Dining, person-centered style:**
Residents are served food from a rolling steam table. Freshly cooked food is placed in chafing dishes and placed inside the steam table. Dietary aides serve the food to the residents on fine china with no thermal dishes or trays. The tables all have tablecloths and centerpieces and residents report the food is nice and hot. The steam table is taken to each unit in order to serve residents who are unable to come to the dining room.

**Dining, person-directed style:**
The resident council at the nursing home requested that breakfast be served to them in their rooms, while the other two meals be served in the dining room. The dietary department purchased a small cart that contains storage space for hot and cold foods. They take this cart room to room and ask the residents what they would like and fill a plate for them directly from the cart. The meals in the dining room are served family style. Food is placed in serving bowls and platters and placed on the tables. Residents who are able to, serve themselves. Staff assist those who need help being served.

(Source: pioneernetwork.net, 2009)
Chapter 2

Perceived Barriers to Implementing Culture Change

As you can see from the previous chapter, Culture Change can be enacted at a wide variety of levels and extremes, from the minimum of changing the language we use to speak about long-term care facilities and the people who call these facilities home, to the maximum of renovating the brick-and-mortar of hospital-style wards to look like miniature neighborhoods with private kitchens and guest rooms.

Naturally, those who own, manage or represent long-term care facilities may have some valid concerns when it comes to making sweeping changes in their facilities. These concerns may range from financial to regulatory in nature and must not be discounted if we wish to accomplish our end goal of a higher quality of life for residents. In this section, we will define and address some of these concerns and offer ideas regarding the effective and lasting implementation of Culture Change despite the many barriers.

Financial: This perceived barrier generally relates to remodeling or structural changes to a facility to create “neighborhoods” or a “home” environment. As you will learn in Chapter 6, many of the environmental changes which can be made in a facility to create or emulate “home” are not cost-prohibitive.

Scope of Change: Owners and administrators of long-term care facilities will often question to what extent he or she should implement Culture Change in his or her facility. This perceived barrier is one that can overwhelm those considering Culture Change as a viable option. Because Culture Change looks different for each facility, an administrator will be more effective in beginning to present and implement Culture Change if he or she is able to define and address just one area at a time. Culture change is described as a journey because the change process is incremental and often drawn over an extended period of time.

Regulatory: Concern about the Center for Medicare & Medicaid Services (CMS) survey process and the regulations is often cited as being one of the major issues confronting and/or exacerbating a facility’s efforts to implement culture change. Consumer Voice (formerly the National Consumer Voice for Quality Long-Term Care or NCCNHR), CMS and others have worked these past years to educate stakeholders on the manner in which the regulations actually support culture change values and practices rather than hinder them. The following are several examples of the statutory requirement and the Aspen Guidelines to interpret the meaning for surveyors.
How Do Regulations Support Culture Change?

- **F151 Exercise of Rights, CFR 483.10(a)(1)&(2)**
  The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

  **Interpretative Guideline**
  Give special attention to resident or staff remarks or behavior that may represent deliberate actions to promote or limit a resident’s autonomy or choice, particularly in ways that affect independent functioning.

- **F240 Quality of Care - 483.15**
  A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident’s quality of life.

  **Interpretive Guideline**
  The intention of the quality of life requirement is to specify a facility’s responsibility to create and sustain an environment that humanizes and individualizes each person. Compliance decisions are driven by the quality of life each resident experiences.

- **F241 Dignity - 483.15(a)**
  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident’s dignity and respect in full recognition of his or her individuality.

  **Interpretive Guideline**
  Dignity means that in interactions with residents, staff members work to assist residents in maintaining and enhancing his or her self-esteem and self-worth. For example:
  - Grooming or assisting residents in grooming as he or she wishes to be groomed
  - Encouraging and assisting residents in dressing in his or her own clothing
  - Promoting resident independence and dignity in dining
  - Respecting residents’ private space and property as if it were the resident’s own home
  - Respecting residents by speaking respectfully, addressing each resident by the name of a resident’s choice and not excluding residents from conversations
  - Refraining from practices demeaning to residents, such as keeping urinary catheter bags uncovered

- **F242 Self-Determination and Participation - 483.15(b)**
  The resident has the right to chose activities, schedules and health care consistent with his or her interests, assessments and plans of care; interact with member of the
community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.

**Interpretive Guideline**
Observe how well staff members know each resident and what aspects of life are important to the resident. Determine if staff make adjustments to allow residents to exercise choice and self-determination.

The intent of this requirement is to specify that a facility must create an environment that is respectful of the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life. For example, if a resident mentions that her physical therapy session was scheduled at the time of her favorite television program, staff members should accommodate the resident to the extent that they are able.

**• F245 Participation in Other Activities - 483.15(d)**
A resident has the right to participate in social, religious, and other community activities that do not interfere with the rights of other residents in the facility.

**Interpretive Guideline**
The facility, to the extent possible, should accommodate an individual’s needs and choices for how he or she spends time, both inside and outside the facility.

**• F246 Accommodation of Needs - 483.15(e)(1)**
A resident has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

**Interpretive Guideline**
“Reasonable accommodations of individual needs and preferences” refers to a facility’s effort to individualize residents’ physical environments. A facility’s physical environment and the behavior of its staff members should be directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity, and well-being to the extent possible in accordance with the resident’s own needs and preferences. This assistance may include making adaptations to ensure resident can open and close drawers, reach faucets, see him or herself in the mirror and reach bathroom supplies or needed adaptive equipment.

**• F248 Activities - 483.15(f)(1)**
The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and physical, mental, and psychosocial well-being of each resident.

**Interpretive Guideline**
The intent of this requirement is that:
• The facility will identify each resident’s interests and needs; and
• The facility will involve the resident in an ongoing program of activities that is designed to appeal to his or her interests and to enhance the resident’s highest practicable level of physical, mental and psychosocial well-being.
• There are 17 pages of interpretive guidelines for this requirement, all focused on individual interests and needs “relevant and valuable to residents’ quality of life.”

• **F252 Environment - 483.15(h)**
The facility must provide a safe, clean, comfortable and homelike environment allowing the resident to use his/her personal belongings to the extent possible.

**Interpretive Guideline**
A “homelike environment” is one that, to the extent possible, de-emphasizes the institutional character of the setting and allows the resident to use his or her personal belongings that support a homelike environment.

Below is a simplified list of items and settings that detract from a homelike environment:
• Overhead paging and music
• Use of trays to bring meals to the dining room
• Institutional signage identifying work rooms and storage areas
• Medication carts
• Audible bed and chair alarms
• Mass-purchased identical furniture, drapes, and bed coverings
• Large, centrally-located nursing stations

Lighting throughout the facility should be comfortable with glare reduced from unshielded windows and reflection from hard surfaces. Floor and table lamps should be provided to residents for individual tasks such as reading. Dimming switches can enable staff to attend a resident at night without waking his or her roommate.

• **F226 Staff Treatment of Residents - 483.13(c)**
The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property.

**Interpretive Guideline**
• The deployment of staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the care needs of individual residents.
• The supervision of staff to identify inappropriate behaviors such as using derogatory language, rough handling, ignoring residents while giving care, or directing residents who need bathroom assistance to urinate or defecate in their beds.
• **F164 Privacy and Confidentiality - 483.10(e), 483.75(l)(4)**
  The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatments, personal care.

  **Interpretive Guideline**
  Facility staff must examine and treat residents in a manner that maintains the privacy of their bodies. A resident must be granted privacy when going to the bathroom and in other activities of personal hygiene. If an individual requires assistance, authorized staff should respect the individual’s need for privacy.

**F371 Sanitary Conditions - 483.35(i)**
This statute states that food must be procured from sources approved or considered satisfactory by Federal, State or local authorities and that food be stored, prepared and distributed under sanitary conditions. This is not intended to restrict resident choice; all residents have the right to accept food brought to the facility by any visitor for the resident.

**F 461 Resident Rooms - 483.70(d)(1)(vi)**
All bedrooms must have at least one window to the outside with a sill height of no more than 36 inches. The room floor must be at or above grade (above the surrounding exterior ground level). Other room requirements are a bed, functional furniture, private accessible closet space separate from roommate’s belongings.

**483.10(j) Access and Visitation Rights (F172)**
Facility must provide 24-hour access to family and non-family visitors with consent of resident. “Reasonable restrictions” may be imposed by facility to protect all facility residents, such as keeping facility locked at night. Access may also be denied to a visitor who has been found to be abusive, exploitative or disruptive and one who is inebriated. Accommodation of late-night visits should be made so as not to disturb other residents.

**483.10(m) Married Couples (F175)**
If a room is available for a couple, married, as well as unmarried residents who wish to share a room should be accommodated because the resident has the right to make decisions regarding his life in the facility that are significant to the resident.
Chapter 3

Benefits to Implementing Culture Change

From the Facility’s Perspective (FHCA January 2010 Pulse)
“We hear it everywhere these days – all the hoopla about ‘Culture Change’ and how the resident is going to direct his or her care. Facilities are becoming more like your own home…You have the keys and the power to create the future… More importantly, the Center for Medicare and Medicaid Services (CMS) is pushing for it. It really is all about building a better life everyday for our residents and a better future for ourselves when we reach the point where we need a skilled nursing facility (SNF) for our own care. The Culture Change movement is not going away; it is not a fad. How many times have you heard someone say they would rather be dead than go into a nursing home? Ask yourself why? Would you want to be there? What’s wrong…what’s missing? Already, baby boomers are moving our census towards assisted living facilities (ALF) and other types of care because SNFs have not kept pace with consumer expectations. Consumers want to continue living their life as always, with the only difference being the addition of someone taking care of their medical needs. They are focused on living and what they CAN do, not on being sick and what they CAN’T do. We need to change our mindset.”

From a Nursing Home Administrator’s Perspective
“Our goal is to keep our residents safe, happy, healthy and as active as possible. The Person-Centered Care Model gives them more choices, self-respect, independence and keeps them physically and mentally active as possible.” (Century, Florida administrator reprinted NorthEscambia.com)

- “CMS is starting to include various aspects of Culture Change in their surveys.”
- “It’s good business; it improves employee retention and resident satisfaction.”
- “Baby Boomers are coming and this is what they will expect.”
- “We recently received corporate funds to update the facility and services. We have chosen a general Culture Change approach.”
- “It is a good framework for making the NH the best in the Panhandle.”
- “A source of ideas for an administrator’s personal interest in improving the quality of residents experience.”

From the Research Perspective The data supporting the positive impacts of culture change found on the NCCNHR website indicates:

Culture Change Outcomes
- 60 percent reduction of in-house pressure ulcers
- 25 percent reduction in the total number of bed-bound residents
- 18 percent reduction in the use of restraints
- 87 percent reduction in use of anti-anxiety as-needed medications
- 100 percent reduction in use of routine anti-psychotics
- 100 percent reduction in the use of sedative hypnotics
- 73 percent reduction of incident reports
• 7 percent *increase* in self-administration of medications
• 50 percent *increase* of residents’ activity levels
• A greater than 100 percent *increase* in social interactions involving residents
• 59 percent reduction in staff absenteeism (the leading overall cause of employee termination)
• A greater than 35 percent reduction in staff turnover (the average facility spends approximately $250K each year on employee turnover, so a savings of 35 percent translates to over $85K – this does not include money saved from reducing agency staffing and sign-on bonuses, which were eliminated)
Chapter 4

Where the Journey Begins

As has been expressed repeatedly, Culture Change is a journey. There is no prescriptive plan for initiating or implementing Culture Change. However, as with any change process, there is a common set of threads that serve as the foundation for most Culture Change movements.

- The education and empowerment of residents
- The education and empowerment of staff members
- The education and empowerment of family members
- The assessment of current practices
- Committed leadership actions
- Establishment of target outcome practices
- The continual evaluation of progress in implementation and maintenance of outcomes

Assessment

An honest assessment is the first step long-term care facilities must take in the journey of Culture Change implementation. A facility owner or administrator’s knowledge of the potential scope of Culture Change and how it may impact his or her residents will serve as a foundation for his or her understanding of these first steps. Many state government offices, consulting groups and long-term care facilities have already developed comprehensive facility assessment tools.

Although there are many different facility assessment tools available, The Artifacts of Culture Change is included in this manual (Appendix A) because this particular tool focuses on practical and concrete changes a facility can make as opposed to merely offering an assessment of a facility’s current practices.

This tool builds on the work done in the HATCH (Holistic Approach to Transformational Change) tool developed for use in Rhode Island and endorsed by CMS which utilized the same Culture Change practices: Care Practice, Environmental, Family and Community, Leadership and Workplace Practice. (Note: Each of the culture change practice areas or types is often referred to as a “domain” in literature.) Chapter 1 provides examples of Culture Change practices in each of the aforementioned areas.

In addition to facility assessment tools, assessment tools have been developed for residents, families and staff. Examples of these tools are also provided in Appendix A.

Education

The need to educate staff may be an obvious one, but several articles indicate that the need to educate residents and families has been less obvious, and failing to do so at the onset has negatively impacted implementation. Residents need to be educated and empowered to become active participants, rather than passive recipients, in their care.
Families must understand the reasons for and intended outcomes of the changes. Staff at all levels and in every position must understand Culture Change and be empowered to actively participate in the process.

Leadership: This is not a primer on leadership, but the literature does stress that culture change is a focused long term commitment, and therefore, requires supportive, stable leadership that fosters input, feedback, flexibility and is focused on what is real for those people who live and work in the facility.

**Outcomes and Evaluation**

The establishment of target outcomes or practical, reasonable goals and the continuous evaluation of a facility’s success is part of the journey.

Some Florida long-term care facility administrators indicated that their facilities did the following when getting started.

- Hired a consultant
- Owner created own plan in which employee teams would be integral; involved residents in various ways such as choosing menus
- Appointed a staff nurse to research ideas and to set up teams to implement various projects
- Administrator chose projects and assigned teams to put them into effect
Chapter 5

The Florida Experience

Two of Florida’s ombudsmen describe facilities in each of their areas that are currently on Culture Change journeys.

Impressions from Facility in Ocala, Florida

- “Culture Change is not a destination; it is a journey from Medical to Social.”
- “In the first months, it is education, selecting leaders and attending seminars.”
- “The only thing that should change when you move into a facility is your address.”
- “What was once the ‘Resident Council Meeting’ is now the ‘Community Members Meeting.’”
- “Wings are renamed to neighborhoods, i.e., Cypress Place & Palmer Place.”
- “The ‘activity room’ is now the ‘community center.’”
- “The ‘secure’ and ‘dementia units’ are now called ‘gated communities.’”
- “CNAs are now referred to as ‘Quality Care Aides.’”
- “Residents look happy, feel happy, and are engaged in talking to one another.”
- “The facility has what’s called a ‘Fun Zone’: The Fun Zone has slot machines, Wii gaming systems, computers with webcams, televisions and four game tables. These activities aren’t just fun; they help the residents with physical therapy. They are also able to engage one another in pizza-making, and using the bread machine, all of which can be therapeutic.”
- “There are two spa areas now: The Venetian Spa and the Serenity Spa.”
- “There are showers, safety tubs, heated towel racks, music and massages for every resident and hot lather shaves for the men.”
- “There is a ‘Garden Spa’ for those in sub-acute.”
- “There is what is called a ‘Quiet Zone’, which is a relaxing area to be used as day room. It contains rocking chairs, gliders, a faux fireplace, television with DVD player and there are hand massages available.”
- “There is a noticeable reduction in residents’ need for and dependency on medications and psychotherapeutic drugs. Residents are found to be more relaxed.”
- “There is what’s called the ‘Pamper Zone.’ It contains a beauty and barber shop, paraffin dips, manicures, and pedicures.”
- “The facility offers aroma therapy with music, rippling water and soothing scents.”
- “There is an ‘iCare Plan’ for each resident, which includes activities like knitting, or crocheting, and helps staff members determine the likes and dislikes of every resident.”
- “There is a focus on ‘wellness.’ As a result, the facility removed all nursing stations and made them into living rooms.”
- “The facility does not have residents just sitting around with nothing to do.”
“Dining-wise, this facility is all about:
- Restaurant-style food and service, with CNAs seating and waiting on residents
- Plenty of seating
- Menu choices and residents being served
- Two hours for meals so residents may come whenever and for however long they wish
- Cloth napkins only
- Steam tables and desert carts”

“At this facility, quality of life is essential. Residents who need assistance with eating will have assistance.”

“Facility changed the name of the dining room to restaurant names and bistros.”

“There is room service for those who wish to dine in or are unable dine out.”

“There are kitchens in each neighborhood.”

“There are extended dining hours, which helps to change the look of the facility. You do not see residents lined up in the hallways waiting to get into the dining rooms.”

“Residents have formed book clubs.”

“There is a sports bar available.”

“There is a happy hour every evening for residents who wish to attend.”

“There is music playing everywhere.”

The residents have to feel that they are living in a community and this is their neighborhood and they make the decisions.

**Impressions from a Facility in Venice, FL – an anecdote**

March, 2010: I recently visited a nursing home at which I have been conducting administrative assessments for the past six years. I was there to do my seventh annual assessment.

Upon first glance, I remember thinking to myself that the facility looked different but I couldn’t put my finger on exactly what had changed. In general, it seemed brighter and more welcoming, but without much more consideration, I continued my assessment. Gradually I began to realize that the facility was rather quiet. *What was missing?* It was the lack of paging over the loudspeaker system. Next, I noticed that the two main hallways had nameplates mounted above the doorframes. The first was called “Cherry Lane” and the other was “Oak Lane.” As I continued with the assessment, I made a visit to the dining room because it was nearing the lunch hour and that is always a great place to find and talk with residents about their concerns and rights. I noticed that something was different in the dining room too. Was it cleaner or brighter? I still
wasn’t sure until I spotted a sign that read “Bistro”. Then I noticed that the tables and chairs were new and trendy and the CNAs and residents were eating lunch together.

Later I went and visited with residents who were in their rooms. While speaking to a resident about her likes and dislikes, I noticed that one of her walls was painted a contrasting color. I noticed the same thing in her bathroom; a painted accent wall which matched the bathroom’s furnishings. I remember thinking to myself that the colors were very helpful for someone with limited vision.

Next, I moved on to the Med Cart and the Mars. A nurse took me to a cart with a computer mounted on it. I was able to look at a resident’s Mars and not see the individual’s name. I was also able to easily check the medications for expiration dates.

Finally, I was preparing to conduct my exit interview. The administrator was out of the building, so I asked to meet with the Director of Nursing and the Social Worker. My first question to them was, “Is this facility on a Culture Change Journey?” Both of their eyes lit up and with big smiles on their faces they said, “Yes, you noticed.” After that, we were off on our own journey sharing ideas and thoughts about Culture Change. I must admit, having immersed myself in Culture Change research for the past four months and stumbling upon a facility that was embarking on this journey in my own backyard was very exciting for me.

The Director of Nursing and Social Worker couldn’t wait to show me the new heated towel rack in the shower room, the new tile work and a describe a recently-ordered bathtub into which a resident may easily walk in and sit down. They were attempting to “make the bathroom have a more spa-like feeling.”

The Director of Nursing and Social Worker explained that the facility had begun the Culture Change journey under the leadership of the facility’s administrator. I promised to return when she was in the office so I could speak with her about her goals and ideas for the facility.

When I returned on another day, I was able to speak with both the Administrator and the CEO. This facility is part of a Continuing Care Retirement Community which is a not-for-profit faith-based facility. This means that it has a campus-like feel with many independent living buildings, an assisted living facility and a 60-bed nursing home. It also means that the facility is not corporately-owned and that making these sweeping changes doesn’t require proof of initial profit. When I asked the Administrator why she chose to start this journey, her reply was that “it just made sense and seemed like the right thing to do.” This particular facility had not hired consultants to help define or implement the changes.

When I questioned the initial means by which she started making changes, the Administrator told me that one of the first things she did was to give all the CNAs permanent assignments. This means that residents would be cared for and served by the same people every day. My heart sang when I heard that. I thought of how often I had
pleaded with administrators to try this method and there always seemed to be reasons for why they would not or could not attempt it.

One of the next changes the administrator implemented was the “Care Tracker” system. It involves a small screen affixed to wall at the start of each hallway. The CNAs themselves were involved in selecting this particular model of care management. In this system, a CNA uses his or her thumbprint to gain access to patient records and make changes based on the day’s activities. It is a HIPPA-compliant way for CNAs to record care they have provided to their residents.

The next area of change on which the Administrator focused was the look and feel of the inside of the building. Both the entrance and lobby floors had been renovated with light-colored wooden floors. Then the administrator, the CEO, the Social Worker, the DON and many other staff members who wanted to help began the job of painting the hallways on weekends and their days off. They chose a cheery yellow for the main rooms and then proceeded to paint all of the resident’s rooms as well.

Other changes this facility enacted involved 24-hour dining. While the main kitchen is not open all night, residents do have access to snacks, drinks and sandwiches any time of the day or night upon request.

Perhaps the best feature of this overall Culture Change Journey was that all of the changes were reviewed and approved by the Resident Council of the facility before any of the projects were begun. The Council gave their approval with one caveat: “Don’t spend too much money”.

Besides just leading the journey of Culture Change in her facility, the administrator personally lives Culture Change. She is a creative person and she converted her office closet into a sewing room, which she used to make each resident his or her own shower poncho with hood from terrycloth. She also makes quilts with residents every Thursday.

Among the many changes, one of my personal favorites was the new Skype portable phone, which residents may use to talk with their friends and family via video conferencing. The Administrator proudly announced that she had purchased the phone very affordably from Amazon.

This administrator chose to begin the Culture Change journey with primarily cosmetic changes but she did also include one of the basic tenants of Culture Change: the continuity of care. With continuity, caregivers are able to get to know the likes and dislikes of the residents they care for. They have the opportunity to form relationships with them and therefore see all residents as people, not objects. This is the first step to a higher quality of care and life for people in long-term care facilities.

The administrator also informed me that she has many other ideas of change for the facility in the future phases of change, such as staff members scheduling their own shifts and doing away with the Nurse’s station.
This facility has truly begun a Culture Change Journey. I am anxious to see where the journey will lead them. They seem to be off to an excellent start and they are allowing common sense and care to be their guide.

Part 2: Advocating for Culture Change

Chapter 6

The Role of the Ombudsman

In June 2007, Sara Hunt published a resource brief for Consumer Voice (formerly NCCNHR) entitled, “The Role of the Ombudsman in Culture Change.” Although the primary examples of ombudsman efforts to promote Culture Change focus on efforts at the State Ombudsman level, the above document is referenced because it provides direction for a volunteer “in-the-field” ombudsman’s role in Culture Change. In the final pages of the resource brief, Hunt answers specific questions about the role of an individual ombudsman (Appendix B). The document is accessible on the Consumer Voice website.

Ms. Hunt indicates individual ombudsmen can educate consumers about good care practices and empower them to advocate for good care. Ombudsmen can do this by:

- Receiving training and resources so they have the knowledge and can incorporate these practices into their conversations with residents, families and providers in their advocacy.
- Seizing opportunities to involve consumers and promote person-directed practices.

Tips for Ombudsmen:
- Stay informed about Culture Change and person-directed care.
- Identify and support provider best practices in the facilities in your area. Initiate dialogue with individual facility staff members, owners and administrators. Reportedly, every facility has a copy of “Bathing Without a Battle.” Ask staff members if they have trained with this video. (videotape is available in the district offices.) If no forum exists among local providers, initiate one to promote Culture Change.
- Share information with consumers. Use one of Consumer Voice’s Fact Sheets or develop your own. When discussing what to look for in a facility, integrate into the discussion some indicators of Culture Change and person-directed care.
- Utilize your knowledge of person-directed care practices when resolving complaints and providing in-service trainings or community presentations.

A PowerPoint presentation on the Consumer Voice website indicates:

Ombudsman work to ensure that...
“Individuals who live in long-term care facilities will exercise their rights and make choices that will enable them to function at their highest level and enjoy life to its fullest—whatever they determine that to be.”

**The Focus of the Ombudsman program**
- Resident empowerment
- Awareness of Residents’ Rights
- Education for families about long-term care
- Awareness and education about the Ombudsman Program
- Share tools and ideas for facilities to improve

**Why it’s Important that Ombudsmen Know & Understand Culture Change**
- Enables you to more effectively educate and empower residents in directing their care.
- Enables you to more effectively advocate for resolutions that promote resident choice.
- Enables you to more effectively educate and empower families in evaluating facilities and establishing expectations for the care of their loved ones.
- Helps you to recognize and support a facility’s Culture Change initiatives.
- As an ombudsman, your first priority is always advocacy, not facility consultation. However, being knowledgeable about person-directed practices enables you to more creatively strategize your advocacy, including referring administrators to the CMS interpretive guidelines.
- More effective advocacy will be a natural outcome of more knowledge.

**Example 1:**
- **Complaint:** Resident says her clothes are stolen.
- **Findings:** The resident’s closet is full of clothes labeled with her name. Resident is in a wheelchair and is unable to see everything in her closet.
- **Typical resolution:** The attending CNA will lay out two or three outfits each day so the resident may see the clothes and choose what to wear.
- **Person-directed care resolution:** Lower the closet’s clothing bar and install a hand-activated, battery-powered light.
- **Tip:** Recommend administrator reviews the CMS interpretive guideline for “Dignity.”

**Example 2:**
- **Complaint:** Facility has no activities.
- **Findings:** Facility has a full activities calendar, but resident does not participate.
- **Typical resolution:** Staff will remind resident of activity and prompt resident to attend.
Person-directed practice resolution: Develop process to identify individual resident’s interests.
Tip: Recommend administrator reviews the CMS interpretive guideline for “Activities.”

Chapter 7

Toolkit

As a resident advocate, an ombudsman can utilize the following person-directed practices in resolving complaints or utilize these practices as quality of life and quality of care indicators in educating residents and families. Remember, as one nursing home administrator indicated, the only thing that should change when a resident moves into a facility is his or her address.

Care Practices: Implementing Individualized Care for Nursing Home Residents
(Quality Partners of Rhode Island)

Below is a brief listing of change ideas and suggestions, including questions facility staff may want to ask themselves with regard to specific areas of care.

Resident Choice change ideas:
- In what areas do residents’ voice count?
- Can they visit their own doctor (do we provide support to make this possible)?
- Are residents really involved in their care conferences?
- Do residents chose waking/sleeping times, daily routine, food preferences, “spur-of-the-moment” cravings or interests?
- How do we know a particular resident’s choices and needs?
- Are we empowering, teaching and setting an example with staff members to ensure they are allowing residents to choose their best life?
- Teach staff members, residents and family members about choice.
- Create a climate of openness that encourages people to creatively find ways to deliver on a resident’s choice.
- Work to discover barriers that prevent resident’s choice from being granted.
- Create an “I think we can” culture rather than a “No” culture.
- Create new systems of admissions to begin to get to know the resident at intake.
- Create communication systems that always include discussion of resident choice and preferences.

Waking and Sleeping change ideas:
- How can sleep be made more comfortable?
- Would you be comfortable sleeping here – with this bed and pillow?
- What are all the factors that must be considered to make a change?
• What could be improved in the following: lighting, noise, bed comfort, privacy and clinical care to help with sleep?
• What evening activities and/or food do people who like to stay up want available?
• What are medical consequences of sleep deprivation on health and well-being?
• What negative outcomes are we causing by constantly interrupting the sleep of our residents?

**Bathing change ideas:**
• Ask the resident about his or her daily routines before he or she moves into the nursing home.
• Does the resident need assistance or can he or she bathe him/herself?
• Establish preferences for bath or shower, time of day, leisure activity (such as a book or glass of wine for 45 minutes) versus an all-functional routine.
• Consider using personal items such as bubble bath, bath salts and a bath pillow.
• Consider warming lights to avoid residents being chilly when finished bathing.
• Consider items that could make the experience more comfortable (warm, fluffy towels; relaxed conversation with caretaker, etc.)
• Provide as private an experience as possible by using a buffer curtain and shower capes.

**Medication Handling change ideas:**
• Physician writes prescription to coincide with “upon awakening” and “at bedtime” or writes prescription to coincide with mealtimes.

**Dining change ideas:**
• Staffing - Consistent Assignment
• Administrators and staff make mutual commitments to consistent staff assignment. Residents are assured then, that they will see the same staff most days.
• Find out from staff what their preferred schedule and assignments would be. Find out who enjoys floating or prefers various assignments rather than destabilizing the whole staff by making everyone float.
• Create teams that work regularly together. Ask teams to work with each other to provide back-ups and substitutes when they need to change their schedule or call in a scheduled shift.
• Figure out when busiest times are in accordance with the residents’ patterns and adjust schedules to meet needs.
• Have regular housekeeping and food service staff working with each care area.

**Environment change ideas:**
Overall goal of entrance and reception into a dining area is to create a welcoming entrance that is accessible to all, attractive, non-institutional, well-lit, secure and provides a variety of seating options. A good dining environment would encourage residents to use the area and would welcome visitors when they arrive.
• Create outdoor entrance sign by enlisting art students to submit designs, residents vote on choice.
• Lighted sign with solar-powered lights.
• Decorate surrounding trees and shrubs for holidays.
• Landscape with flowers using local school colors and school volunteers.
• Repaint curb cut-out.
• Invite neighborhood children to “trick or treat” at Halloween & hunt Easter eggs.
• In reception area concentrate on good smells, pleasant sounds and attractive views.
• Create coffee desk or cart that includes bread from bread-making machine, jam, cookies and beverages.
• Instead of a counter use a concierge desk.
• Bouquets of potted or cut flowers on desks and tables.
• Provide music appropriate to the season.
• Provide ample and moveable seating for residents and visitors.
• **Color:** Create a contrast between hues, contrasts between light and dark and contrasts between cold and warm colors.
  - Contrast chair seats with the floor.
  - Contrast toilets and toilet seats with both the floor and walls.
  - Contrast table settings between plates and tablecloth/placement.
  - Avoid flooring with high-contrasting bold patterns or borders.

• Create a common “**gathering space**”: This social space would function similarly to a neighborhood coffee shop – a place that is down the corridor from your home, which you travel to for the purpose of enjoying a treat, the company of others or just for a change of scenery. This can be as simple as a counter to dispense ice cream or a coffee shop with tables and chairs. Create spaces that serve a purpose such as a post office, bank, or vending area with tables and chairs.

• Renovate **corridors**: Though the main purpose of a corridor is to serve as a passageway for people to travel from one part of a building to another, clear and prominent signage, walking distance and functionality must be taken into consideration. The use of tasteful, age-appropriate decorations and colors are helpful in distinguishing one corridor from another. Always with residents’ input, consider the following improvements:
  - At entrance, replace directories on the wall with staff, volunteer or residents who sit at a concierge desk and offer directions if needed.
  - Take inventory of current pictures on corridor walls and replace them often.
  - Create a theme for the overall facility and decorate each corridor in accordance with theme.
  - Replace institutional looking light fixtures with residential type fixtures.
  - Create a gallery along the wall with resident, community, student artwork.
- Create “wall of honor” with individual photos of residents 100 years old.

- Renovate residents’ rooms: When stepping over the threshold into a resident’s room, staff members, family members and other residents must be made aware that by doing so, he or she is entering the front door to this resident’s home. Always with a resident’s input, consider the following improvements:
  - Paint each dorm frame a different color to increase individuality and make it easier for a resident to locate his or her room.
  - Solicit correspondence from community to residents and develop facility-wide newsletter.
  - Install mailbox outside of each resident’s room to receive correspondence.
  - Identify and furnish the space as a “living space,” not just a “sleeping space.”
  - Make all rooms well-lit. Pay close attention to providing adequate illumination levels from task and fixed light fixtures as well as natural window light.
  - Create attractive nameplates with large lettering on contrasting colored backgrounds.
  - In shared rooms, differentiate the two equal spaces as “belonging” to each resident.
  - Paint each side of a room a contrasting color or use armoires, shelving, etc. as room dividers to identify separate space.
  - Create attractive privacy curtains by purchasing fire rated fabric or curtains, attaching them with shower or drapery rings. Velcro straps can create an attractive tie-back effort.
  - Add wallpaper borders and/or shelving to the upper 1/3 of wall for display space.
  - When not in use, wheelchairs in room can create an obstacle. In close proximity to bed, build “wheelchair bin” with flat surface for display or workspace.
  - Install “cane hooks” for cane storage near bed and chair.
  - Renovate built-in standardized storage cabinets and replace with flexible storage units tailored to resident storage needs and interests or hobbies.
  - Renovate built-in storage with new handles, drawer pulls and paint.

- Renovate residents’ bathrooms: Residents often share a bathroom, so it will be challenging to personalize the bathroom to the specific needs of each resident while creating an attractive and functional bathroom with ample storage space.
  - Consider storage needs for each resident and provide storage units specific to those needs.
  - Differentiate colors of storage units between residents. Many affordable varieties and colors are available at local home improvement stores.
  - Consider methods to increase counter space around sink.
  - Clean and re-grout tile.
  - Paint room or door molding to contrast from one another.
  - Replace sink faucet hardware with single lever.
• Install illuminated light switches or motion-activated lights.
• Replace light fixtures with more decorative residential-style fixtures.
• If mirror is without a border, install decorative wooden moldings.
• Add residential-type amenities such as Kleenex box covers that differ between bathrooms.
• Replacing towel bars with colorful bars or multi-purpose hooks.
• Provide towels in colors other than white and beige.

• Renovate shared Shower/Tub Room: Think “spa” and create a pleasant, relaxing environment that residents may look forward to and feel pampered by.
  • Change signage at entrance to read “spa room.”
  • Equip room so residents may also have hair styled, be given a manicure or other spa treatment or use bath salts or bubble bath.
  • Remove visible instructional signs like “clean tub after every use” and place in area which only staff members see (inside cabinet doors, etc.).
  • Clean and repaint. Replace worn grout, fixtures, and outdated lighting.
  • Use brightly-colored shower curtains and coordinate towels and décor.
  • Provide brightly-covered hooks and shelf for resident’s belongings.
  • Provide terrycloth bathrobes for all residents and have an available towel warmer.

Learning Center change ideas: Create a learning center for residents, family members and staff that provides educational materials and wellness incentives.
• Provide several comfortable chairs, each with an adjacent table and adjustable lamp.
• Create library or reading center with tables, shelves, adjustable lighting, reading aids, large print books, diaries for personal writings and space for Book Club members to meet together.
• Provide computers at individual stations and schedule high school volunteers to assist.
• Designate a desk as the “newsroom” where a facility newspaper can be developed with volunteer help. Enlist residents to be reporters.
• Designate a corner for the movie theater with large screen television, comfortable chairs, room-darkening shades and a popcorn machine.
• Consider installing an “invisible fence” for pet control inside facility rather than relying on wander guard or gates.
• Install an aquarium with large, brightly-colored fish.
• Consider designating a space to create centers for crafts such as pottery, jewelry-making, clay sculpting, piano lessons, hand bell choir, pet care, concerts or lectures. Create opportunities that encourage residents to engage on another and be creative.

Carts change ideas:
• Install a single kitchen cabinet to create a space in which medications could be kept and locked in a resident’s room.
• Utilize enclosed laundry hampers in each resident’s room and empty frequently.
• Create cabinet space in the bathroom for toilet paper, paper towels and even cleaning supplies.

Outdoor Environment change ideas: Create a “welcoming” patio at the front entrance of the facility. Accommodate and encourage residents and staff to use all outdoor space.
• Create front porch area reminiscent of porches from the past.
• Directly outside entrance, create functional and inviting patio space with areas both in the sun and shade to sit, watch and socialize.
• Enlist volunteer students or scouts to plant flower gardens.
• Provide overhead covering for all seating.
• Plant vegetable garden and use, donate, or sell the produce as a fundraising function. Provide personal “plot” for residents who like gardening.
• Provide bird feeders and raised garden areas for resident involvement, including those in wheelchairs.
• Create a marked walking path, landscaped with covered sitting areas.

Lighting change ideas: Make improvements to compensate for changes in aging eyes.
• Raise overall level of illumination.
• Provide consistent and even light levels.
• Eliminate glares.
• Provide frequent and easy access to natural daylight.
• Provide gradual changes in light levels.
• Increase illumination at task locations.
• Use indirect lighting and improve color rendering.
• Use lighting controls.
• Develop a lighting maintenance schedule.

Alzheimer’s/Dementia-Specific ideas:

Learning to Speak Alzheimer’s – Joan Coste

Lighting
How can lighting help control behavior, increase safety, and offer comfort and a feeling of security to the resident? The goal of lighting is to mimic daylight, which is the most comfortable kind of light of residents. There are many different kinds of light bulbs such as “day glow,” “vita lite,” or “pink light.” Fluorescent ceiling fixtures can be made to feel more like natural light by replacing the cover with a parabolic grid, which resembles rows of two-inch plastic cubes. The grid diffuses light and eliminate shadows, which an Alzheimer’s resident may misinterpret or find threatening.

Leaving lights on at night seems practical when remembering that many bathroom accidents can be avoided simply by lighting the way to the bathroom or using reflector tape to mark the way from the resident’s room to the bathroom.
Install dimmer switches throughout and turn up the lights as the sun starts to go down to help the resident who may become influenced by “sundown syndrome.”

As part of the effort to simplify the environment as much as possible, try to replace floor lamps with lighting that is attached to the wall. That will help make the house as clutter-free as possible.

**Color Schemes**

Studies have found that Alzheimer’s affects resident reactions to colors. It has been found that using unique colors for different areas and spaces can help with resident orientation and enable the resident to move about spaces without getting lost. Flat rather than high-gloss paint on walls helps eliminate both glare and shadows.

- Find wall colors that contrast with the functional objects in a room.
- Paint the wall behind the toilet a darker, contrasting color so it is easy to spot from a doorway.
- If sofas and chairs blend with the background, use colorful throws or afghans so residents know where to sit.

Color can be used not only to highlight utilitarian items but also to camouflage objects to avoid. To keep a resident out of harm’s way, place a black mat inside the front door to suggest a dark chasm that can’t be crossed. Many LTC facilities specializing in the care of Alzheimer’s residents have found this to be a great way to keep their residents from wandering off. Staff members report that the most positive aspect of using black mats is not having to issue negative commands. When the Alzheimer’s resident sees the “hole,” he simply turns back in the other direction.

Along the same lines, painting or wallpapering entry doors to match the surrounding walls makes them harder to see. Place functioning locks, and even doorknobs, up high or down low on doors, leaving the useless locks and knobs in place so residents may believe them to be broken or stuck.

**Flooring**

At some point, a resident’s gait will become shuffling and perhaps scissors-like. Many residents have a history of falls, and frequently the floor covering is to blame. Eliminate scatter rugs and be mindful of shadows that may be created on flooring and adjust window coverings or lights to eliminate the sometimes terrifying visual illusions that can form in the perception of a person with Alzheimer’s. Also, repair or level uneven flooring.

**Interior Pathways**

Establishing clear interior pathways will help the person with Alzheimer’s negotiate spaces safely. He will also feel a sense of accomplishment at being able to find important places – the bathroom, kitchen, or even a favorite chair more easily.
Furniture & Hangings
Remove furniture that is difficult to get into and out of. As the person’s motor skills diminish, sturdy chairs with arms to push up from and seats with short depth from front to back may be required. Large, overstuffed furniture can prove difficult for the person with Alzheimer’s. A glider may be a wonderful addition. Unlike rocking chairs, gliders do not actually lift off the floor. Built in shelves are always safer and less threatening than free standing units.

Simplicity is the watchword for any item that hangs on a wall. For example, at some time, mirrors will do more harm than good. A glance in the mirror may make the Alzheimer’s resident believe that another person is in the room….an intruder. Replace reflective glass with no-glare glass on photos so that the resident may focus on the photograph. Textured wall hangings that can be touched can be a source of enjoyment. Faux windows with familiar scenes can break up stretches of blank walls. Eliminate reminders of hobbies that resident’s can no longer do while encouraging hobbies that the resident can still perform. A sturdy fish tank will provide hours of viewing pleasure and as well as the interaction of seeing the fish. Place a comfortable chair in front of the tank – not beside it.

Use Images to Replace Words
As directions become more difficult and memory less reliable, use images of items to replace words. Put a picture of dishes on the door of the cabinet where the dishes are stored, a picture of a toilet on the bathroom door or next to the door if you want to leave the door open, especially at night. Frequently assess the environment to adjust or compensate for changes in the patient.

Safety Devices
Install child safety gates at the tops and bottoms of stairs. Install childproof locks on knobs of closets and cabinets. Camouflage fireplace openings with colorful baskets of yarn or flowers. Of course, keep matches and lighters hidden at all times. Research safety techniques for electric and glass stoves.

Home Areas
Creation of cozy places (keeping furniture placement as close to the original pattern as possible) offers clues for conversation; but awareness of an individual’s need for reflection and introspection is also important.

Outdoors
Repair cracked, uneven, or potholed pavement, trying to make the surface as level and smooth (but not slick) as possible. Being outdoors and having contact with nature can contribute to the person’s well-being and sense of security. Utilize bird feeders, birdbaths, fountains, wind chimes, and windsocks, for example. Gardening can provide enjoyment from feeling dirt between their fingers to watching plants grow and flourish. Raising the garden to eye level is visually obvious but also saves strained backs. Look, listen, and smell.
**Noise and Sound**

Noise is also part of the environment. The patient’s ability to hear does not change, but sounds may be interpreted differently as time goes on. Research has shown that many of the sounds we take for granted actually disturb patients with progressive dementia. The sounds of television, telephones, flushing toilets, running water, radios, doorbells, alarm clocks and traffic, for example, can be over stimulating and agitating to a person with Alzheimer’s. However, research has also shown, that patients’ difficulty in processing sounds is upsetting for only a short period of time during the progression of the disease. Perhaps as the person with Alzheimer’s retreats more into her own world, she is bothered less by the noises and acoustical interruptions from the outside world. Again, continued assessment and awareness of the person’s condition is very important.

Noise can be used to enhance the patient’s safety. Jingle bells can be hung on a door or a garden gate to alert a caregiver to an attempt; to get out, averting a potentially harmful situation.
Development of
the Artifacts of Culture Change Tool


Submitted to
Centers for Medicare & Medicaid Services
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April 21, 2006

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This report is a product of the project: Quality of Life Proxy Indicators, HHSM-500-2005-00076P between the Centers for Medicare & Medicaid Services (CMS) and Edu-Catering, LLP and co-authored by Carmen S. Bowman and Karen Schoeneman. For more information, contact Carmen S. Bowman at 303-981-7228 or carmen@edu-catering.com or Karen Schoeneman of CMS at 410-786-6855 or karen.schoeneman@cms.hhs.gov.
Special Thanks
The opportunity to co-develop this tool with Karen Schoeneman of CMS has been exciting. In the course of the project, Karen and I became partners truly developing the Artifacts of Culture Change tool and authoring this report in tandem. This work fills a gap in data collection within the culture change movement thus far. It offers a means for innovative providers to capture the real changes they have made after making a conscious commitment to resident-directed care. To date, what has been collected has largely consisted of clinical data, satisfaction measures and assessment of organizational stages.

I would like to thank Karen Schoeneman for her partnership, insight and wise counsel in the writing of this report.

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ARTIFACTS OF CULTURE CHANGE DEVELOPMENT

The movement sweeping the country called culture change represents serious reform of institutional culture to one that gives voice like never before to the people living and working in such a culture. Pioneering leaders have adopted principles and worked toward making actual, concrete changes to their policies and practices such as how they manage staff, how they honor those in their care, and environmental changes to create home. Culture change is not a singular item, it is multifaceted with homes deciding to make changes that may be different from other homes. The beauty of becoming more person-centered and less institutional is that it is based on what the persons living and working in each home decide.

Culture is comprised of beliefs and values, basic underlying assumptions, and behaviors and artifacts. In any culture, artifacts are the physical evidences that can be readily seen by an observer: structures for living and working, objects for daily use, rituals and activities, dress, and ways in which people interact (Shein, 1992). The presence of artifacts distinguishes facilities that have progressed in making changes from those that are still in the thinking stages and those that have not begun the culture change journey.

Turnover is perhaps the most researched outcome of culture change. Results thus far, reported by both researchers and providers, is that once culture change is underway and a home has made changes to how it operates, great declines in turnover take place. Homes that have been innovators for many years find that not only is their turnover relatively low, but that the longevity of their nursing staff and their administrator is quite long compared to other homes. (Refer to Outcomes section of this report.)

Recent research shows that implementing culture changes can also affect turnover within a short amount of time. 51 homes took part in the QIO Improving Nursing Home Culture pilot study from August 2004 to October 2005. The baseline quarter of August-October 2004 was compared with the re-measurement quarter of March-May 2005. The homes experienced a 5.6% decline in their annualized turnover rates from 55.2% to 49.6%. Besides showing that turnover can be affected in such a short period of time, the pilot “has proven that transformational changes within nursing homes that will positively affect the lives of residents and staff can take place in a very short span of time (Quality Partners of RI, 2005).”

Envisioning the Future

“I’d rather die than live in a nursing home.”

Let’s change that sentiment uttered by so many at the slightest mention of the words “nursing home.” As we know, culture change is a journey: there are benchmarks, steps backward, and steps forward. People contribute individual skills, talents, and ideas, while teams, communities, and organizations work together to get there. (Misiorski, 2004).
Purpose

The Artifacts of Culture Change tool fills the purpose of collecting the major concrete changes homes have made to care and workplace practices, policies and schedules, increased resident autonomy, and improved environment. It results from study of what providers and researchers have deemed significant things that are changed and are different in culture changing homes compared to other homes.

There are many entities, including researchers, provider organizations, nursing home chains, and CMS, who desire to compare culture changing homes to all other homes on variables such as deficiencies, Quality Measures/Quality Indicators, turnover, etc. to determine if changing culture has any positive effects. But in order to make these comparisons, it is necessary to first measure the culture changes themselves, in order to array culture changing homes on a continuum of actual changes they have accomplished, rather than lumping together as “culture change homes” all homes that indicate they are on the journey of culture change. Because of this need, the Artifacts of Culture Change tool was developed to collect concrete artifacts of the culture change process that a home has and which they do not have. The items are not research-validated measures nor are they indicators of something else. They are also purposely not based on resident or staff interviews, thus making collectability simpler. Interview-based tools tend to capture what changes people desire and/or the degree of approval/satisfaction of residents and staff with the home, while the Artifacts tool seeks to directly capture the actual concrete changes themselves. As artifacts of a changed culture, the items on this tool are becoming of more interest to the general public as well since research reveals these are practices and things consumers want, e.g., private rooms versus shared and greater levels of autonomy.

Other Culture Change Tools

There are a few tools developed thus far to distinguish between homes on a culture change journey and homes that are not.

Some measurement tools that are currently available and in use are:

- The Stages Tool developed by Les Grant and LaVrene Norton is a stage model of culture change in nursing facilities. This tool assesses the degree of culture change from an organizational development perspective in the four stages of Stage I - Institutional model, Stage II - Transformational model, Stage III - Neighborhood model and Stage IV - Household model describing the organizational status of Decision Making, Staff Roles, Physical Environment, Organizational Design and Leadership Practices in each.
- Culture Change Staging Tool is a web-based questionnaire that assesses 12 key culture change domains determining the highest model stage (of the four stages of the Grant and Norton Stages Tool) based on a facility’s responses.
- Eden Warmth Surveys. Questionnaires are used with Elders, Families and Employees to rate from Strongly Agree to Strongly Disagree items such as participation in decision-making, choices and work has meaning and purpose.
• The Culture Change Indicators Survey developed by the Institute for Caregiver Education indicates to what degree there is a commitment to culture change. For the domains of Environment, Organizational Procedures, Resident Involvement and Staff Empowerment, indicators such as consistent staff assignments, involving residents in the day-to-day operations of the home, care planning in the first person and kitchen accessibility 24/7 are rated by staff on a five point scale from Not Even Considered to Fully Implemented.

• Some researchers have developed tools specific to their studies such as the QIO Person Centered Care Pilot and the Colorado QIO culture change study (CFMC, 2006), but none concentrates solely on concrete changes.

The Artifacts of Culture Change tool is not intended to replace any available tools, only to add to them an instrument to collect actual policy and building changes that many culture change innovators are making. The change process represents change in heart, mind and attitude. The change process includes vision and leadership, but these elements are not visible. What results from these non-visible elements are concrete changes facilities have made, and are in the process of making, which demonstrate the principles behind them. These concrete changes are the markers and artifacts of the change of mind that occurs in a journey toward home (Schoeneman, 2006).

Artifacts of Culture Change Tool Development

This tool was first conceived in 2001 by Karen Schoeneman and Mary Pratt of CMS, who were co-project officers of the CMS Quality of Life study, “Measures, Indicators, and Improvement of Quality of Life in Nursing Homes” led by Dr. Rosalie Kane of the University of Minnesota. The tool was conceived as an additional proxy for quality of life, which had no set of “indicators.” Schoeneman and Pratt completed an initial draft of the tool and tested it in a volunteer facility in Pennsylvania. Following this test, the tool was edited by co-developers Karen Schoeneman and Carmen Bowman while Ms. Bowman was working at CMS in 2001. These items were refined through collaboration with Dr. Rosalie A. Kane of the University of Minnesota, who conducted a larger test of many of the items for collection feasibility and clarity, as part of the Quality of Life study (Chapter 9). Results of Dr. Kane’s work were studied, and development continued through the award of a contract by CMS to Carmen S. Bowman of Edu-Catering in 2005. Karen Schoeneman and Carmen Bowman then co-developed and completed the Artifacts of Culture Change tool. All items represent actual changes observed, read or heard of by the developers and highlighted by those who implemented them as important changes and effective components of a changed culture.

Four focus facilities were recruited to complete the tool and provide feedback as to the collectability and instructions for each item, and the items in general. Since we had a need to select homes that had many of the tool items, we selected three nationally prominent culture change leading homes that the authors had personally visited and verified the concrete results of their culture change efforts, and the fourth as an Eden facility and on a culture change journey but small, independently owned.
The focus facilities and administrators/CEOs who worked with the tool were:

- Ken Arneson, NHA Evergreen Retirement Community Oshkosh, WI
- Sister Pauline Brecanier Teresian House, Abany NY
- Garth Brokaw, CEO Fairport Baptist Home Fairport, NY
- Donna Zunker, NHA GranCare Nursing Center, Green Bay, WI

Five researchers volunteered to be commenters on the value of the items, clarity of language and the structure and scoring of the tool:

- Joe Angelelli, PhD, Pioneer Network Director of Networking and Development. Prior to joining the Pioneer Network, Dr. Angelelli was a Penn State professor of Long-term Care Management and Research Methods.
- Maggie Calkins, PhD, IDEAS Institute and SAGE (Society for the Advancement of Gerontological Environments). Maggie is a renowned design expert on the long-term care environment and SAGE board member.
- Les Grant, PhD, University of Minnesota. Dr. Grant developed the Culture Change Staging Tool with LaVrene Norton that has been used by the Beverly Corporation and My Innerview. Dr. Grant has conducted research on some of the earliest pioneering homes such as Big Fork Valley.
- Yael Harris, PhD, CMS, OCSQ, Quality Improvement Organization Culture Change Initiative Lead
- Vivian Tellis-Nayak, PhD, My InnerView. Dr. Tellis-Nayak is known for extensive research done on the CMS-672 Resident Census and Conditions collection tool used in each standard survey and is the Vice President of Research at My Innerview.

The invited researchers were selected as commenters for their expertise in applying research methods to culture change practices.

Analysis of both focus facilities’ and researchers’ comments resulted in some items being deleted and others added or reworded. From the suggestion of a researcher, a scoring system was added to the tool. Thus, a baseline for each facility is a score of zero, having none of the artifacts of culture change, and a benchmark becomes the total possible score for a home that has achieved a perfect score, having them all.

Artifact Categories and the HATCh Model

The HATCh - Holistic Approach to Transformational Change – model was successfully used by the QIO Person Centered Care pilot (Quality Partners, 2005) and currently as part of the 8th scope of work with nursing homes in all states. The HATCh model domains were selected to categorize the Artifacts of Culture Change so as to be consistent with a model already endorsed by CMS and familiar to many homes across the country.

The HATCh model uses six domains that lead to personal, organizational, community, and systems changes, all of which are necessary for a transformation from institutional to individual care. The HATCh model is also depicted as a diagram to show the interrelatedness of the domains. The center domains are the overlapping areas of Workplace
Practice, Care Practice, and Environment. Leadership surrounds them. Each nursing home is encircled by Family and Community, and lastly by the domain of Regulations and Government. The QIO pilot hypothesized that specific changes within these domains could affect the movement from institutional to individualized care:

"Transformational change requires first a change in the Domain of Workplace Practice. We based our curriculum in this domain on the research of the late Susan Eaton, who identified five key management practices that made the difference between high and low turnover for nursing homes in the same labor market. In the Domain of Care Practice, we drew on the work of Joanne Rader who has transformed practice in our field, first with her work on individualized dementia care, then in rethinking the use of restraints, and most recently in the area of bathing practices…. Judith Carboni’s 1987 work on home and homelessness among nursing home residents provided the framework for the Domain of the Environment…. Her finding that home is where a 'fluid, intimate, dynamic relationship exists between person and place' provided nursing homes a yardstick for their efforts in this domain. These domains all operate within the Domain of Leadership. In addition to Eaton, we relied on the work of Kouzes and Posner and Jim Collins. Their field guides to leadership facilitated our transfer of knowledge into practice…. A dynamic shift in relationships with family members, close friends, community organizations and volunteers is captured in the Domain of Family and Community. Lori Todd and her staff from Loomis House, and Carolyn Blanks from the Massachusetts Extended Care Federation provided powerful examples to support efforts in this domain. The Domain of Regulation and Government grounds HATCh in the requirements of OBRA’87, that each facility ‘must provide care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. (Quality Partners, 2005).

The HATCh Domain of Care Practice explores ways to restore to elders as much control, choice, and normalcy as possible. The Domain of Environment seeks to create a meaningful relationship between the person and her/his living environment. The Domain of Family and Community seeks to embrace and draw family members into a shared partnership of supporting and caring for the resident. Domain of Workplace Practice entails management practices that affect a culture of retention. The Domain of Leadership recognizes it takes the willingness to change policies, systems and practices and the Domain of Regulation/Government includes the regulatory piece and connection.

Because the Artifacts of Culture Change tool represents concrete changes, the tool’s leadership section is small since much of leadership is intrinsic and hard to capture as concrete items, and the HATCh Domain of Regulation is not applicable for this tool, since it deals with outcomes in terms of survey results, rather than concrete changes homes have made.
ARTIFACTS OF CULTURE CHANGE CATEGORIES AND ITEMS

Care Practice Artifacts

Dining has traditionally been one of the most institutional practices of nursing home life and work - telling people when and what they will eat. And it is the one event that happens the most every day. Offering more common dining practices such as restaurant, family and buffet styles and opening up dining times has had many positive outcomes such as weight gain, savings in unwasted food, and increased resident choice as experienced by Providence Mt. St. Vincent (Ronch and Weiner, 2003) and Crestview (Rantz and Flesner, 2004). Many homes have also transitioned to having the kitchen open and/or pantries and snack bars where food is available 24 hours a day, often pointing out we all have “refrigerator rights” at home. Another source documents that as residents are able to eat food they desire, weight loss declines (Rantz and Flesner, 2004). Additionally, homes have realized the value of baking in resident living areas. Aromas increase appetite, and residents eat better, as already experienced by the Green Houses (The Green House Project DVD, 2005).

One intervention that is becoming popular in culture changing homes is aromatherapy, which is being used as either decorative felt pads attached to clothing or in small diffusers, when a whole room affect is desired. An example of the use of specific aromatherapy formulas occurred in 2001, when Patricia Bishop, a nurse at the Mattie C. Hall Nursing Home in Aiken, SC contracted with an aromatherapist to develop a set of oils for appetite stimulation and relief from sun-downing, among other issues. The home conducted a small study using the oils and had excellent results. From October, 2001 to September 2002, in this 44 resident home, the rate of residents losing 3 or more pounds per month dropped from 10 to 2 and the rate of residents using psychotropic medications dropped from 9 to 2. From September 2003 to March 2006 Mattie C. Hall reports zero residents with weight loss and zero with psychotropic drugs. “One resident diagnosed with dementia, constantly yelled out without apparent reason. This resident’s behavior was unresponsive to several psychotropic medications. …. The staff applied two drops of [a selected blend of oils] on a towel and draped the towel over her shoulders like a shawl. The resident sniffed, sniffed again, and then sniffed deeply. She smiled, stopped yelling and sat down in a rocking chair where she slept for approximately thirty minutes. This home won South Carolina’s Best Practice Award in 2003 for their aromatherapy program. Two university-based research studies are currently in process at East Carolina University and Texas State University, regarding this particular set of aromatherapy blends, which are now in use in over 300 homes, nationwide and 6 in Great Britain. One home, the Lutheran Home in Frankenmuth, MI reports success using an appetite stimulating oil blend: “All 10 of our weight loss residents have either gained or maintained their weights. One resident was found to be more alert and is now conversing with others. She gained 7.3 pounds in just 8 weeks!” (Farnell, 2006)

More and more homes are also recognizing the value of massage and offering it to residents. It has been found that hand massage and gentle touch reduce anxiety (Buschmann, 1999) and agitation (Snyder, 1995).
The prevalence of animals in nursing homes is growing. As documented by the Eden Alternative, among many other benefits, animals help eliminate loneliness, depression, and medical ailments, increase socialization and motivate residents to become more active (Haleigh’s Almanac, 2002). In the Quality of Life study, of the 1,988 residents in 40 homes, only 2% had a dog, cat or other pet (Cutler et al, 2006).

Just as people did prior to living in a nursing home, they should have the opportunity to follow their personal routine. The QIO 2004-2005 culture change pilot report summarized this as follows, “People now wake up, spend their days, and go to bed according to their own routines, and as they are restored to their own rhythms, they are thriving. So are those who care for them. As work is reorganized to follow the pace of each resident, instead of a rigid institutional routine, workers are able to fulfill their intrinsic motivation to care for others, and to experience respect and care from their organizations” (Quality Partners of Rhode Island, 2005).

Bathing without a Battle concepts comprise another avenue to honor each person, and there is much documented evidence, including video scenarios, of the value of individualized techniques. It no longer is acceptable to force people to bathe if it indeed causes them stress or “a battle.” Evidence also shows that such “battles” are not only distressing for residents but for staff as well and lead to burn out (Rader et al, 2002).

A common care practice change that culture changing homes are beginning to make is a move from the medical model care plan to care plans in the voice of the resident. Homes that utilize this new “I” format care planning, write about the resident’s issues, problems, desires, and goals as if the resident is directly reporting what they need and want. Thus, the medical model “problem” statement that the resident “wanders, is transformed into “I like to walk.” Users of this new “I” format report it is a “powerful” tool for assisting staff in better knowing and understanding residents (Tschop, 2003). And it is a method that puts the resident’s wishes, rather than staff’s decisions, into the driver’s seat.

Environment Artifacts

The most dramatic change in environment being made by culture change innovators is the physical renovation from staff-centered, long, impersonal and noisy hallways to small, intimate, resident-centered households and the use of household designs in new construction. The physical design of a household is a small home setting with a full kitchen, dining room, living room and work area for a small number of residents and their dedicated staff, with the institutional nurses’ station eliminated (Calkins, 2002).

A household model naturally creates a “family life” where staff can support resident choices and decisions about their daily life such as meals and activities. For staff, tools and supplies are decentralized helping them to give more efficient care. Typical of household models, staff are cross-trained, roles are blended and staff consistently work with the same residents. “Residents are walking more and they can sleep in if they want to. We also enjoy group planning of special events and home cooking and snacks” as explained by a certified household resident assistant of Fairport Baptist Home. “Perhaps
the most dramatic news has been residents’ discovery that they have a voice. This has always been true – but in a household of no more than 12 residents, it is much easier for one’s voice to be heard!” (Fairport Homes News, 2002.) Because the household design and model affects life and work globally as an advanced stage of culture change, it is given an advanced level of points in this tool.

The neighborhood model to some, and according to the Stages Tool, reflects a step along the way of moving into a household model. Features of this model include dining on the neighborhood, consistent staff, and practices such as Community meetings without structural changes. Neighborhoods are also referred to in the culture change movement as clusters of households and include common community areas reflective of a neighborhood in the community at large such as libraries, beauty/barber shops, community rooms, courtyards, cafes and snack bars, and shared staff spaces (Calkins, 2003). Neighborhoods are not used in the Artifacts tool so as to not cause confusion and because they include no structure change. The other aspects of the neighborhood such as consistent staff assignment and dining in the neighborhood are covered in other sections of the Artifacts tool. The physical design aspects of the household model are included in the Environment section and given a significant number of points due to the significant commitment of resources that it takes to move from corridors and units to a household design.

One feature of nursing home living people have expressed they do not want is to share a room with a stranger. As such, private rooms were given a higher score in this tool also reflective of the commitment of the home to make structural changes, give up shared rooms for private or the foresight of original construction into private rooms. Some homes dedicated to culture change have eliminated all or the majority of shared rooms for private ones. The Quality of Life study showed that those facilities deemed to have high quality of life had the most private rooms and that residents who were interviewed greatly preferred private rooms to shared rooms. (Kane et al, 2003).

A 2005 study by Calkins & Cassella found moderate to strong evidence supporting the benefits of private rooms in terms of

- clinical factors - especially nosocomial infection rates,
- psychosocial factors - preferences for privacy, better family visiting, especially at end of life, more control over personal territory,
- operational factors - less time spent managing roommate conflict, easier to market and
- building/construction factors - The difference in construction costs between private and traditional shared room can be made up in approximately 14 months if beds are occupied, and in less than 22 months if a bed remains unoccupied because someone refused to live with a stranger (www.IDEASInstitute.org).

Privacy enhanced rooms where residents can access their own space without trespassing through a roommate’s space feel like a private room and result in fewer instances of roommate conflict in the traditional shared bedrooms (www.SAFEFederation.org). Crestview’s experience is that residents preferred the privacy enhanced rooms because
they had privacy and “someone else was there.” They were more requested than private rooms (Haider, 2001). The typical semi-private room only offers a cloth curtain for privacy. Some homes have made a commitment to privacy by designing shared rooms with a wall between the two sides of the room giving residents privacy while sharing a common bathroom and closet area. Of 40 homes in the Quality of Life study, only 2 had privacy enhanced shared rooms (Cutler et al, 2006).

"Often the first thing people see when they visit the traditional medical model nursing home is the nurses' station. It is the control center amid a buzz of activity, and it stands as a physical barrier separating the nursing staff from residents and family members as if to say, 'We (staff) are in charge.' Recreating spaces to be shared by residents reduces the barrier between residents and staff created by the titanic nurses' station. Caregivers are more available to residents and family members. Together they can sit in the comfort of the living room to discuss care plans instead of standing at a large desk in the lobby area. Responses from residents, families, and workers in nursing homes that have made these changes are primarily positive…. Now, with room to converse, play cards, host visitors, and interact with staff, once-listless residents are awakening to the possibilities of friendships and community…. Simply put, 'If it looks like a hospital, we'll feel like a patient. If it looks like a house, we'll feel at home (Norton, 2005).

Removal of traditional nurses’ stations is included as an item with a higher level of points, due to the dedication, physically and monetarily, to removing such barriers to creating a changed community.

The environment in most nursing homes does not support residents autonomy to the fullest extent possible. In many nursing homes, sensory deprivation and lack of control over the environment cause boredom, anxiety, and depression, and may induce learned helplessness because of residents’ perceptions that they have no control over their lives (Langer & Rodin, 1976; Seligman, 1976). In the Quality of Life study, the following lacking items were discovered. Of the 1,988 residents studied in 40 homes, 82% had wheelchair clearance under their sinks, but only 10% had a mirror suited for a wheelchair user, and only 1.5% had a refrigerator in the room. 48% of the of the entry doors had lever-type hardware and sink hardware was “rarely lever style.” Although 65% of the individuals used wheelchairs, only 7% of the closet rods were located 36-48 inches from the floor. 52% of resident rooms had adjustable heat and 46% adjustable air conditioning. Only 23% of the resident rooms provided the opportunity to control the intensity of the light with a dimmer switch and heat lamps were in only 15% of the shower rooms (Cutler et al, 2006). Each of these features is an Environment Artifacts item.

Making computers and the Internet accessible to residents has impacted residents of all cognitive functioning levels. From watching screen savers to researching topics of interest, residents experience increase in communication, socialization, enhanced self-esteem, increase in group activity attendance and self-expression either verbally or using adaptive keyboard and less agitation (Dunning, 2001).
Some homes dedicated to re-creating home have replaced traditional call systems with telephone call systems. Resident calls register directly with the appropriate staff member and staff can communicate directly with each other. Results are reduced overhead paging, improved staff response time to assist residents, and reduced complaints that call bells were not answered in a timely fashion, (Brokaw, 2006).

An environmental feature and practice of transforming homes that is becoming more popular is the elimination of overhead paging. Fairport Baptist Home reports that it improves the working environment, creates a more normal living environment by significantly decreasing white noise throughout the facility and this in turn has decreased resident agitation especially of those dealing with dementia (Brokaw, 2006).

A positive environmental feature to households is installing household washers and dryers for residents’ personal laundry as has been done by Teresian House and Fairport Baptist Home. Each report a decrease in lost clothing and complaints, residents have the opportunity to do their own laundry and/or family members can stay and visit while doing laundry, shrinkage and wrinkling is eliminated and even if clothing is not marked, staff can identify who it belongs to due to the smaller number of residents staff care for on the neighborhood/household (Brecanier, 2005). Useable outdoor areas is another feature of well-being that is lacking in many nursing homes.

As found in the Quality of Life study done for CMS, although 97.5% of the 40 facilities had an outdoor space, in reality only 44.3% of the residents in these homes had access to the space. Of 1068 who were able to complete an interview regarding how often they get outdoors, 32.2% went outdoors less than once a month, 13.4% less than once a week, 16.8% about once a week, 15.8% several times a week and 21.8% everyday. Also discovered was that most often direct access to outdoor spaces was locked and residents were only able to use the space if escorted by staff or family or “on the rare occasion when outdoor activities were scheduled.”

**Family and Community Artifacts**

Items befitting to this category include regularly scheduled intergenerational programming, making space available for community groups, having a private guestroom for resident guest, a café/restaurant/tavern/canteen where anyone can purchase food, a special dining room for resident gatherings and a kitchenette or kitchen area were baking and cooking can take place.

The Eden Alternative teaches that children give residents the opportunity to give care, and help to diminish loneliness and boredom. Participation in activities with small children lowers residents’ agitation levels (Activities, Adaptations and Aging, 1996).

Homes with a café/restaurant/tavern/canteen, give residents the opportunity to dine in a normal community setting out of the traditional dining room and to “give back.” Residents appreciate the opportunity to once again “foot the bill” in a restaurant setting (Brecanier, 2001). Kitchenette and kitchen areas can afford residents the opportunity to
cook and bake for others. Elders experience joy when able to prepare a favorite recipe for friends and once again share meals with families (Bump, 2005).

Homes that have successfully integrated many of these approaches have been named “generative communities,” the first example being the original Eden home in NY, Chase Memorial Home. "More than 200 birds, four cats, two dogs, dozens of plants, a child care centre, a garden, and a visiting school-children's program help create what founder Dr. Bill Thomas and his wife Judy call 'a holistic environment….' One of the principles they enacted is that people need to give care as well as receive care to feel valuable…. Compared to a nearby control facility, the Thomas’s documented statistically significant reductions in mortality and in illness as well as drug use” (Eaton, 2000).

**Leadership Artifacts**

Leadership includes the ability to serve, listen to, and honor all those involved in the organization. A simple way to honor CNAs and involve them more deeply in the provision of care is to include them in care conferences. Facilities where CNAs participate in care planning have lower rates of turnover (Eaton, 2001).

Although not all that common yet, some wise pioneers have included residents and family members in their quality assessment and assurance process stating “that family member or resident cares just as much as you do about your home” (Irtz, 2004).

When Evergreen Retirement Community’ Quality Council was formed in 1990, a resident was included as a full member with the same voting rights as all other members, half of which are direct-care, and the other half leadership, staff. “The participation of a resident has always been regarded as important since residents are the primary beneficiaries of our efforts. The QC was originally responsible for implementing Continuous Quality Improvement as the key element of our management philosophy. We recognized that in order to use households as the basic service delivery unit of long-term skilled nursing care we needed a fundamental change in the management philosophy. We could no longer use the traditional direct/inspect management approach. CQI is based on teamwork where each team member has a unique role, and data is the basis of decision making” (Green, 2006).

In addition, Evergreen has had three residents as full voting members of the Board of Directors since 2000. Prior to that, residents served on the board as representatives of the Resident Council for many years. After a board crisis in 1999 where residents had to be excused for executive sessions, Evergreen decided that there needed to be resident board members as they are stakeholders with the greatest investment in the organization. Recognizing the inherent conflict-of-interest as residents, i.e. a potential self-interest agenda, residents accepted the responsibility to wear the hat of board member keeping “the big picture” in mind (Green, 2006).

Another concept becoming popular is a “buddy” or Guardian Angel program where staff check regularly with residents. This approach has dramatically dropped complaints from
residents and families as it builds relationship and matters of concern get tended to quickly (personal experience of co-author Bowman). Two other forms of servant leadership are the use of Learning Circles and Community Meetings which each serve as a means to get people talking, get people to know each other, build community and solve problems.

The idea of community meetings came about to test a simple hypothesis: “Bring the elders together regularly in a community that promotes meaning and connection and it will change their lives and cause a ripple effect that will impact the culture of the institution.” Residents grew more aware of one another, became more present, more energetic and responsive. Staff noticed residents whom they had previously assumed were not capable of communication, began to interact with them. “This progress challenged their assumptions about what is possible. They began to act differently, responding to the elders in a more individualized way and helping them to make choices. They shared their perceptions with co-workers and family members, many of whom expanded their expectations and changed the way they related to the elders” (Barkan, 2002).

**Workplace Practice Artifacts**

Having consistent staff work with the same residents, self-scheduling, career ladders, on-site child day care, awards, sending non-managerial staff to outside training and cross-training all contribute to improving the work culture for staff. In the Eaton Beyond ‘Unloving Care’ study of high and low quality homes, said one DON at a high quality Quaker facility, "I take care of my staff, and they take care of the patients. If I treat them badly, they will treat the patients badly" (Eaton, 2000).

Overwhelmingly, consistent staff is a hallmark of a changed culture. When the same staff care for the same residents, that is when relationships form, staff get to know residents needs and preferences, and staff pick up on resident changes in condition (CMS satellite broadcast, 2002, Misorski). Consistent staffing correlates to low turnover and nurses prefer it (Eaton, 2001). From the Kane study, those facilities determined to have high quality of life implemented permanent CNA staffing. Similarly, self-scheduling has been found to resolve scheduling issues and results in staff being more responsible to each other and to their residents (Eaton, 2001).

As a means to make it clear to employees that a home is committed to transforming into a culture of person-centered care, some homes are including in their employee performance evaluations competencies that reflect a transformed culture. One such home is Pennybyrn at Mayfield in North Carolina, whose performance evaluation covers the areas of Team Builder, Person Centered Relationships, Initiative, Willingness to Grow, Critical Thinking-to-Action and Judgment.
Outcomes

Naturally occurring, unplanned positive outcomes have been experienced by many homes that have made these concrete changes, top on the list being reduction in turnover.

Turnover in nursing homes is high and has traditionally been high. Industry statistics show turnover to be 100% for CNAs, 66% for RNs/LPNs, 50% for Directors of Nursing and 25% for Administrators (IOM 2001).

Culture changing homes have experienced the opposite. Turnover at Providence Mt. St. Vincent reduced from 50 to 22% from 1992 to 2003. Big Fork Valley, formerly Northern Pines Communities, adjusted turnover rate declined from 52 to 13% with the implementation of communities from 1999 to 2000. The communities celebrated 100% retention of all employees in all positions during the first 6 months of 2000, only three months after transition (Culture Change Now Vol. 1, 2001). Apple Health Care, a small privately owned nursing home chain having implemented culture change practices since 1997, experiences overall staff turnover rates at 30-40% compared to national rates as high as 70% (Ronch and Weiner, 2003). “Substantially reduced staff turnover” was documented in a three year study of two Rochester, NY culture changing homes (Dannefer and Stein, 1999, 2002, reported in CC for LTC, 2003).

In her studies of low and high service quality nursing homes, Susan C. Eaton has documented that for the traditional low-service quality model, aide turnover in usually exceeds the 100% industry annual average and reports that industry informants estimate turnover to cost $4000 per nurse aide (or three months' wages) and has a negative impact on care. "The relationship of turnover to patient care is clear and well documented: higher turnover interrupts continuity of care and is associated with lower patient care outcomes (Harrington 1996 as reported by Eaton, 2000).

Although workforce stabilization was not the objective of Meadowlark's embarking into a culture change journey in 1997, it is one of its significant - and early – outcomes with staff turnover plummeting from 80 percent to 30 percent in the first year and holding that range ever since (Wagner, 2005).

Retention translates into increased efficiency. Retention leads to better quality outcomes. Better quality outcomes lead to lower costs on average $13.50 less PPD and an annual savings (90 residents/day) of $440,000 (Rantz, 2003).

Homes committed to changing their culture also seem to be keeping their staff. Currently the literature reveals little information on longevity. Providers report that longevity increases in pioneering homes. However, there are no large scale longevity figures that have been collected to date. Individual Pioneering homes have reported their home’s data but there are no accumulated scores. Thus, the four focus facilities included in this project were used to create a starter average score. From these four homes, longevity averages were:
Since turnover is usually highest in the categories of nursing and the administrator, these are the categories we also used for longevity, namely CNAs, LPNs, RNs, DON and NHA. For the purposes of this tool, our definition of longevity includes all years worked at the facility, not only the years in their current positions. This idea came from pioneer Sister Pauline Brecanier, NHA of Teresian House in Albany, NY who kept bringing to our attention the dramatic length of staff longevity when staff years in any position are considered. For instance, although her DON has held that position for 6 years, in total she has worked at Teresian House for 26. CNA longevity was the only item of these five, for which we did not include all years in any position since the CNA position is typically a first step position to any career ladder in nursing, and they typically do not serve in any other position before becoming a CNA. In addition, we believed it would be overly burdensome to have a home calculate the total length of service years in any position for CNAs, since they are usually such a large group of staff members.

A recent 2006 study, The Use of Contract Licensed Nursing Staff in U.S. Nursing Homes, found that use of contract nursing staff is relatively rare averaging around 5%. The study did not include CNAs. One recent study reports that one solution homes are using for the staffing shortage is the use of contract nursing staff. “This type of staffing is costly, disrupts continuity of care (Guillard 2000), and may also contribute to poor patient care” (Bourbonniere, 2006). The researchers found that homes employing a higher than 5% proportion of contract nurses, “fell disproportionately into the top quartile ranks of health deficiency citations.” For purposes of this report, because this was the only research based figure found, we used it in the point schematic for the item of agency use; higher than 5% getting 0 points, 1-5% 3 points and 0% 5 points. Because no information was found in the literature review, the same figure was used for CNA agency use.

Many culture changing homes deliberately try to reduce and eliminate the use of agency staff knowing that care is impacted by staff who are strangers to residents versus consistent facility staff who know the residents. We conferred with the homes in our focus group and other culture change leaders about the best way to calculate a number for the use of agency staff. It was pointed out by Anna Ortigara that agencies typically bill the nursing home monthly for the number of staff shifts that were covered by an agency staff member, with separate totals for CNAs and nurses. A staff shift is defined as one person serving on one shift on one day no matter the length of the shift.
We have adopted this method of calculation in the hope that it will prove to be the least burdensome way of a home answering the question. If the home has, for example, 10 CNAs for day, 7 for evening, and 5 for night shifts per day, then they have a total of 22 CNA shifts for the day. Since weekdays and weekends may typically have a different number of CNAs scheduled, we are asking the home to figure, for the previous month, how many total CNA shifts they had scheduled. Then the next step is determining how many of those shifts were covered last month by agency CNAs, and finally dividing agency shifts by total shifts to result in a percent. The same process is done for nurse shifts, which includes LPNs and RNs grouped together, excluding the DON.

Increase in census is another positive outcome experienced by culture changing homes. According to the most recent data, from the CMS Nursing Home Data Compendium 2005, the average occupancy rate in 2004 was 84.2%. A two year study of Eden homes showed an 11% increase in census (Ransom, 1999). An increase in private pay census has been experienced by pioneering homes as reported by the Pioneer Network (Culture Change in LTC, 2003, pg. 136). An Artifacts item of occupancy rate is included as an Outcome.

**Future of the Artifacts of Culture Change Tool**

Both the domains and the line items that the authors have selected are not intended to be comprehensive of all the possible changes a home might make on the culture change journey. We have selected the tool’s items based on our findings both from research and from provider communications that these items represented significant concrete changes that many homes have made. In addition we are aware that a bright future lies open for homes to create entirely new innovations as yet not thought of in long term care. We congratulate the many homes that have embarked on the culture change journey. They have stepped out of the box of the institution and are moving toward creating a real home for residents as well as a place where staff and families like to be.

CMS is making this tool available for public use. Although it is to be given away freely, as a CMS developed tool it is to remain in its final form. Changes to the tool should not be made without permission of CMS and Edu-Catering.

This tool has been developed through review of current research and provider literature, as well as personal discussions with several culture change leaders, our focus group of homes and the researchers who commented on both content and structure of the tool. Currently the tool only exists “on paper” as a questionnaire that a home or a chain or group of homes can fill out and score, in order to compare their scores in particular items to what a perfect score would be. We are hopeful that homes on the culture change journey may find items that they have not considered changing and now would like to consider, or perhaps items that they have had in place for a long time, even before they ever heard of culture change. Homes that have started significant changes 10 or 15 years ago may find it useful to complete the tool in retrospect, comparing how they would have completed it before they started to their scores at present, in order to see how much they have changed in these concrete artifacts of culture change. Saying you’re a culture
changing home doesn’t say how much you’ve changed. Taking and scoring this tool and its sub-domains may reveal how close to a perfect score a home may be in some domains while being farther away in others. And for researchers who would desire to compare culture change homes to other homes in terms of other variables such as quality measures/indicators or survey process results, it might benefit them from using this tool, among others, to determine which homes belong in a culture change group, based on them passing a threshold they would set for the purpose of their studies.

It would add value to the tool if it is computerized and made available on a website for any facility to complete easily with programmed computations. It is also recommended that a data base be built on a website so a home can compare itself to a normative group of peers who have completed the tool. It would assist researchers, providers and CMS to be able to compare facilities on the same items, features, artifacts, evidences of culture change. And with a data base, it could be seen which homes are scoring above their peers. This tool has been designed to be used only as a data collection tool for purposes of capturing where a facility is and has been in regards to changing its culture and improving quality of life for both residents and staff. The point assignment to each item is intended to capture whether a facility has a certain thing, is making progress toward it or does not have it at all. Points reflect total change, partial change or no change to individual items. The tool has potential for further work such as assigning weighted points to the prevalence and importance of individual items

Two homes completing the tool may have the same overall score but have two very different focuses. The relevance of the sectional scores then becomes indicating to the facility where they stand with possible changes reflected in that domain or category. It would be good at a future date to have a large group of providers give input as to the importance of items, but that effort is not part of the scope of this contract. For items that have no established prevalence through research, such as such as longevity, it would beneficial to re-set them in the future, after a large pool of homes has filled out this tool on a website from which a pool of data is generated. We are hopeful that interested providers or stakeholder organizations will wish to take on these efforts.

Innovative providers who have heard of the tool have been asking when they can use it stating they are “hungry” for tools to capture culture change features in their homes. Assisted living providers have also expressed interest in the tool and the idea of possibly working with the authors to modify it to capture items unique to assisted living.

Ohio Quality Improvement Project Leader Jennifer Brezinski, ADN, RNC, CLNC quoted in the Quality Partners of Rhode Island

"I loved sharing the HOPE that we are in a position to make life in a nursing home a wonderful experience… I learned that I can make an impact… I also learned a humble experience - as much as I had always prided myself on being an accomplished nurse and DON, I had not fully let go of the institutional style of
managing resident care… But after learning so much from collaborative work and Pioneer conferences, I realized how very much more there is to do…. One of the things that I felt was a very proud moment was when I entered one of the homes that had been in the RCC [Resident Centered Care] collaborative. The change in the atmosphere was so tangible and so different from when I had first been there almost two years before. A resident met me at the door and asked me if I wanted to buy any crafts. Her 'street' was going to have a cookout for their 'care assistants' and she and her 'neighbors' were helping to raise money for the food by selling crafts. At the same time, I heard laughing off in the distance; I noticed one of the residents delivering newspapers - knocking at each doorway and waiting to be given permission to enter. I saw a group of three of four residents conversing in the lounge area; and every resident and staff member that I saw was smiling. Overhead paging had vanished. It was a quiet, calm, but very warm feeling that took hold. I found myself smiling and I could not believe this was the same place that I had first seen. What a long way they came without one structural change! It was all the mindset of the staff and the residents that made the difference (QIO, p. 190).

These honest thoughts from a seasoned long term care professional who admitted to “institutional” thinking, beautifully express that a change in mindset can result in tangible changes that truly improve the lives of those who both live and work in institutional nursing homes.

**Main Points regarding the Artifacts of Culture Change Tool**

1. The tool is not connected to enforcement, is not punitive, and no surveyors will be collecting data using this tool.
2. This is a government product that homes and provider organizations can freely use to showcase positive changes they are making.
3. The tool is a concrete set of changes homes make to practice and policies in the process of transforming an institutional culture into one that resembles home and that takes seriously the residents’ direction of their own lives.
4. The tool affords the opportunity for an individual home to gauge its progress and do its own benchmarking of where they are on a culture change journey.
5. The tool is a data collection instrument meant to reflect progress by a simple points structure of total change, partial change or no change to specific items.
6. The tool may change in the future if a sufficient number of homes complete it and the information from each home is captured in an online data base that could generate more information about averages and prevalence.
7. This tool is a CMS developed product. As such it is to remain in its final form but to be given away freely.
APPENDIX A

ARTIFACTS OF CULTURE CHANGE TOOL
### Artifacts of Culture Change

**Home Name** ________________________________  Date ________________

City __________________ State _______  Current number of residents ________

Ownership: _____ For Profit  _____ Non-Profit  _____ Government

<table>
<thead>
<tr>
<th>Care Practice Artifacts</th>
<th>Score</th>
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<tbody>
<tr>
<td><strong>1. Percentage of residents who are offered any of the following styles of dining:</strong></td>
<td></td>
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<tr>
<td>- restaurant style where staff take resident orders;</td>
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<td>- buffet style where residents help themselves or tell staff what they want;</td>
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<td>- family style where food is served in bowls on dining tables where residents help</td>
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<td>themselves or staff assist them;</td>
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<td>- open dining where meal is available for at least 2 hour time period and residents</td>
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<td>can come when they choose; and</td>
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<td>- 24 hour dining where residents can order food from the kitchen 24 hours a day.</td>
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<td>_____ 100 – 81 % (5 points)</td>
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<td>_____ 80 – 61% (4 points)</td>
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<td>_____ 60 – 41% (3 points)</td>
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<td>_____ 40 – 21% (2 points)</td>
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<td>_____ 20 – 1% (1 point)</td>
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<td>_____ 0 (0 points)</td>
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<td>**2. Snacks/drinks available at all times to all residents at no additional cost, i.e.,</td>
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<td>in a stocked pantry, refrigerator or snack bar.</td>
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<tr>
<td>_____ All residents (5 points)</td>
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<td>_____ Some (3 points)</td>
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<td>_____ None (0 points)</td>
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<td><strong>3. Baked goods are baked on resident living areas.</strong></td>
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<td>_____ All days of the week (5 points)</td>
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<td>_____ 2-5 days/week (3 points)</td>
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<td>_____ &lt; 2 days/week (0 points)</td>
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<td>**4. Home celebrates residents’ individual birthdays rather than, or in addition to,</td>
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<td>celebrating resident birthdays in a group each month.</td>
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<td>_____ Yes (5 points)</td>
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<td>_____ No (0 points)</td>
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<td><strong>5. Home offers aromatherapy to residents by staff or volunteers.</strong></td>
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<td>_____ Yes (5 points)</td>
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<td>_____ No (0 points)</td>
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<tr>
<td><strong>6. Home offers massage to residents by staff or volunteers.</strong></td>
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<tr>
<td>_____ Yes (5 points)</td>
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<td>_____ No (0 points)</td>
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</tbody>
</table>
### 7. Home has dog(s) and/or cat(s).

- At least one dog or one cat lives on premises (5 points)
- The only animals in the building are when staff bring them during work hours (3 points)
- The only animals in the building are those brought in for special activities or by families (1 point)
- None (0 points)

### 8. Home permits residents to bring own dog and/or cat to live with them in the home.

- Yes (5 points)
- No (0 points)

### 9. Waking times/bedtimes chosen by residents.

- All residents (5 points)
- Some (3 points)
- None (0 points)

### 10. *Bathing without a Battle* techniques are used with residents.

- All (5 points)
- Some (3 points)
- None (0 points)

### 11. Residents can get a bath/shower as often as they would like.

- Yes (5 points)
- No (0 points)

### 12. Home arranges for someone to be with a dying resident at all times (unless they prefer to be alone) - family, friends, volunteers or staff.

- Yes (5 points)
- No (0 points)

### 13. Memorials/rememberances are held for individual residents upon death.

- Yes (5 points)
- No (0 points)

### 14. “I” format care plans, in the voice of the resident and in the first person, are used.

- All care plans (5 points)
- Some (3 points)
- None (0 points)

**Care Practice Artifacts Subtotal:** Out of a total 70 points, you scored __________.

### Environment Artifacts

<table>
<thead>
<tr>
<th>15. Percent of residents who live in households that are self-contained with full kitchen, living room and dining room.</th>
<th>100 – 81%</th>
<th>80 – 61%</th>
<th>60 – 41%</th>
<th>40 – 21%</th>
<th>20 – 1%</th>
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<tr>
<td></td>
<td>(100 points)</td>
<td>(80 points)</td>
<td>(60 points)</td>
<td>(40 points)</td>
<td>(20 points)</td>
<td>(0 points)</td>
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<td>16. Percent of residents in private rooms.</td>
<td>100 – 81% (50 points)</td>
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<td></td>
<td>80 – 61% (40 points)</td>
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<td>60 – 41% (30 points)</td>
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<td>40 – 21% (20 points)</td>
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<td>20 – 1% (10 points)</td>
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<td>0 (0 points)</td>
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<td>17. Percent of residents in privacy enhanced shared rooms where residents can access their own space without trespassing through the other resident’s space. This does not include the traditional privacy curtain.</td>
<td>100 – 81% (25 points)</td>
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<td></td>
<td>80 – 61% (20 points)</td>
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<td></td>
<td>60 – 41% (15 points)</td>
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<td>40 – 21% (10 points)</td>
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<td>20 – 1% (5 points)</td>
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<td>0 (0 points)</td>
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<td>18. No traditional nurses’ stations or traditional nurses’ stations have been removed.</td>
<td>No traditional nurses stations (25 points)</td>
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<td></td>
<td>Some traditional nurses’ stations have been removed (15 points)</td>
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<td></td>
<td>Traditional nurses’ stations remain in place (0 points)</td>
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<td>19. Percent of residents who have a direct window view not past another resident’s bed.</td>
<td>100 – 51% (5 points)</td>
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<td></td>
<td>50 – 0% (0 points)</td>
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<td>20. Resident bathroom mirrors are wheelchair accessible and/or adjustable in order to be visible to a seated or standing resident.</td>
<td>All resident bathroom mirrors (5 points)</td>
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<td></td>
<td>Some (3 points)</td>
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<td>None (0 points)</td>
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<td>21. Sinks in resident bathrooms are wheelchair accessible with clearance below sink for wheelchair.</td>
<td>All resident bathroom sinks (5 points)</td>
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<td></td>
<td>Some (3 points)</td>
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<td>None (0 points)</td>
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<td>22. Sinks used by residents have adaptive/easy-to-use lever or paddle handles.</td>
<td>All sinks (5 points)</td>
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<td></td>
<td>Some (3 points)</td>
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<td>None (0 points)</td>
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<td>23. Adaptive handles, enhanced for easy use, for doors used by residents (rooms, bathrooms and public areas).</td>
<td>All resident-used doors (5 points)</td>
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<td>None (0 points)</td>
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<td>24. Closets have moveable rods that can be set to different heights.</td>
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<tr>
<td>25. Home has no rule prohibiting, and residents are welcome, to decorate their rooms any way they wish including using nails, tape, screws, etc.</td>
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<td>26. Home makes available extra lighting source in resident room if requested by resident such as floor lamps, reading lamps.</td>
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<td>27. Heat/air conditioning controls can be adjusted in resident rooms.</td>
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<td>28. Home provides or invites residents to have their own refrigerators.</td>
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<td>29. Chairs and sofas in public areas have seat heights that vary to comfortably accommodate people of different heights.</td>
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<td>30. Gliders which lock into place when person rises are available inside the home and/or outside.</td>
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<td>31. Home has store/gift shop/cart available where residents and visitors can purchase gifts, toiletries, snacks, etc.</td>
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<td>32. Residents have regular access to computer/Internet and adaptations are available for independent computer use such as large keyboard or touch screen.</td>
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<tr>
<td>33. Workout room available to residents.</td>
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<td>34. Bathing rooms have functional and properly installed heat lamps, radiant heat panels or equivalent.</td>
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<td>35. Home warms towels for resident bathing.</td>
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</tbody>
</table>
36. **Protected outdoor garden/patio accessible for independent use by residents.** Residents can go in and out independently, including those who use wheelchairs, e.g. residents do not need assistance from staff to open doors or overcome obstacles in traveling to patio.  

<table>
<thead>
<tr>
<th></th>
<th>Yes (5 points)</th>
<th>No (0 points)</th>
</tr>
</thead>
</table>

37. **Home has outdoor, raised gardens available for resident use.**  

<table>
<thead>
<tr>
<th></th>
<th>Yes (5 points)</th>
<th>No (0 points)</th>
</tr>
</thead>
</table>

38. **Home has an outdoor walking/wheeling path which is not a city sidewalk or path.**  

<table>
<thead>
<tr>
<th></th>
<th>Yes (5 points)</th>
<th>No (0 points)</th>
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</thead>
</table>

39. **Pager/radio/telephone call system is used where resident calls register on staff’s pagers/radios/telephones and staff can use it to communicate with fellow staff.**  

<table>
<thead>
<tr>
<th></th>
<th>Yes (5 points)</th>
<th>No (0 points)</th>
</tr>
</thead>
</table>

40. **Overhead paging system has been turned off or is only used in case of emergency.**  

<table>
<thead>
<tr>
<th></th>
<th>Yes (5 points)</th>
<th>No (0 points)</th>
</tr>
</thead>
</table>

41. **Personal clothing is laundered on resident household/neighborhood/unit instead of in a general all-home laundry, and residents/families have access to washer and dryer for own use.**  

<table>
<thead>
<tr>
<th></th>
<th>Available to all residents (5 points)</th>
<th>Some (3 points)</th>
<th>None (0 points)</th>
</tr>
</thead>
</table>

**Environment Artifacts:** Out of a total 320 points, you scored ___________.

**Family and Community Artifacts**

<table>
<thead>
<tr>
<th></th>
<th>Yes (5 points)</th>
<th>No (0 points)</th>
</tr>
</thead>
</table>

42. **Regularly scheduled intergenerational program in which children customarily interact with residents at least once a week.**  

43. **Home makes space available for community groups to meet in home with residents welcome to attend.**  

44. **Private guestroom available for visitors at no, or minimal, cost for overnight stays.**  

45. **Home has café/restaurant/tavern/canteen available to residents, families, and visitors at which residents and family can purchase food and drinks daily.**  

46. **Home has special dining room available for family use/gatherings which excludes regular dining areas.**  

47. **Kitchenette or kitchen area with at least a refrigerator and stove is available to families, residents, and staff where cooking and baking are welcomed.**  

<table>
<thead>
<tr>
<th></th>
<th>Yes (5 points)</th>
<th>No (0 points)</th>
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</thead>
</table>
**Family and Community Artifacts Subtotal:**
Out of a 30 possible points, you scored __________ points.

<table>
<thead>
<tr>
<th>Leadership Artifacts</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>48. CNAs attend resident care conferences.</strong></td>
<td></td>
</tr>
<tr>
<td>[ ] All care conferences (5 points)</td>
<td></td>
</tr>
<tr>
<td>[ ] Some (3 points)</td>
<td></td>
</tr>
<tr>
<td>[ ] None (0 points)</td>
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</tr>
<tr>
<td><strong>49. Residents or family members serve on home quality assessment and assurance (QAA) (QI, CQI, QA) committee.</strong></td>
<td></td>
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<tr>
<td>[ ] Yes (5 points)</td>
<td></td>
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<tr>
<td>[ ] No (0 points)</td>
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<tr>
<td><strong>50. Residents have an assigned staff member who serves as a “buddy,” case coordinator, Guardian Angel, etc. to check with the resident regularly and follow up on any concerns. This is in addition to any assigned social service staff.</strong></td>
<td></td>
</tr>
<tr>
<td>[ ] All new residents (5 points)</td>
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<tr>
<td>[ ] Some (3 points)</td>
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</tr>
<tr>
<td>[ ] None (0 points)</td>
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</tr>
<tr>
<td><strong>51. Learning Circles or equivalent are used regularly in staff and resident meetings in order to give each person the opportunity to share their opinion/ideas.</strong></td>
<td></td>
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<tr>
<td>[ ] Yes (5 points)</td>
<td></td>
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<tr>
<td>[ ] No (0 points)</td>
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<tr>
<td><strong>52. Community Meetings are held on a regular basis bringing staff, residents and families together as a community.</strong></td>
<td></td>
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<tr>
<td>[ ] Yes (5 points)</td>
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<tr>
<td>[ ] No (0 points)</td>
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</tbody>
</table>

**Leadership Artifacts Subtotal:** Out of a total 25 points, you scored __________.

<table>
<thead>
<tr>
<th>Workplace Practice Artifacts</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>53. RNs consistently work with the residents of the same neighborhood/household/unit (with no rotation).</strong></td>
<td></td>
</tr>
<tr>
<td>[ ] All RNs (5 points)</td>
<td></td>
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<tr>
<td>[ ] Some (3 points)</td>
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<tr>
<td>[ ] None = 0 points.</td>
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<tr>
<td><strong>54. LPNs consistently work with the residents of the same neighborhood/household/unit (with no rotation).</strong></td>
<td></td>
</tr>
<tr>
<td>[ ] All LPNs (5 points)</td>
<td></td>
</tr>
<tr>
<td>[ ] Some (3 points)</td>
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<tr>
<td>[ ] None (0 points)</td>
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</tr>
<tr>
<td><strong>55. CNAs consistently work with the residents of the same neighborhood/household/unit (with no rotation).</strong></td>
<td></td>
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<tr>
<td>[ ] All CNAs (5 points)</td>
<td></td>
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<tr>
<td>[ ] Some (3 points)</td>
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<tr>
<td>[ ] None (0 points)</td>
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<tr>
<td><strong>56. Self-scheduling of work shifts.</strong> CNAs develop their own schedule and fill in for absent CNAs. CNAs independently handle the task of scheduling, trading shifts/days, and covering for each other instead of a staffing coordinator.**</td>
<td></td>
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<tr>
<td>[ ] All CNAs (5 points)</td>
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<td>[ ] Some (3 points)</td>
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<td>[ ] None (0 points)</td>
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<td></td>
<td><strong>57. Home pays expenses for non-managerial staff to attend outside conferences/workshops, e.g. CNAs, direct care nurses.</strong> Check yes if at least one non-managerial staff member attended an outside conference/workshop paid by home in past year.</td>
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<td></td>
<td>_____ Yes (5 points)</td>
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<td>_____ No (0 points)</td>
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<thead>
<tr>
<th></th>
<th><strong>58. Staff is not required to uniforms or “scrubs.”</strong></th>
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<td>_____ Yes (5 points)</td>
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<td>_____ No (0 points)</td>
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<tr>
<th></th>
<th><strong>59. Percent of other staff cross-trained and certified as CNAs in addition to CNAs in the nursing department.</strong></th>
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<td></td>
<td>_____ 100 – 81% (5 points)</td>
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<td></td>
<td>_____ 80 – 61% (4 points)</td>
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<td>_____ 60 – 41% (3 points)</td>
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<td>_____ 40 – 21% (2 points)</td>
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<td>_____ 20 – 1% (1 point)</td>
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<td>_____ 0 (0 points)</td>
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<tr>
<th></th>
<th><strong>60. Activities, informal or formal, are led by staff in other departments such as nursing, housekeeping or any departments.</strong></th>
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<tbody>
<tr>
<td></td>
<td>_____ Yes (5 points)</td>
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<td>_____ No (0 points)</td>
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<tr>
<th></th>
<th><strong>61. Awards given to staff to recognize commitment to person-directed care, e.g. Culture Change award, Champion of Change award.</strong> This does not include Employee of the Month.</th>
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<tr>
<td></td>
<td>_____ Yes (5 points)</td>
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<td>_____ No (0 points)</td>
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<tr>
<th></th>
<th><strong>62. Career ladder positions for CNAs, e.g. CNA II, CNA III, team leader, etc.</strong> There is a career ladder for CNAs to hold a position higher than base level.</th>
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<td></td>
<td>_____ Yes (5 points)</td>
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<td>_____ No (0 points)</td>
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<tr>
<th></th>
<th><strong>63. Job development program, e.g. CNA to LPN to RN to NP.</strong></th>
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<td>_____ Yes (5 points)</td>
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<td>_____ No (0 points)</td>
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<th><strong>64. Day care onsite available to staff.</strong></th>
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<td>_____ Yes (5 points)</td>
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<td>_____ No (0 points)</td>
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<tr>
<th></th>
<th><strong>65. Home has on staff a paid volunteer coordinator in addition to activity director.</strong></th>
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<td>_____ Full time (30 hours/week or more) (5 points)</td>
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<td>_____ Part time (15-30 hours/week) (3 points)</td>
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<td></td>
<td>_____ No paid volunteer coordinator (0 points)</td>
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<tr>
<th></th>
<th><strong>66. Employee evaluations include observable measures of employee support of individual resident choices, control and preferred routines in all aspects of daily living.</strong></th>
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<tbody>
<tr>
<td></td>
<td>_____ All employee evaluations (5 points)</td>
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<td></td>
<td>_____ Some (3 points)</td>
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<td></td>
<td>_____ None (0 points)</td>
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**Workplace Practice Artifacts Subtotal:** Out of a total 70 points, you scored ________.
### Outcomes

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</table>
| **67. Average longevity of CNAs.**  
Add length of employment in years of permanent CNAs and divide by number of staff. | _____Your home figure  
Above 5 years (5 points)  
3-5 years (3 points)  
Below 3 years (0 points) |   |
| **68. Average longevity of LPNs (in any position).**  
Add length of employment in years of permanent staff LPNs and divide by number of staff. | _____Your home figure  
Above 5 years (5 points)  
3-5 years (3 points)  
Below 3 years (0 points) |   |
| **69. Average longevity of RN/GNs (in any position).**  
Add length of employment in years of all permanent RNs/GNs and divide by number of staff. | _____Your home figure  
Above 5 years (5 points)  
3-5 years (3 points)  
Below average (0 points) |   |
| **70. Longevity of the Director of Nursing (in any position).** | _____ Longevity as DON  
_____ Longevity at home  
Above 5 years (5 points)  
3-5 years (3 points)  
Below average (0 points) |   |
| **71. Longevity of the Administrator (in any position).** | _____ Longevity as NHA  
_____ Longevity at home  
Above 5 years (5 points)  
3-5 years (3 points)  
Below average (0 points) |   |
| **72. Turnover rate for CNAs.**  
Number of CNAs who left, voluntary or involuntary, in previous 12 months divided by number of total CNAs employed = turnover rate  
Your home’s figure |   |  
0 percent (5 points)  
20-39 % (4 points)  
40-59 % (3 points)  
60-79 % (2 points)  
80-99 % (1 point)  
100% and above (0 points) |
| **73. Turnover rate for LPNs.**  
Number of LPNs who left, voluntary or involuntary, in previous 12 months divided by number of total LPNs employed = turnover rate  
Your home’s figure |   |  
0 – 12 % (5 points)  
13-25 % (4 points)  
26-38 % (3 points)  
39-51 % (2 points)  
52-65 % (1 point)  
66 % and above (0 points) |
<table>
<thead>
<tr>
<th>Question</th>
<th>Formula/Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>74. Turnover rate for RNs.</td>
<td>Number of RNs who left, voluntary or involuntary, in previous 12 months divided by number of total RNs employed = turnover rate</td>
<td>Your home’s figure ______________</td>
</tr>
<tr>
<td>75. Turnover rate for DONs.</td>
<td>_____ Number of DONs in the last 12 months</td>
<td>1 (5 points) 2 (3 points) 3 (0 points)</td>
</tr>
<tr>
<td>76. Turnover rate for Administrators.</td>
<td>_____ Number of NHAs in the last 12 months</td>
<td>1 (5 points) 2 (3 points) 3 (0 points)</td>
</tr>
<tr>
<td>77. Percent of CNA shifts covered by agency staff over the last month.</td>
<td>Total number of CNA shifts in a 24 hour period (all shifts no regardless of hours in a shift) ________ Multiplied by number of days in last the last full month ________ Of this number, number of shifts covered by an agency CNA ________ ________ Your percentage (agency shifts/total number X days X 100)</td>
<td>0 % (5 points) 1-5% (3 points) Over 5% (0 points)</td>
</tr>
<tr>
<td>78. Percent of nurse shifts covered by agency staff over the last month.</td>
<td>Total number of nurse shifts in a 24 hour period (all shifts no regardless of hours in a shift) ________ Multiplied by number of days in last the last full month ________ Of this number, number of shifts covered by an agency nurse ________ ________ Your percentage (agency shifts/total number X days X 100)</td>
<td>0 % (5 points) 1-5% (3 points) Over 5% (0 points)</td>
</tr>
</tbody>
</table>
79. Current occupancy rate.

<table>
<thead>
<tr>
<th>Your home figure</th>
<th>Current occupancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Above 86 %</td>
<td>(5 points)</td>
</tr>
<tr>
<td>At average 83-85 %</td>
<td>(3 points)</td>
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<tr>
<td>Below 83 %</td>
<td>(0 points)</td>
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</tbody>
</table>

(Using the national 2004 average of 84.2% from CMS)

**Outcomes Subtotal:** Out of a total 65 points, you scored ___________.

<table>
<thead>
<tr>
<th>Artifacts Sections</th>
<th>Potential Points</th>
<th>Your Subtotal Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Practices</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>Environment</td>
<td>320</td>
<td></td>
</tr>
<tr>
<td>Family and Community</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Leadership</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Workplace Practice</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>Outcomes</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>Artifacts of Culture Change</td>
<td>580</td>
<td>Grand Total</td>
</tr>
</tbody>
</table>

Developed by the Centers for Medicare and Medicare Services and Edu-Catering, LLP. For more information contact Karen Schoeneman at karen.schoeneman@cms.hhs.gov or Carmen S. Bowman at carmen@edu-catering.com.
APPENDIX B

ARTIFACTS OF CULTURE CHANGE
SOURCE INFORMATION FOR LINE ITEMS
## Artifacts of Culture Change

### Source Information for Line Items

<table>
<thead>
<tr>
<th><strong>Line Items</strong></th>
<th><strong>Source</strong></th>
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<tbody>
<tr>
<td><strong>1. Percentage of residents who receive any of the following styles of dining:</strong></td>
<td>Food and drinks were available at any time including access to the kitchen in the evening and on the night shift. As the residents were able to eat food they desired whenever they desires, weight loss declined. (Rantz and Flesner, 2004, p.25).</td>
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<tr>
<td>- restaurant style where staff take resident orders;</td>
<td>At Providence Mt. St. Vincent, “far less food is wasted” due to residents choosing foods each meal at fully functioning neighborhood kitchens. Average number of residents with weight loss in 1995 was twenty and in 2001, only three (Ronch and Weiner, 2003).</td>
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<tr>
<td>- buffet style where residents help themselves or tell staff what they want;</td>
<td>Sixteen Texas Transition Health Services homes started in 2002 and in four years is one of the leading culturally transformed provider organizations in the country. These homes have embraced liberalized dining, I-Format care plans, individualized bathing practices, full-time live-in animals, and neighborhood teams. Outcomes in these homes include improved surveys, increased census, reduced employee attrition and increased overall elder and team member satisfaction. In addition to providing a career path structure for nursing assistants, personal growth programs for all employees, in-services solutions and mentoring programs to these homes, the Institute for Caregiver Education also provided Culture Change training. (Institute for Caregiver Education, 2006).</td>
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<tr>
<td>- family style where food is served in bowls on dining tables where residents help themselves or staff assist them;</td>
<td>Open dining resulted in decreased dietary costs and less food waste since residents choose foods they liked and they ate them (Rantz and Flesner, 2004, p. 51).</td>
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<tr>
<td>- open dining where meal is available for at least 2 hour time period and residents can come when they choose; and</td>
<td>&quot;Food is the heart of the home... The ideal is to have what the residents want to eat available 24 hours a day, seven days a week with the opportunity to eat with whom they wish, in places they choose to be” (Bump, 2005).</td>
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<tr>
<td>- 24 hour dining where residents can order food from the kitchen 24 hours a day.</td>
<td>Aromas of baked goods increase appetite and residents eat better (The Green House Project DVD, 2005).</td>
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<td><strong>2. Snacks/drinks available at all times to all residents at no additional cost, i.e. in a stocked pantry, refrigerator or snack bar.</strong></td>
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<td><strong>3. Baked goods are baked on resident living areas.</strong></td>
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<td><strong>4. Facility celebrates residents’ individual birthdays rather than, or in addition to, celebrating resident birthdays in a group each</strong></td>
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<td></td>
<td>Most Pinon Management managed homes, 16 in Colorado, celebrate individual residents’ birthdays instead of in a large monthly group party (Irtz, 2006).</td>
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Individual residents’ birthdays are celebrated in each household at Evergreen Retirement Community instead of the traditional all-facility monthly group birthday party (Green, 2006).

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<tr>
<th>5. Facility offers aromatherapy to residents by staff or volunteers.</th>
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| Studies have shown that use of essential oils reduced anxiety and improved quality of life in cancer patients (Cerrato); relieved signs of distress, anxiety, and agitation in nursing home residents with Alzheimer's disease (Brown University, 1998); significantly reduced agitation, without producing the side effects that may come with the use of drugs, in people with dementia (Futurist, 2003); and helped one very anxious nursing home resident who could not sleep to develop good sleep patterns (Healthcare Review, 2001). Buckle (1999), in her review of nine studies utilizing aromatherapy to address pain in a range of patients, found that subjects reported positive effects including perceptions of reduction in pain, improved sleep patterns, and improved ability to cope. She suggests there is sufficient evidence to demonstrate that aromatherapy can play a complementary role in pain management (Kunstler, 2004).

In a monitored and documented study on the Alzheimer's Unit at Mattie C. Hall Health Care Center in Aiken, South Carolina, special blends of essential oils used at certain times of the day improved appetites; all but stopped "sun-downing" which results in increased noise and disruptive behaviors in the early evening; decreased pain and insomnia; and stimulated short-term memory so that patients could enjoy activities. Additionally, from October 2001 to September 2002, there was a decrease from 10 to 2 residents with weight loss of 3 pounds or more per month and a decrease in residents receiving psychotropic medications from 9 to 2. By May 2005, there were no residents with weight loss problems and no residents using psychotropic medications (www.scentsiblesolutions.net website).

The East Carolina University in North Carolina research study *The Influence of Aromatherapy on the Biological and Behavior Markers of Individuals with Alzheimer’s Disease* is using the Scents-ible Solutions Aromatherapy Program protocol in 14 nursing homes with 144 residents with Alzheimer’s disease beginning June 2005. Initial results suggest the essential oils used have shown some decrease
<table>
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<tr>
<th>6. Facility offers massage to residents by staff or volunteers.</th>
<th>Hand massage and gentle touch reduces anxiety (Buschmann, 1999) and agitation (Synder et al, 1995).</th>
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<tr>
<td>7. Facility has dog(s) and/or cat(s).</td>
<td>See below, 5 and 6 combined</td>
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| 8. Facility permits residents to bring own dog and/or cat to live with them in the facility. | From the Quality of Life study, homes with high quality of life had the most house pets (Kane et al, 2004)

Benefits to companion animals:
1. Lower blood pressure and pulse rate
2. 21% fewer visits to doctor
3. Less depression
4. Easier to make friends (enhanced social opportunities)
5. Seniors become more active
6. Pets offer affection and unconditional love
7. Pets ease the loss of a loved one
8. Pets fight loneliness
9. Taking better care of themselves
10. Sense of security (Haleigh’s Almanac, 2002, pp. 61-63).

“In 1990, Judith Siegal from the University of California, Los Angeles, reported in the Journal of Personality and Social Psychology that elderly people who owned a pet needed fewer doctor visits… Her examination of almost 1000 Medicare recipients took into account a person’s living conditions, underlying chronic disease, education and other factors known to influence health… She found that people without pets average 9.49 visits to the doctor in one year, while pet owners had only 8.42 visits during the year studied” (Haleigh’s Almanac, 2002, pp. 61-63).

From “Pets and Your Health” from the Mayo Clinic Health Oasis Newsletter, July 20, 2000, Edward T. Creagan, M.D. oncologist at Mayo Clinic, Rochester, MN says: “A study published in the March of 1999 Journal of the American Geriatrics Society showed that senior citizens who own pets are less likely to be depressed, are better able to tolerate social isolation, and are more active than those who do not own pets. And these increased levels of activity
are not explained solely because dog owners take their dogs for a walk. Cat owners are equally active. We all need something to live for and something to focus on, besides ourselves…Pets offer us unconditional love, which is significant to our over all well-being” ((Haleigh’s Almanac, 2002, pp. 61-63).

From “Pet Owners are a Healthy Breed,” Richard Avanzino, President, San Francisco SPCA, “One ten-month study that focused on general health turned up some interesting differences between pet owners and non-pet owners. Researchers found that pet owners reported fewer headaches, fewer bouts of indigestion and less difficulty sleeping…”(Haleigh’s Almanac, 2002, pp. 61-63).

Sixteen Texas Transition Health Services homes started in 2002 and in four years is one of the leading culturally transformed provider organizations in the country. These homes have embraced liberalized dining, I-Format care plans, individualized bathing practices, full-time live-in animals, and neighborhood teams. Outcomes in these homes include improved surveys, increased census, reduced employee attrition and increased overall elder and team member satisfaction. (Institute for Caregiver Education, 2006).

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<th>9. Waking times/bedtimes chosen by residents.</th>
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<td>“The environment under PCC promotes autonomy for both the residents and employees of Crestview. Residents who have control of their lives and schedules are found to have increased overall morale (as reported by Ryden 1984) (Rantz and Flesner, 2004, p.61).</td>
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<tr>
<td>“People now wake up, spend their days, and go to bed according to their own routines, and as they are restored to their own rhythms, they are thriving. So are those who care for them. As work is reorganized to follow the pace of each resident, instead of a rigid institutional routine, workers are able to fulfill their intrinsic motivation to care for others, and to experience respect and care from their organizations.” (Quality Partners of Rhode Island of Rhode Island. 2005 p. 5).</td>
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<tr>
<th>10. Bathing without a Battle techniques are used with residents.</th>
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<tr>
<td>“Both teams found that when we individualized the bath and the bathing care plan we were able to dramatically reduce the aggressive behaviors” (Rader et al, 2002).</td>
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Sixteen Texas Transition Health Services homes started in 2002 and in four years is one of the leading culturally transformed provider organizations in the country. These homes have embraced liberalized dining, I-Format care plans, individualized bathing practices, full-time live-in animals, and neighborhood teams. Outcomes in these homes include improved surveys, increased census, reduced employee attrition and increased overall elder and team member satisfaction. (Institute for Caregiver Education, 2006).

Hickory Creek Healthcare Foundation, IN implemented Bathing without a Battle as corporate program for all their facilities (Quality Partners of Rhode Island, 2005).

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<td>11. Residents can get a bath/shower as often as they would like.</td>
<td>Examples of changes within the domain of Care Practices included: Resident-inclusive choices in the areas of … daily routine which included bathing - frequency, time, and method (Quality Partners of Rhode Island of Rhode Island, 2005, p. 13).</td>
</tr>
<tr>
<td>12. Facility arranges for someone to be with a dying resident at all times (unless they prefer to be alone) - family, friends, volunteers or staff.</td>
<td>“Yet facility managers or social workers could work on helping people deal with the inevitable approach of death for at least some of their residents. Attending to death carefully and explicitly is a practice that is drawing increasing attention, both for staff and residents, in the ‘culture change’ community in long-term care” (Eaton, 2001).</td>
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<tr>
<td>13. Memorials/remembrances are held for individual residents upon death.</td>
<td>Included in the Improving Nursing Home Culture Pilot training to 51 facilities, was “the change to I-format care plans” (Quality Partners of Rhode Island, 2005).</td>
</tr>
<tr>
<td>14. “I” format care plans, in the voice of the resident and in the first person, are used.</td>
<td>Included in the Improving Nursing Home Culture Pilot training to 51 facilities, was “valuing life through a dignified death” (Quality Partners of Rhode Island, 2005).</td>
</tr>
<tr>
<td></td>
<td>In the Improving Nursing Home Culture Pilot study, under the domain of Care Practices, the 51 homes were encouraged to consider innovative, creative care solutions including “I” format care plans” and included in the Pilot training was “the change to I-format care plans”</td>
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Apple Health Care corporation homes (25) and homes trained by the Institute for Caregiver Education utilize I format care planning and report that it is a “powerful” tool for assisting staff in better knowing and understanding residents. (Carol Tschop, Pioneer Network conference 2003).

Sixteen Texas Transition Health Services homes started in 2002 and in four years is one of the leading culturally transformed provider organizations in the country. These homes have embraced liberalized dining, I-Format care plans, individualized bathing practices, full-time live-in animals, and neighborhood teams. Outcomes in these homes include improved surveys, increased census, reduced employee attrition and increased overall elder and team member satisfaction (Institute for Caregiver Education, 2006).

15. Percent of residents who live in households that are self-contained with full kitchen, living room and dining room.

Teresian House, Evergreen Retirement Community, Big Fork Valley, Meadowlark Hills, Fairport Baptist Home all operate and physically renovated into the household model. A household model naturally creates a “family life” where staff can support resident choices and decisions about their daily life such as meals and activities. For staff, tools and supplies are decentralized helping them to give more efficient care. Typical of household models, staff are cross-trained, roles are blended and staff consistently work with the same residents. “Residents are walking more and they can sleep in if they want to. We also enjoy group planning of special events and home cooking and snacks” as explained by a certified household resident assistant of Fairport Baptist Home. “Perhaps the most dramatic news has been residents’ discovery that they have a voice. This has always been true – but in a household of no more than 12 residents, it is much easier for one’s voice to be heard!”(Fairport Homes News, 2002.)

16. Percent of residents in private rooms.

Recent study by Calkins & Cassella found moderate to strong evidence supporting the benefits of private rooms in terms of clinical factors (especially nosocomial infection rates), psychosocial factors (preferences for privacy, better family visiting, especially at end of life, more control over personal territory), operational factors (less time spent managing room mate conflict, easier to market) and building/construction factors (difference in construction costs between private and traditional shared room can be
made up in approximately 14 months if beds are occupied, and in less than two months if a bed remains unoccupied because someone refused to live with a stranger). Paper available at www.IDEASInstitute.org

From the Quality of Life study, homes with high quality of life had the most private rooms at 23.6% (Kane et al, 2004).

A remodel in the late 1990’s of Teresian House into neighborhoods, included conversion of all shared rooms into private rooms, resulting in 300 private rooms (Ronch and Weiner, 2003, p. 227).

Evergreen Retirement Community has two neighborhoods with 4 household each. In the 36 resident neighborhood, 20 residents have private rooms. In other words, of 28 rooms, 20 are private. In the 44 resident neighborhood, 28 residents have a private room. In other words, of the 36 rooms, 20 are private. The original SNF unit, opened in 1967, has 25 rooms, all originally intended as semi-private. Three are larger and used as doubles but the remaining 22 rooms are now all private (Green, 2006).

In the Green Houses in Tupelo, MS, 10 elders live in self-contained houses with private rooms and baths (Kane et al, 2005).

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<th>17. Percent of residents in privacy enhanced shared rooms where residents can access their own space without trespassing through the other resident’s space. This does not include the traditional privacy curtain.</th>
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In Post-Occupancy Evaluation at Freedom House, Air Force Village, San Antonio, a resident is an enhanced bedroom said she felt like she had a private room but shared a bathroom. Staff reported fewer instances of roommate conflict in the enhanced bedrooms shared bedrooms than in the traditional shared bedrooms. Results presented at 2005 AAHSA conference. Presentation available at www.SAFEFederation.org.

Crestview’s experience is that residents preferred the enhanced privacy rooms because they had privacy and “someone else was there.” They were more requested than private rooms (Haider, 2001).

“Privacy is the most significant thing” (Kaup, 2005).

Only two of 40 homes in the Quality of Life study, had double room configurations with an almost complete floor-to-ceiling wall separating the two sides of the room, and a window for each resident; only the bathroom and closet area were shared but each resident accessed those spaces.
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| 18. No traditional nurses’ stations or traditional nurses’ stations have been removed. | “We want to go back to the neighborhood concept, get rid of the nurses’ station. We believe we will retain staff in the future because of this (Administrator/CEO).” “We will remove the nurses’ station so it is less institutional and has a more home like look. We are hoping that there will be space for people to sit and visit. We have to think outside the box, there are tons of ideas! (Administrator)” (Eaton, 2001).  
The Village in Indianola, a Wesley Retirement Community, was building households but staff was impatient. As a result, they removed the nurses’ station before remodeling and captured over 600 square feet of living space for a resident living room (Norton, 2006).  
Facility examples: Special Care Center at Heather Hill, Creekview at Evergreen Retirement Community, Oshkosh, WI; Green Houses, Tupelo, MS (Norton, 2006).  
In the Measures, Indicators, and Improvement of Quality of Life in Nursing Homes: Final Report, nurses stations were identified as an "Environmental Problem Area" along with a recommendation to consider removing the high counter nurses’ stations since they physically separate residents and staff (Kane et al, 2004). |
| 19. Percent of residents who have a direct window view not past another resident’s bed. | Common nursing home room design consists of two beds arranged in such a manner that one resident must look past the other in order to see out the window. Because a thin privacy curtain may be pulled, the view may be blocked at some or all times depending on the pattern and considerations of the resident with the window view and/or staff.  
Evergreen Retirement Community has two neighborhoods. 8 rooms in each neighborhood are shared. In the shared rooms, each resident has the same square footage as in a private room, and both have windows. (Green, personal correspondence, 2006).  
In focus groups conducted by Calkins & Cassella, residents mentioned window view (open or blocked by curtain) was one of the issues that sometimes caused conflict with roommate. Paper available at www.IDEASInstitute.org. |

In a well documented study of the effects of a window
view of nature on outcomes for surgical patients by Ulrich in 1984 found that those with the view went home three-quarters of a day earlier, had reduced costs, used fewer heavy medications, had fewer minor complications such as nausea and exhibited better emotional well-being as compared to patients in identical rooms who viewed a bring wall as reported by Barry et al, 2004 (Brawley, 2006).

| 20. Resident bathroom mirrors are wheelchair accessible and/or adjustable in order to be visible to a seated or standing resident. | Based on the real experience living as a resident in a nursing home for three days, interior designer and gerontologist Migette Kaup discovered that many usual amenities most take for granted were missing. For example, she could only see the top of the head in the mirror over the sink while sitting in a wheelchair (Kaup, 2005).

In the Quality of Life study, of the 1,988 residents in 40 homes, only 10% had a mirror suited for a wheelchair user (Cutler et al, 2006). |
|---|---|
| 21. Sinks in resident bathrooms are wheelchair accessible with clearance below sink for wheelchair. | In the Quality of Life study, of the 1,988 residents in 40 homes, 82% had wheelchair clearance under their sinks (Cutler et al, 2006).

Teresian House installed sinks that can be adjusted for a taller or shorter person (observed by co-developers 2002). |
| 22. Sinks used by residents have adaptive/easy-to-use lever or paddle handles. | In the Improving Nursing Home Culture Pilot study, under the domain of Environment the 51 homes were encouraged to consider changes such as: designing for accessibility; diminishing barriers…” (Quality Partners of Rhode Island, 2005, p. 13).

Of 40 homes in the Quality of Life study, sink hardware was rarely lever style (Cutler et al, 2006). |
| 23. Adaptive handles, enhanced for easy use, for doors used by residents (rooms, bathrooms and public areas). | In the Improving Nursing Home Culture Pilot study, under the domain of Environment the 51 homes were encouraged to consider changes such as: designing for accessibility; diminishing barriers….” Quality Partners of Rhode Island, 2005, p. 13).

Of the 40 homes in the Quality of Life study, only 48% of the entry doors had lever-type hardware (Cutler et al, 2006). |
| 24. Closets have moveable rods that can be set to different heights. | Out of a review of 1,988 resident rooms, adjustable closet rods or those placed 3-4 feet from the floor was found in only 137 or 6.9% cases...." (Kane et al, 2004).

Of the 1,988 residents in 40 homes in the Quality of Life |
study, although 65% of the individuals used wheelchairs, only 7% of the closet rods were located 36-48 inches from the floor (Cutler et al, 2006).

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<th>25. Facility has no rule prohibiting, and residents are welcome, to decorate their rooms any way they wish including using nails, tape, screws, etc.</th>
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<tr>
<td>In the Improving Nursing Home Culture Pilot study, under the domain of Environment the 51 homes were encouraged to consider changes such as the creation of sanctuary, shelter and peace that provides a sense of community, safety and free of unwanted intrusions; the creation of beauty and comfort;... encourage personal items that reflect individuality; personal items such as refrigerators, calendars, pictures, comforters, personal space, shrines....” (Quality Partners of Rhode Island, 2005, p. 13).</td>
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<tr>
<th>26. Facility makes available extra lighting source in resident room if requested by resident such as floor lamps, reading lamps, etc.</th>
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<tr>
<td>In the Improving Nursing Home Culture Pilot study, under the domain of Environment the 51 homes were encouraged to consider changes such as: attention to adequate lighting…” (Quality Partners of Rhode Island. 2005, p 13).</td>
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<tr>
<td>Architect David Dillard portrayed an elder living with early dementia for 24 hours and discovered “a poorly lit room” and vowed to plan “better lighting (no more bluish florescent!” in his future designs (Dillard, 2005).</td>
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<tr>
<td>Lighting is notoriously bad in many facilities. There is clear and solid evidence that older people need three times the amount of light as younger individuals to see as clearly. Closets, for instance, are an area that are often much too dark. It is no wonder people need so much assistance with dressing when they cannot see their clothing in the wardrobe or dresser (Calkins, 2002).</td>
</tr>
<tr>
<td>Of the 40 homes studied in the Quality of Life study, only 23% of the resident rooms provided the opportunity to control the intensity of the light with a dimmer switch (Cutler et al, 2006).</td>
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<th>27. Heat/air conditioning controls can be adjusted in resident rooms.</th>
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<td>Bigfork Valley in Bigfork, MN decided that if residents were going to be in charge of their own lives, that it was a must that they control the temperature in their physical environment. Thus, each room has a thermostat (Norton, 2006).</td>
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<tr>
<td>In the Quality of Life study, 52% of resident rooms had adjustable heat, 46% adjustable air conditioning (Cutler et al, 2006).</td>
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<th>28. Facility provides or invites residents to have their own refrigerators.</th>
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<td>Teresian House invites residents to bring a refrigerator if they so desire. This affords residents the opportunity to have their own snacks and specialty items that may not be...</td>
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</table>
offered at the facility such as a specific kind of soda, for families to bring ethnic foods which staff then warm at meal times; also affords families the opportunity to bring picnic food items and have a place to store them.

In the Improving Nursing Home Culture Pilot study, under the domain of Environment the 51 homes were encouraged to consider changes such as the creation of sanctuary, shelter and peace including personal items such as refrigerators.” (Quality Partners of Rhode Island. 2005, p. 13).

Food is intertwined with practically every aspect of our being. With a little refrigerator and a microwave in a resident’s room almost everyone can have a mini-kitchen (Bump, 2005)."

In the Service Houses at Lyngblomsten Care Center, and at Bigfork Valley, skilled nursing residents not only have refrigerators in their rooms but a sink and microwave as well (Norton, 2006).

Of the 1,988 residents living in the 40 homes in the Quality of Life study, only 1.5% had a refrigerator in the room (Cutler et al, 2006).

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<th>29. Chairs and sofas public areas have seat heights that vary to comfortably accommodate people of different heights.</th>
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<tr>
<td>“It is important to specify chairs with the right seat height, pitch of the back and arms that make them comfortable and easy to get in and out of. What we need are chairs that fit and support. Chairs should be sized to the person; a resident’s feet should be flat on the floor when seated. A chair that is comfortable for a six-foot-tall man will most likely not be comfortable for a five-toot-tall woman. Just as you might find in the home, a variety of chair styles and sizes should be available.” Hip joints can be shattered and broken when frail elderly individuals attempt to rise from an inappropriate chair and it can be difficult to rise from an upholstered chair if the seat is too deep. Chairs of different sizes and varying seating heights should be offered to accommodate residents. To assist older persons to rise from their chairs independently and safely, seating heights should be slightly higher than standard, between 18 and 19.5 inches (Brawley, 1997).</td>
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<tr>
<td>While ADA recommends seating at 17.5 – 18.5 inches, this may be too high to be comfortable for shorter women. Thus having some chairs that are lower for shorter</td>
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43
| 30. Gliders which lock into place when person rises are available inside the facility and/or outside. | Glider use has been shown to significantly improve emotions and relaxation after 10 minutes of swinging (Snyder, et al, 2001). Rocking chairs can redistribute and cycle the pressure between resident’s seat and back, stimulating circulation. The rocking motion also stimulates the vestibular canal in the ear, which creates a calming effect. For residents with Alzheimer’s disease who can be aggressive rockers, a rocking chair with a stable base can be calming and therapeutic (Brawley, 1997). |
| 31. Facility has store/gift shop/cart available where residents and visitors can purchase gifts, toiletries, snacks, etc. | Life Care Centers of America (approximately 200 homes) typically have an ice cream parlor and gift shop in newly constructed buildings and usually in any acquired buildings (experience of one of the co-developer Bowman). |
| 32. Residents have regular access to computer/Internet and adaptations are available for independent computer use such as large keyboard or touch screen. | Study by Christian Living Campus, Troy Dunning, ADC of 34 computer lab participant residents from 11/00 – 10/01 who learned to use email, computer use, genealogy, music, news, internet and watching screen savers, games, writing letters, researching topics of interest, online shopping, checking stocks, creating online cards, journaling using adaptive equipment or software. Results were: 65% experienced an increase in communication with family; 44% experienced an increase in socialization with other residents and staff; 24% experienced enhanced self-esteem; 24% experienced in increase in group activity attendance; 18% an increase in self-expression either verbally or using adaptive keyboard; 15% showed a lessening of agitation through visual and mental stimulation (Dunning, 2001 unpublished). Computer technology provides the opportunity to present a large multimedia database of stimuli to use in reminiscence. CIRCA is an interactive hypermedia-based system designed for people with dementia to facilitate and support conversation and social interactions. The system contains a large database of media presented via a touch screen to act as a prompt for interactions between people with dementia and caregivers. We evaluated the usefulness of CIRCA by comparing it with one-to-one reminiscence sessions conducted using traditional reminiscence stimuli. |
Unlike traditional reminiscence CIRCA gives people with dementia the opportunity to direct interactions and make choices. This enables them to regain their status as interaction partners. Prompted memories care givers had never heard before, people who reacted poorly to traditional reminiscence, were more involved and alert (Astell et al, 2003).

| 33. Workout room available to residents. | In 2004, the Creekview Fitness Center and Aquatic Center (and café) were built in the middle of the skilled nursing facility which consists of two neighborhoods of 4 households each: Creekview North and Creekview South. This location makes the fitness center and pool most available to the residents who can benefit the most from both aquatic and land-based exercise. 40% of the SNF residents use the Fitness Center and Aquatic Center on a regular basis (Green, 2006).

A structured resistive training program implemented with elderly persons with dementia improved muscle strength and power (Kuiak et al, 2003).

A progressive functional fitness strength training program with dumbbells and ankle weights improved muscle strength, functional performance and depression symptoms (Brill et al).

| 34. Bathing rooms have functional and properly installed heat lamps, radiant heat panels or equivalent. | In the Quality of Life study of 40 homes, heat lamps were in only 15% of the shower rooms (Cutler et al, 2006).

Wellstar Paulding Nursing Center in GA added heat lamps, aromatherapy, and music to bathing rooms (Quality Partners of Rhode Island, 2005).

Evergreen Retirement Community has claims supplemental heat in their bathing rooms is essential and have discovered residents prefer the temperature to be about 85 degrees. Creekview North and South neighborhoods, both heat lamps over the tub and wall heaters are used. In addition, Creekview South (newer neighborhood which opened in 2004), has an electric fireplace rather than just a standard wall heater, to create more ambiance suggested by the architect (Green, 2006).

| 35. Facility warms towels for resident bathing. | Ft. Collins Good Samaritan Home Ft. Collins, CO has a midsize industrial towel warmer in their living room making warm towels available to residents at all times, not just during bathing (personal observation of co-developer Bowman).

| 36. Protected outdoor garden/patio accessible | Outdoor spaces help to maintain a connection with the |
Residents can go in and out independently, including those who use wheelchairs, e.g. residents do not need assistance from staff to open doors or overcome obstacles in traveling to patio.

natural environment, and provide added opportunities for socialization and outdoor activities (Brawley, 1997).

From an architect student who lived as a resident for a month: “A courtyard offered a sunny respite but poorly placed doorways and gaps in the concrete footpath discouraged access by wheelchair and cane.” (Kiyota, 2005).

Of the 131 unit environments in the Measures, Indicators, and Improvement of Quality of Life in Nursing Homes study, 55.7% had no outdoor amenities items. Of those residents who were physically able to go outdoors, 32% do so less than once a month. “Beyond therapeutic benefits, being outdoors arguably is positively associated with improved perceptions of quality of life. Yet outdoor space, outdoor amenities, and access to outdoor space have often been ignored in the design phase or simply value engineered out of a project due to cost when in reality outdoor spaces are especially important to persons sequestered in institutional settings. When outdoor spaces are available to nursing home residents, most often the accessibility and functionality of those spaces are ignored. It is as if they are not considered an integral part of the overall physical environment. Yet we argue that outdoor spaces have the potential of increasing a resident’s quality of life and well-being and should be maximized for the potential of providing additional living spaces (Cutler and Kane, 2006).”

Access to a pleasant and safe outside area that provides refuge for residents was found to be a predictor of satisfaction in a study by Greene, Hawes, Wood and Woodsong in 1998 according to how family members define quality of life in long term care settings (Cutler and Kane, 2006).

Several hours of outdoor activity in the morning greatly reduced unwanted behaviors later in the day and reduced psychotropic medications 40 % as reported by Gold in 2004 (Cutler and Kane, 2006).

Well-designed garden activities including mobility and access can reduce participants’ frustrations with gardening and give self-esteem, success, and self-confidence (Kwatch, 2004, pp. 1-13).
In the Measures, Indicators, and Improvement of Quality of Life in Nursing Homes study, limited access to outdoor space was identified as an “Environmental Problem Area” with only 32% of residents outdoors less than once a month, 13% less than once a week, and “outdoor activities such as gardening in raised planting containers are great but consider access issues such as the difficulty of moving a wheelchair on the grass” (Kane et al, 2004).

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<tr>
<th>38. Facility has an outdoor walking/wheeling path which is not city sidewalk or path.</th>
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<tr>
<td>Clearly defined pathways that circle back to the starting point assist residents in finding their way. Well designed areas allow for wandering while ensuring that an individual is safe and can be easily supervised. Pathways that flow in loops bring residents back to where they started allowing for a safe outdoor journey (Brawley, 1997).</td>
</tr>
<tr>
<td>Providing a hard surface wandering path at least 3 inches wide for exercise is one principle in the Healing Gardens: Therapeutic Benefits and Design Recommendations by Cooper-Marcus and Barnes 1999 (Brawley, 2006).</td>
</tr>
<tr>
<td>In the Quality of Life study, of 131 units, only 44.3% had direct access to an outdoor environment, of those, a hard surface walking path at least 3 feet wide was available only 58.6% of the time (Cutler and Kane, 2006).</td>
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<tr>
<th>39. Pager/radio/telephone call system is used where resident calls register on staff members’ pagers/radios/telephones and staff can use it to communicate with fellow staff.</th>
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<tr>
<td>Advantages to the Telephone Nurse Call system: Reduced overhead paging by 85%, care staff can call each other for assistance in care delivery, care staff know which resident is calling for help, has reduced complaints that call bells were not answered in a timely fashion to almost zero, improved staff response time to assist residents (Brokaw, 2006).</td>
</tr>
<tr>
<td>&quot;Wireless call systems are gaining ground in the culture change movement as a tool promoting better services and a more calming environment for residents without the ringing and flashing of call lights&quot; (Bowman, 2005).</td>
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<td>Brewster Village in Appleton, WI has used personal phone/pager/radios since 2000 when they moved into their new households (Norton, 2006).</td>
</tr>
<tr>
<td>Each apartment in the Lyngblomsten Service House, St. Paul, MN, has a call system wired directly into the care assistants’ pagers. Care assistants are universal workers responsible for housekeeping, food service, activities, and nurse aide assistance (Grant, 2001).</td>
</tr>
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<td>40. Overhead paging system has been turned off or is only used in case of emergency.</td>
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<tr>
<td>41. Personal clothing laundered on resident household/neighborhood/unit instead of in a general all-facility laundry and residents and families have access to washer and dryer for own use.</td>
</tr>
<tr>
<td>42. Regularly scheduled intergenerational program in which children customarily interact with residents at least once a week.</td>
</tr>
<tr>
<td>43. Facility makes space available for community groups to meet in facility with residents welcome to attend.</td>
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</table>
Laguna Honda, San Francisco, CA also allows groups to meet in their home welcoming residents to attend (Harris, 2006) as does Evergreen Retirement Community, Oshkosh, WI (Green, 2006).

44. Private guestroom available for visitors at no or minimal cost for overnight stays.

Teresian House and Providence Mt. St. Vincent have guest rooms. Teresian House reports it is used by families who come from out of town as well as families of residents passing away. There is a nominal fee for the use of the room and meals but much less than a hotel. Residents visit their families in the guest room and even parties are held there (Brecanier, 2005).

45. Facility has café/restaurant/tavern/canteen available to residents, families, and visitors at which residents and family can purchase food and drinks daily.

“A cocktail/coffee shop has become so popular with residents and their families that reservations are now being requested” (Ronch and Weiner, 2003, p. 228).

Shalom Village in Overland Park, KS has a kosher café open residents, families, staff and the public (experience of the co-developers, 2001).

Food is intertwined with practically every aspect of our being. It can be as simple as a social corner in a living or dining room for cookies, fresh fruit, crackers, and juice; a place to sit quietly with a cup of tea; a coffee shop in the lobby; bringing the community in to share a waffle breakfast” (Bump, 2005).

46. Facility has special dining room available for family use/gatherings which excludes regular dining areas.

Life Care Centers of America (approximately 200 homes nationally) typically have a separate “private dining room” in newly constructed buildings and usually in any acquired buildings (experience of co-developer Bowman).

47. Kitchenette or kitchen area with at least a refrigerator and stove is available to families, residents, and staff where cooking and baking are welcomed.

Elders experience joy when able to prepare a favorite recipe for friends and once again share meals with families (Bump, 2005).

Most household models with a full household kitchen make it available to residents, families and staff (Norton, 2006).

48. CNAs attend resident care conferences.

“Recent research has confirmed that facilities where CNAs participate in care planning have lower rates of turnover compared to facilities where they do not. Yet in virtually no facility, high or low turnover, were CNAs actively involved in care planning” (Eaton, 2001).

LEAP research by Linda Hollinger-Smith, Mather Lifeways 6/02-6/03 shows that nursing staff who are the
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<td>49.</td>
<td>Residents or family members serve on facility quality assessment and assurance (QAA) (QI, CQI, QA) committee.</td>
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<td>Former NHA Beth Irtz included residents and family members in the home’s QA and A process and explained “that family member or resident cares just as much as you do about your home” (Irtz, 2004). When Evergreen Retirement Community’ Quality Council was formed in 1990, a resident was included as a full member with the same voting rights as all other members, half of which are direct-care, and the other half leadership, staff. “The participation of a resident has always been regarded as important since residents are the primary beneficiaries of our efforts. The QC was originally responsible for implementing Continuous Quality Improvement as the key element of our management philosophy. We recognized that in order to use households as the basic service delivery unit of long-term skilled nursing care we needed a fundamental change in the management philosophy. We could no longer use the traditional direct/inspect management approach. CQI is based on teamwork where each team member has a unique role, and data is the basis of decision making” (Green, 2006).</td>
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<td>50.</td>
<td>Residents have an assigned staff member who serves as a “buddy,” case coordinator, Guardian Angel, etc. to check with the resident regularly and follow up on any concerns. This is in addition to any assigned social service staff.</td>
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<td></td>
<td>Most of the Life Care Centers Mountain Region facilities (23) have a Guardian Angel program that has resulted in decreased resident/family complaints and increased relationships (experience of co-developer, Bowman).</td>
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<td>51.</td>
<td>Learning Circles or equivalent are used regularly in staff and resident meetings in order to give each person the opportunity to share their opinion/ideas.</td>
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<td>I would say the 100% of the 80 facilities that we work with use the Learning Circle - with staff, residents and families (Norton, 2006). Lead supporter of Learning Circles, LaVrene Norton explains it as a leveling technique that can get everyone involved (residents, staff, families) and that “encourages quiet people to speak, talkative people to listen and everyone to share in making decisions.” Staff and residents in households often use the circle daily to “connect with each other, address concerns and work through problems” (Ronch and Weiner, 2003, p. 287).</td>
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<tr>
<td>52. Community Meetings are held on a regular basis bringing staff, residents and families together as a community.</td>
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<td>The idea of community meetings to test a simple hypothesis: “Bring the elders together regularly in a community that promotes meaning and connection and it will change their lives and cause a ripple effect that will impact the culture of the institution.” Residents grew more aware of one another, became more present, more energetic and responsive. Staff noticed residents whom they had previously assumed were not capable of communication, began to interact with them. “This progress challenged their assumptions about what is possible. They began to act differently, responding to the elders in a more individualized way and helping them to make choices. They shared their perceptions with co-workers and family members, many of whom expanded their expectations and changed the way they related to the elders” (Barkan, 2002). Community Meetings take place in all of the Pinon Management homes, 16 in Colorado giving voice to residents and staff (Irtz, 2006).</td>
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<tr>
<th>53. RNs consistently work with the residents of the same neighborhood/household/unit (with no rotation).</th>
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<td>“Nurses also like the patient contact. 95% like one unit as opposed to moving around” (Eaton, 2001).</td>
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<th>54. LPNs consistently work with the residents of the same neighborhood/household/unit (with no rotation).</th>
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<td>“Still among the care practices that were observed to vary (from low to high turnover) in the course of this study in the nine facilities were the following: floating staff and consistent vs. irregular assignment” (Eaton, 2001). At the Center for Nursing and Rehabilitation, “rather than float, staff are consistently assigned to the same neighborhood team, and instead of knowing residents only by diagnosis, they develop personal relationships with each resident in the neighborhoods” (Ronch and Weiner, 2003).</td>
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<th>55. CNAs consistently work with the residents of the same neighborhood/household/unit (with no rotation).</th>
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<td>“Particularly for residents with dementia, continuity of relationship with direct caregivers is important” (Wunderluch and Kohler, 2001). CNAs “permanent assignment” to unit correlated with high quality of life (Kane et all, 2004). Meeting of Pioneers in Nursing Home Culture Change, Fagan et al 1997. Misiorski: “We started a CNA empowerment program whereby they now have primary care assignments; they are no longer rotated. That was a huge change for us, a real huge change and met with some</td>
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resistance, as all change sometimes is. But the overall outcome has just been amazingly positive. And people who were negative about it in the beginning have become huge advocates of that program.”

“In summary, the problem with the work organization and care practices observed in most of the facilities was that they didn’t seem to be allowing the caring for people as they wished to be cared for, even if they could so communicate. And where they could not communicate, the assignment system of rotation diminishes the likelihood of making a positive match between nurse’s aides and residents” (Eaton, 2001).

Of the 111 designated culture change homes in the CFMC study that responded regarding staff working consistently with the residents of a neighborhood/household/unit, 55 reported they do it throughout the whole building, 32 reported they do it in some areas of the building (CFMC, 2006).

56. Self-scheduling of work shifts.
CNAs develop their own schedule and fill in for absent CNAs. CNAs independently handle the task of scheduling, trading shifts/days, and covering for each other instead of a staffing coordinator

“Nursing facility organizational research literature has suggested that self-scheduling is the preferred way to resolve scheduling for CNAs. … In those cases, workers felt more responsible to each other, and to their residents, to come to work on the shifts they had committed to work” (Eaton, 2001).

At the Meeting of Pioneers in Nursing Home Culture Change, in 1997, Sue Misiorski, nurse consultant with Apple Health Care shared, “We also implemented the CNAs doing their own patient assignments as well as their own work schedules, which has just been amazingly fantastic. It has reduced call outs, they replace themselves; it just solved all kinds of problems for us and that is all benefiting the residents, which is why we are all there” (Fagan et al, 1997).

In the first Eden facility, Chase Memorial in NY, Dr. Bill Thomas asked the nurse aides to make their own schedules and “immediately, staff attendance improved as people worked out their responsibilities at home and at work for themselves rather than having these imposed on them by a supervisor” (Eaton, 2000).

57. Facility pays expenses for non-managerial staff to attend outside conferences/workshops, e.g. CNAs, direct care nurses. Check yes if at
In the Improving Nursing Home Culture QIO Pilot study, “Other Workplace Practices encouraged and adopted “becoming a learning organization by sharing the wealth
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<td>least one non-managerial staff member attended an outside conference/workshop paid by facility in past year.</td>
<td>and value of education by sending staff to conferences, workshops…” (Quality Partners of Rhode Island, 2005, p. 14).</td>
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<td>58.</td>
<td>Staff is not required to wear uniforms or “scrubs.”</td>
<td>At the Center for Nursing and Rehabilitation, to foster a team mind-set, “separate uniforms that define roles were eliminated. Now everyone, regardless of function, dresses in the same manner, in multi-colored tops and matching pants or skirts, with only name badges to identify an individual as an RN, LPN or CNA” (Ronch and Weiner, 2003). Homes that do not require uniforms include St. John’s in Milwaukee, WI (Almost Home PBS special 2006) and Providence Mt. St. Vincent where for 6 years no staff have worn uniforms, this includes ancillary and contract staff (Boyd, 2006). Illinois ombudsman Tammy Wacker reports that one of the changes she is seeing in nursing homes in the QIO culture change pilot is the elimination of staff uniforms (Clements, 2004).</td>
</tr>
<tr>
<td>59.</td>
<td>Percent of other staff cross-trained and certified as CNAs in addition to CNAs in the nursing department.</td>
<td>Regarding the Providence Mt. St. Vincent. neighborhoods: &quot;Activity planning, assistance with individualized food preparation, and social and rehabilitation planning were integrated into resident aide jobs on each neighborhood. Also aides' job descriptions now include talking with residents, attending to requests for companionship, and helping them eat at times of their choice. This required that aides be cross-trained as nursing assistants, so they could help with toileting and bathing at times when residents preferred, not on an institutional schedule&quot; (Eaton, 2000).</td>
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<tr>
<td>60.</td>
<td>Activities, informal or formal, are led by staff in other departments such as nursing, housekeeping or any departments.</td>
<td>“Still among the care practices that were observed to vary (from low to high turnover) in the course of this study in the nine facilities were the following: activities – extent and type, aide’s involvement” (Eaton, 2001). In household models like Meadowlark Hills in Manhattan, KS all staff have been trained and have the responsibility to facilitate activities (Norton, 2006).</td>
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<tr>
<td>61.</td>
<td>Awards given to staff to recognize commitment to person-directed care, e.g. Culture Change award. This does not include Employee of the Month.</td>
<td>Christopher House in Wheat Ridge, CO awards a Culture Change award to any staff member who shows an observable commitment to changing the institutional culture and only when warranted, e.g., not monthly (personal experience of co-developer Bowman).</td>
</tr>
<tr>
<td>62.</td>
<td>Career ladder positions for CNAs, e.g.</td>
<td>From Mather Lifeways current website: LEAP - Learn</td>
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| **CNA II, CNA III, team leader.** There is a career ladder for CNAs to hold a position higher than base level. | Empower, Achieve, Produce – structures for advancement. An evaluation study of forty communities who have completed 6 and 12 month post LEAP surveys showed improved resident satisfaction measures (www.matherlifeways.org).

Sixteen Texas Transition Health Services homes started in 2002 and in four years is one of the leading culturally transformed provider organizations in the country. THS provides a career path structure for nursing assistants and personal growth programs for all employees. (Institute for Caregiver Education, 2006).

Career ladders for all staff is an area that distinguishes between low vs. high turnover (Eaton, 2001).

Notre Dame nursing home in MA designed a CNA career ladder training. Providers in Modesto, CA are funding a CNA career ladder program. 150 nursing homes, nearly 25 percent, of the Massachusetts Extended Care Federation have participated in state-funded career ladder programs, which so far have trained 3500 CNAs.... Holyoke Community College in MA has a partnership with 4 facilities to offer a CNA professional development career ladder. When student staff members pass the modules, they get pay raises (Wagner, 2005). |
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<td><strong>63. Job development program, e.g. CNA to LPN to RN to NP.</strong></td>
<td>Notre Dame nursing home in MA designed an LPN program for their staff. Providers in Modesto, CA are funding a nursing program. Holyoke Community College in MA partners with 4 facilities to offer LPN training and have graduated 16, with 9 in process. Each of the four facilities report dramatic rises in employee retention. They hope to add an LPN to RN course, and help RNs get master's degrees (Wagner, 2005).</td>
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| **64. Day care onsite available to staff.** | Having a preschool on site correlated with high quality of life (Kane et all, 2004).

A new model of long-term care should include “specialized assistance for child care” as an "essential element" of a stable paraprofessional job (“Direct-care health workers; The Unnecessary Crisis in Long-term Care,” 2001.)

Pioneering homes with on-site day care available to staff: Teresian House, Fairport Baptist Home, Providence Mt. St. Vincent. |
<p>| <strong>65. Facility has on staff a paid volunteer</strong> | The volunteer coordinator for Elms Haven Nursing Center |</p>
<table>
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<tr>
<th>66. Employee evaluations include observable measures of employee support of individual resident choices, control and preferred routines in all aspects of daily living.</th>
<th>Pennyburn at Mayfield performance evaluation covers the areas of Team Builder, Person Centered Relationships, Initiative, Willingness to Grow, Critical Thinking-to-Action and Judgment (from actual performance evaluation).</th>
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<tr>
<td>67. Average longevity of CNAs. Add length of employment in years of permanent CNAs and divide by number of staff.</td>
<td>In a comparison study, “the share of staff with more than 3 years’ service varied from only 19% in the most problematic home to 80% of employees in the no-deficiency home.” (Eaton, 1997).</td>
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<td></td>
<td>2003 Crestview RNs averaged 5.1 years of employment (Rantz and Flesner, 2004).</td>
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<td>An average of 5.7 years for CNA longevity was calculated using longevity figures from the four focus facilities used in this report.</td>
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<tr>
<td>68. Average longevity of LPNs (in any position). Add length of employment in years of permanent staff LPNs and divide by number of staff.</td>
<td>2003 Crestview LPNs averaged 5.6 years of employment (Rantz and Flesner, 2004).</td>
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<tr>
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<td>An average of 7.3 years for LPN longevity was calculated using longevity figures from the four focus facilities used in this report.</td>
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<tr>
<td>69. Average longevity of RNs/GNs (in any position). Add length of employment in years of all permanent RNs/GNs and divide by number of staff.</td>
<td>2003 Crestview CNAs averaged 3.0 years of employment (Rantz and Flesner, 2004).</td>
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<td>An average of 9.8 years for RN longevity was calculated using longevity figures from the four focus facilities used in this report.</td>
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<tr>
<td>70. Longevity of the current Director of Nursing (in any position).</td>
<td>2003 Crestview Administration average was 7.2 years. (Rantz and Flesner, 2004).</td>
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<td></td>
<td>Staff turnover averages 50% for DONs (Wunderluch and Kohler, 2001).</td>
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<td>Of 109 designated culture change homes in the CFMC culture change study that responded, the mean tenure for DONs was 5.7 years (CFMC, 2006).</td>
</tr>
<tr>
<td></td>
<td>An average of 6.25 years for NHA longevity as the NHA and 9.25 years working at the home in total was calculated using longevity figures from the four focus facilities used in this report.</td>
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</table>
### 71. Longevity of the current Administrator (in any position).

- 2003 Crestview Administration average was 7.2 years. (Rantz and Flesner, 2004).
- Staff turnover averages 25% for administrator (Wunderluch and Kohler, 2001).
- The employment stability of nursing home administrators ranges from 20% to 50% (Singh & Schwab 1998)” as reported by (Rantz/Flesner, M.K. 2004)
- An administrator in place for 2 yrs or more correlated with high quality of life (Kane et all, 2004).
- Of 108 designated culture change homes in the CFMC culture change study that responded, the mean tenure for administrators was 7.8 years (CFMC, 2006).
- An average of 14.5 years for NHA longevity as the NHA and 16.25 years working at the home in total was calculated using longevity figures from the four focus facilities used in this report.

### 72. Turnover rate for CNAs.

- AHCA 2002 National Turnover: RNs = 50%.
- Staff turnover averages 66% for RNs and LPNs (Wunderluch and Kohler, 2001.)
- Reduced staff turnover has been reported by many culture changing homes (see Artifacts of Culture Change report).

### 73. Turnover rate for LPNs.

- AHCA 2002 National Turnover rate for LPNs is 50%.
- Staff turnover averages 66% for RNs and LPNs. (Wunderluch and Kohler, 2001.)

### 74. Turnover rate for RNs.

- AHCA 2002 National Turnover rate for CNAs is 70%.
- Staff turnover averages 100% for CNAs. A careful study has shown the average cost to be about $3200 in 1992 (Zahrt, quoted in Straker and Atchley, 1999) (Eaton, 2001).
- Findings suggest that pressure ulcer incidence rates are lower in facilities with lower staff turnover and higher retention relative to facilities with higher turnover and higher retention. Although both types of facilities reported that more than 50% of their nurse aide staff had tenure of 2 or more years, outcomes were poorer for those with higher turnover. One possible explanation for this is that the time and effort required to
continually train new nurse aides in the high-turnover homes, where on-the-job training may involve peer mentoring, could be invested in direct resident care by experienced nurse aides. This supports the finding of Bowers, Esmond, and Jacobson (2000), in which experienced nurse aides reported that working with new staff parallels that of working “short staffed,” often compromising resident care (Barry et al, 2005, pg. 309).


From “Direct-care health workers; The Unnecessary Crisis in Long-term Care,” Submitted by the Paraprofessional Healthcare Institute. The Aspen Institute Domestic Strategy Group. January 2001. “…more than 40 states now report critical shortages of paraprofessionals. Turnover rates range between 40 and 100 percent annually. Vacancies and turnover are dangerously high…” "Staff vacancies and high turnover create 1) high recruitment and orientation costs, 2) high retention costs, 3) high separation costs, 4) high temporary replacement costs, and 5) foregone revenues."

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<th>75. Turnover rate for DONs.</th>
<th>50% for Directors of Nursing (Wunderluch and Kohler, 2001).</th>
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<td>76. Turnover rate for NHAs.</td>
<td>25% for Administrators (Wunderluch and Kohler, 2001).</td>
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<tr>
<td>77. Percent of CNA shifts covered by agency staff over the last month.</td>
<td>“Most facilities in this study had stopped using agency staff, because they found them both to be more expensive and less reliable than was acceptable.” “Still among the care practices that were observed to vary (from low to high turnover) in the course of this study in the nine facilities were the following: use of agency staff” (Eaton, 2001).</td>
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“Staffing at the right level in this study was not just a matter of more bodies. For instance, agency staff were sometimes felt to be more trouble than they were worth since they had to be trained and supervised and usually, they did not know the residents, did not know where their dentures are, whether they wore glasses, how they needed to be fed, dressed and toileted. Yet agency staff were paid almost twice as much for every hour on the job as regular staff, and often brought with them a negative attitude about anyone who would do this kind of work for less than they did, according to both managers and CNAs” (Eaton, 2001).
Of 111 designated culture change homes in the CFMC culture change study, the median yearly agency hours over the last 12 months for CNAs was 220, for LPNs is 649 and for RNs is 80 (CFMC, 2006).

78. Percent of nurse shifts covered by agency staff over the last month.

A recent 2006 study, *The Use of Contract Licensed Nursing Staff in U.S. Nursing Homes*, found that use of contract nursing staff (not CNAs) is relatively rare averaging around 5%. The study did not include CNAs. One recent study reports that one solution homes are using for the staffing shortage is the use of contract nursing staff. “This type of staffing is costly, disrupts continuity of care (Guillard 2000), and may also contribute to poor patient care” (Bourbonnire, 2006).

79. Current occupancy rate.

Average 2004 occupancy rate: 84.2 % (Nursing Home Data Compendium, 2005).

Developed by the Centers for Medicare and Medicare Services and Edu-Catering, LLP. For more information contact Karen Schoeneman at karen.schoeneman@cms.hhs.gov or Carmen S. Bowman at carmen@edu-catering.com.
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THE ROLE OF LONG-TERM CARE OMBUDSMEN
IN CULTURE CHANGE:
Promoting Resident Directed Care in Nursing Homes
and Assisted Living Facilities

A Resource Brief
Developed by Sara S. Hunt, Consultant

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ABOUT THE PAPER

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I. Introduction

Purpose
The intent of this paper is to generate ideas about how long-term care ombudsmen (LTCO) can promote systemic, resident directed care practices in facilities. This paper provides examples of state and local long-term care ombudsman programs (LTCOP) involvement in promoting culture change practices, offers tips for ombudsman advocacy, discusses the role of the ombudsman, including typical questions about participating in culture change activities, and lists salient resources.

For some LTCOPs, stretching to become more than peripherally involved in culture change efforts seems a questionable use of resources. Twenty years after the enactment of the Nursing Home Reform Law emphasizing individualized care and after a decade of various targeted efforts to achieve quality of care and quality of life for each resident, LTCO know that problems persist. Ombudsman programs nationwide continue to struggle to keep up with the need for individual advocacy and to address systems issues and provide public education. This paper is intended to help LTCOPs consider the potential to use culture change as a systems approach to achieve individualized care for residents. For LTCOPs already involved in culture change activities, this paper is intended to provide some new ideas and encouragement.

Joani Latimer, Virginia State LTCO, eloquently articulated why she believes devoting resources to culture change is consistent with the LTCO role. An excerpt from her remarks follows.

“In my work over the years, I have participated in so many meetings where the best minds and best advocate hearts have engaged in diligent and even impassioned struggle to find the ANSWER to this or that piece of the problem of care that falls far too short—stronger regulations, tougher enforcement, aggressive litigation, improved reimbursement, informed consumers… And I have this image of our frantically trying to apply a plug to the hole in one end of the ship only to see water pouring through another…And meanwhile, there’s hardly time to look up and notice that the ship is actually not moving toward the desired destination…

So, that’s why I believe nothing less than the sea change that’s involved in true culture change will make a difference.”

Culture Change
Culture change is a complete change in facility perspective and in practice. It is more than changing one practice, such as eliminating physical restraints or providing buffet style dining. It is much more than improving a quality measure such as pain or pressure sores. It is more than adding plants and animals. Changing one practice may lead to

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1 Presentation at the NCCNHR Annual Meeting, October 2006.
changing another area, then another, until transformation of the facility’s culture has occurred. One step may lead a facility into the ongoing journey of culture change.

A primary resource, “Ombudsman Best Practices: Supporting Culture Change to Promote Individualized Care in Nursing Homes,” provides a solid rationale for LTCOPs to engage in culture change activities and gives concrete examples from several programs. That paper defines culture change as follows.

“Culture change engages all facility staff in a total transformation of thinking and practice, instead of changing an element or a program within the prevailing culture. Changing the culture is a means to the end of building resident-directed approaches to care responsive to residents’ experience and needs.” p. 2

Recently there has been a renewed national dialogue about culture change and improving care practices. Clearly, LTCO cannot single-handedly instigate and implement culture change, only providers can do that. LTCO can be vocal advocates for culture change, sources of information, identifiers of good practices, and proponents of making culture change a reality. This paper offers updated examples and a rationale for LTCOPs to actively engage in promoting culture change.

**Background on Related Initiatives**

Since 2001 there have been several national and state initiatives focusing on different aspects of promoting good care practices which include individualizing care. The Nursing Home Quality Initiative by the Centers for Medicare & Medicaid Services (CMS) was one of the first to promote measurable change in selected provider care practices and education for consumers and advocates. A curriculum for LTCOPs was produced as part of this effort. Beginning in 2004, the 8th Scope of Work contract between CMS and Quality Improvement Organizations (QIOs) initially had achieving resident directed care through culture change as one of its objectives. There have been other initiatives undertaken by CMS through contracts with QIOs that focus on improving specific areas of care.

In addition to these efforts, other organizations have promoted improving care practices through workforce initiatives. National organizations such as the Pioneer Network, the Paraprofessional Health Care Institute, the Direct Care Alliance, the American Health Care Association and the Association of Homes and Services for the Aging, have actively promoted good care practices and better workforce practices—elements that are inextricably intertwined. The most recent national initiative is the Advancing Excellence Campaign which is a voluntary provider commitment to making measurable changes and to having the results accessible to consumers.

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3 National Association of State Units on Aging, developed by Sara Hunt, December 2002. Contact NORC to obtain a copy, (202)332-2275.

4 For more information, go to the NORC website, [www.ltcombudsman.org](http://www.ltcombudsman.org)
While these initiatives have achieved some positive results in resident care, one initiative does not accomplish culture change in a facility. An initiative may prompt a facility to begin an ongoing process that results in culture change where resident direct care is a pervasive norm.

II. A Sample of Current Ombudsman Activities

Several LTCOPs have been involved in promoting culture change for years such as Colorado, Illinois, Michigan, Missouri, and Washington State. The examples in this section are included to provide ideas and encouragement for other programs. There are innumerable ways that LTCOPs can promote culture change. Many programs have been engaging in culture change activities for years. This section features just a few examples of recent activities, other LTCOPs may be taking similar steps. Two types of activities are discussed in this section.

- Culture change activities where a total transformation is the goal are the first set of examples.
- The second set are activities focused on changing one or more practices, typically in conjunction with a specific initiative. The LTCOP involvement in these activities is using the opportunity to promote initial steps, hoping that the result will lead to a culture change journey for facilities. In reality it is taking systems advocacy actions, keeping in mind that this might provide leverage for long-term transformation beyond the stated objectives. These actions might lead to culture change.

The next section of this paper offers specific tips for LTCO action. As you read Sections II and III, consider what your role is and can be—encourager, collaborator, trainer, advocate, leader—in making culture change more widespread in your state.

Culture Change

Go to the top with partners.

In 2004 the South Dakota State LTCO, Jeff Askew, began building momentum for culture change by acquiring resources on culture change for use in teaching ombudsmen, conducting in-service training in facilities, and to loan to facilities. The LTCOP has a history of working with other agencies and programs to address long-term care issues. The focus on improving quality of care through the CMS contract with quality improvement organizations (QIO), provided the impetus for forming the South Dakota Culture Change Coalition including the LTCOP as a stakeholder group.

To gain visibility and a public commitment to transforming the culture of long-term care in the state, the coalition obtained a gubernatorial proclamation declaring 2006 as “The Year of Culture Change in South Dakota Nursing Homes”. The proclamation urges the leadership of all nursing homes “to join in a statewide effort to promote person-centered care for every elder residing in a nursing home.” This proclamation provided opportunities for educating consumers about culture change, for increasing publicity about culture change, for supporting nursing homes that are moving ahead with individualizing care, and for asking other facilities to begin moving from an institutional culture to one of person directed care.

LTCO Role in Culture Change
NORC, June 2007
The QIO contracted with the LTCOP to provide training for facilities participating in culture change initiatives. Each facility committed to sending a team to the series of meetings, thirty-two facilities and about two hundred individuals attended. There were five, two day, learning sessions over a fifteen month period. The LTCOP contributed funds to reimburse the travel expenses for participants. Although the statewide sessions have ended, ongoing dialogue and learning is occurring through regular, regional meetings of the providers, the QIO, and when possible, the Health Department (licensing and certification agency) and the SLTCO. Participating in the educational sessions with providers has improved the relationships between LTCO and providers. They share a positive focus and energy about changing practices. Contact Jeff Askew, (605) 773-3656, for more information.

Do your homework, be flexible, and use different approaches.

State Level

The Louisiana State LTCO, Linda Sadden, is one of the two contacts listed on the state website for culture change and is a co-author of the concept paper, “Bringing Culture Change to Louisiana Nursing Homes.” Thus, the program has established itself in a leadership position working to change providers’ practices to benefit residents and staff. One of the first major activities was to take nursing home administrators and staff, surveyors and ombudsmen on a bus trip to visit a Missouri facility where culture change was the norm benefitting residents and staff. Each participant, or their agency or program, paid for the trip. A representative from the Louisiana Health Care Review (QIO) and from the Social Work Department of the flagship university were also able to join the visit. Following this visit, the licensing and survey agency sponsored a culture change conference held in three areas around the state using civil monetary penalty funds. The SLTCO helped to plan the conference. Building on the momentum generated by the conference, a culture change coalition was launched. The coalition adopted the Colorado model—having providers in leadership positions, but making sure that the licensing and survey agency and the ombudsman program remained part of the project.

The local LTCO used a survey instrument adapted from the Kansas PEAK-ED\(^5\) materials to gather information from nursing homes about culture change. The survey covered the following topics: resident control, staffing, meals, community activities, and home environment. The specific questions under each topic reflected practices indicative of culture change. Information was gained about the level of provider knowledge, changes that were being discussed or that were underway, and perceived barriers to implementation. This process provided the impetus for LTCO to talk with providers about culture change in an organized and systematic way. In some facilities it became an educational tool and opened a different type of dialogue with the ombudsman. The results of these surveys are currently being analyzed by a university.

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\(^5\) Promoting Excellent Alternatives in Kansas Nursing Homes Education Initiative. Center on Aging. Kansas State University. [http://www.k-state.edu/peak/](http://www.k-state.edu/peak/)
Local Level Supported by the State
New Orleans: Workforce Issues Workgroup

Although hurricanes Katrina and Rita dealt a detour to the plans for advancing culture change, the setback also offered a new opportunity in the New Orleans area. Workforce issues were overwhelming. The idea for the project came out of the discussions of a Workforce Issues Workgroup which has no legislative mandate or formal structure. Convened through an outreach effort on the part of the Louisiana Health Care Review (QIO), the workgroup is comprised of organizations concerned with helping New Orleans nursing homes address the immediate staffing crisis caused by the devastation of the storm. Barbara Frank served as a support and guide to their deliberations. The group soon realized that some of the measures being considered in the desperation of the moment would have actually perpetuated the crisis, and they determined instead to look at workplace and management practices that could stabilize staffing for the longer term.6

Once the Workgroup identified their shared desire to find a path to recovery that would lead to lasting improvements, they received a grant to bring a team of consultants, including Frank, Cathie Brady, Marguerite McLaughlin, and Dr. Susan Wehry 7 to New Orleans every two months. Based on their work with CMS and the QIOs, the team began assisting individual facilities on-site and in a group setting using a collaborative learning style in November of 2006. The series of visits focuses on changing the workplace culture, adapting the work of Susan Eaton on *What a difference management makes!* to the circumstances in play as homes are still struggling with the aftermath of the storm.

During the on-site facility visits, the consultants talk with management and staff about what they are experiencing and what they need to be able to function under their circumstances. The State LTCO and individuals from the QIO, the Louisiana Nursing Home Association, and from Gulf States Association of Homes & Services to the Aging, make appointments for the facility visits and go with the presenters as note takers. The one on one time in the facilities may be the most productive in changing ways of thinking and practice. While it is clearly the hope that residents will ultimately benefit from this project, the key to provider interest and participation in these sessions is the focus on workforce issues, knowing that a stable workforce is necessary for good resident care and essential for individualized care and other culture change hallmarks. The lessons learned from the New Orleans Workforce Project will be shared through conferences held around the state. The project is supported primarily with civil monetary penalty funds. Contact Linda Sadden, (866)632-0922 for more information.

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6 Workgroup members: the LA Health Care Review, the LTCOP, LA Nursing Home Association, Gulf States Association of Homes & Services to the Aging, Department of Health & Hospitals: Health Standards Section & Office of Aging & Adult Services Administrator, the Haven Nursing Home, a leader in culture change initiatives, Barbara Frank, a Rhode Island consultant with expertise in workforce issues, LA Community & Technical College systems, LA Geriatrics Society, & the LA Board of Practical Nurse Examiners.

7 Barbara Frank (bfrank1020@aol.com) and Cathie Brady (cbrady01@snet.net) are co-founders of B & F Consulting, Inc. (401)245-0965. Marguerite McLaughlin is the Manager of Education Services with the Quality Partners of Rhode Island, (401)528-3259. Susan Wehry works with the Vermont Department of Disabilities, Aging, and Independent Living, Waterbury, VT, susan.wehry@state.vt.us.
**Other Local Areas**

**Southwest Louisiana**

The previously mentioned bus trip to the Missouri facility was the impetus for interest in culture change in southwestern Louisiana. Seeing the spark of interest spurred the regional LTCO Coordinator, Charman Cruseturner to act. The Calcasieu Regional LTCOP hosted an open house and long-term care health fair in May 2006. The fair included a panel presentation focusing on culture change. The presenters were the State LTCO, a representative from the QIO, a representative from the local office of emergency preparedness, and three nursing home residents, one of whom moved out of the facility and into the community through coordinated service efforts.

The health fair attendance indicated the widespread interest in continued dialogue about culture change in the region. The LTCO initiated monthly meetings with interested individuals. Participants choose a topic or a speaker, have lunch together, then conclude with a learning circle giving everyone an opportunity to speak. The group consistently averages eighteen to twenty-five different facilities, LTCO, and someone from the QIO participating in each meeting.

The LTCOP obtained a grant from a foundation to support a regional long-term care caregiving conference emphasizing best practices in long-term care and culture change in May 2007. The conference was entitled, “Synergy Energy: because we work better when we work together.” More than one hundred people attended including surveyors, LTCO, staff from sixteen facilities in the region and two facilities outside of the region, and community providers from the parish [county] and the state. It was a full day event with three national speakers and two breakout sessions each with four concurrent sessions.

Contact Charman Cruseturner, (337)474-2583, for more information.

**Northwest Louisiana**

In April 2003, the Shreveport LTCO staff attended a culture change workshop sponsored by the Arkansas State Long-Term Care Ombudsman Program. Eric Haider and Joanne Rader8 were the presenters. The LTCO left with an unrelenting desire to see Eric’s facility in Missouri. A visit to the facility in May 2004 provided the opportunity to “see culture change in action”. This resulted in the LTCO telling everyone about culture change and what a difference it makes in the lives of residents and staff. Mira Walton, the Shreveport (Caddo) LTCO Coordinator had a deep desire to find a way to share culture change with the facilities in her area through education and training. At the encouragement of the Area Agency on Aging director, Mira wrote a grant proposal for funding to support these activities.

While seeking a funding source, the impetus for further action was participating in the survey on culture change as part of the statewide LTCOP effort. Mira realized that some facilities had changed a few practices. The survey also reinforced the need for education

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8 Eric Haider, a pioneer in culture change, former Missouri nursing home administrator, founder of Person Centered Care Model, [http://www.idealnursinghome.com/](http://www.idealnursinghome.com/); Joanne Rader, RN, MN, founding member and Board member of the Pioneer Network, [Joanne.rader@worldnet.att.net](mailto:Joanne.rader@worldnet.att.net)
and training to enable culture change practices to be more widespread. The LTCOP received a grant from the Shreveport-Bossier Community Foundation to support four training sessions in 2007 for nursing home providers. The purpose of the sessions is to create a dialogue about culture change among providers and LTCO that will result in more widespread practices within and among facilities.

Every nursing home received a letter inviting them to participate and to send at least two people. The half day sessions are convened at the council on aging and has providers and ombudsmen attending. Each session has different speakers such as the QIO and a certified nurse assistant presenting information and sharing resources. Each session also has a local provider describing a best practice and how it was implemented.

As a result of the meetings held to date, some facilities have visited others to observe a featured best practice. Other facilities volunteered to increase their community interaction by delivering in-home meals for the council on aging, one of these facilities invites residents to ride in the van as the meals are being delivered. The LTCO hopes to continue these meetings next year. She views this work as planting seeds of ideas and encouragement. It is making a difference for some residents. Contact Mira Walton, (318)632-2090, for more information.

Persist until others join the effort and make something happen.

For many years, Joani Latimer, Virginia State Long-Term Care Ombudsman talked about culture change and the need for a focused effort in Virginia. After much perseverance the Virginia Culture Change Coalition (VCCC) was formed and hosted a training conference in November 2005. The State LTCO is the current chair of the VCCC. The VCCC has been working to “plant seeds” to spread understanding of, and momentum toward, culture change throughout the state. The VCCC is currently focusing efforts on growing regional culture change coalitions through regional seminars and events. For example, the VCCC is working with the Northern Virginia Long-Term Care Ombudsman Program and other advocates to conduct a regional culture change seminar in July 2007. In the fall of 2007, the VCCC will provide a session on culture change at the Virginia Coalition for the Aging’s fall conference. Similarly, the Virginia Elder Rights Coalition will devote its fall meeting to a presentation on culture change. The information about change and the impetus to change is spreading throughout the state.

In addition, Virginia’s LTCO Program spearheaded an effort in the General Assembly to pass a legislative bill and budget amendment calling for the Department of Medical Assistance Services (Medicaid) to form a task force to look at quality improvement in nursing homes. The Department’s Quality Improvement Program Task Force is charged with developing plans to use civil monetary penalty (CMP) funds to improve nursing home care. The State LTCO and other advocates are taking full advantage of their “seats at the table” to strongly advocate for the use of CMP fund to foster the kinds of comprehensive and deeply resident-centered change that significantly improves quality and that are at the heart of the culture change philosophy and model.
Systems Advocacy As An Initial Step
Target specific care areas, work with others, equip local ombudsmen.

California’s incidence of restraint use is twice the national average and the second highest in the country. Pressure ulcers also continue to be problematic for residents of California’s nursing homes. A coordinated effort to prevent pressure ulcers and minimize the use of restraints was needed to address these problems. Complicating these problems, culture change activities and person-directed care have been slow to take hold. A group of Local Area Network for Excellence (LANE) members, including Joe Rodrigues, California State LTCO, decided to target these issues by conducting a training session in seven locations throughout the state.

In 2007, “CMS/DHS Summit: Reducing Restraints and Preventing Pressure Ulcers” provided training for more than 1,500 individuals. This collaborative effort had leadership participation and presentations from the Office of State Long-Term Care Ombudsman; CMS Region IX, the California Department of Health Services; Lumetra, the California QIO; Clinical Specialist Joanne Rader; Aging Services of California and the California Association of Health Facilities. The target audience was skilled nursing facility staff and California Department of Health Services surveyors. The content on reducing and eliminating restraints and preventing pressure ulcers was presented in the context of culture change. It is hoped that the incidence of pressure ulcers and the use of restraints will decline and that more person-directed care will be realized in the state over the next year.9

To equip local LTCO to talk about restraint reduction with families and family councils, the State LTCO adapted an educational module from the Texas LTCOP and disseminated it to every local LTCOP. The intent is for ombudsmen to educate consumers about good care practices and to empower them to advocate for good care. This two pronged effort is designed to educate providers and consumers about restraint reduction during the same time period. Contact Joe Rodrigues, (916)419-7510, for more information.

Seize opportunities to promote person directed practices and to involve consumers.
Inform consumers and change expectations
The Ohio State LTCOP used the opportunity to participate in the Advancing Excellence Campaign to develop consumer information. The program’s message to consumers is “Expect Excellence.” This message is incorporated into information sheets for consumers who are choosing a facility, for resident councils and for family councils. This message is also being incorporated into training activities. The Ohio long-term care website for consumers has been updated to include the campaign message. The site says, “Residents and Families: Expect Excellence! Providers: Be Excellent!” The LTCOP sees its role as taking the message to consumers and is sending information to all volunteer LTCO about their role. The 2007 statewide LTCO conference will focus on resident and family empowerment and expecting excellence. The long-term care website is: http://www.ltcohio.org/consumer/index.asp Contact Beverley Laubert, (614)644-7922, for more information.

Provide a viable role for consumers

In Wisconsin, Heather Bruemmer, Ombudsman Services Supervisor, diligently worked to convince the LANE that they needed a consumer voice on the committee. The State LTCOP is a co-convener of the LANE. Every meeting begins with resident or family member input. The regional LTCO have been distributing a one page handout to families, residents, family and resident councils, and to providers about the Advancing Excellence Campaign. The regional LTCO are encouraging facilities to sit down with residents and families when choosing their goals for the Advancing Excellence Campaign. The consumer voice is critical in this campaign. The one page document for consumers can be found on the LTCOP’s website at: http://longtermcare.state.wi.us. The regional LTCO staff are also presenting resident and family educational sessions at long-term care facilities about person directed care and culture change. These educational sessions have brought increased awareness to families and residents in long-term care facilities on how to be proactive in their care and have a better understanding about what to expect regarding quality of life and care. The regional LTCO has empowered residents and families to be involved in their facilities resident and family councils. Contact Heather Bruemmer, (800)815-0015, for more information.

Apply principles to assisted living

The Washington State LTCOP developed a “Consumer Expectations Checklist” to help prospective assisted living residents and their families assess and evaluate facilities. Many of the items in the checklist reflect elements of culture change and various aspects of the state requirements for assisted living facilities. Because many of the items pertain to courtesy, basic dignity and human rights, other states might adapt the checklist even though the requirements may differ. The checklist is a good beginning point for making observations and for engaging providers in a dialogue. It can be accessed on the NORC website under the Assisted Living section of the Current Issues menu. Contact Louise Ryan, State LTCO, (800)422-1384, for more information.

Equip all LTCO to promote person directed practices.

Some of the ways that state and local LTCOPs have provided training and resources to all LTCO have been mentioned in preceding sections. LTCO must be knowledgeable about person directed care practices and culture change in order to incorporate this in their conversations with residents, families, and providers and in their advocacy.

Many state LTCOPs have had presenters on culture change as featured speakers at their statewide conferences or other training programs. Some states include this type of presentation on an annual basis, inviting other organizations such as the QIO and/or providers. A few examples follow although all of these states have exposed LTCO to culture change training for several years.

- Colorado: An administrator and a few other staff from the facility, including a CNA and four residents, discussed their culture change journey.
- Oregon: In addition to nationally known presenters, the conference had two Oregon administrators talk about the transformations in their facilities. One of the facilities was a small residential care facility.
• Texas: In one of the regular training meetings with the staff ombudsmen from the local programs, Cheryl Cordell with the SLTCOP, used the “Mr. McNally: finding the clues to person-centered care exercise.” After experiencing this exercise, each ombudsman received a set of cards to use in working with volunteer ombudsmen, consumers and facilities. Texas also introduces LTCO to culture change during certification training through Module 6, “Advocacy from Individual Complaints to Culture Change.”

• Florida: The State LTCOP recently gave every local program a copy of the educational CD-Rom and videotape of “Bathing Without a Battle” for use in training.

III. Tips For Long-Term Care Ombudsmen

Stay informed about culture change and person centered care.

• Check out available information and resources to learn and gain ideas. Begin with the NORC website, www.ltcombudsman.org and the NCCNHR website, www.nursinghomeaction.org. There are some excellent information sheets on the NCCNHR site that provide a succinct overview and others that apply culture change practices to specific areas of care. Read the “Ombudsman Best Practices: Supporting Culture Change to Promote Individualized Care in Nursing Homes” paper available through NORC. Go to the resource section of this paper for other major resources.

• Participate in free teleconferences and online training opportunities. NCCNHR and NORC offer conferences that are directly applicable to LTCO work. CMS is offering a series of web cast seminars featuring national experts and providers who are implementing person centered changes. The web casts are available for viewing for many months after the broadcast. Go to the resource section of this paper for more information.

• Read the Culture Change section of the NORC Gazette for LTCOP ideas and resources.

• Check out other online resources such as the websites of culture change coalitions in various states and the Pioneer Network’s website which contains several video clips related to culture change.

• Remember that changing one practice is not culture change. However facilities have to start with one step at a time. One change might provide the impetus and vision to engage in a culture change process. Pick up tips from related initiatives and stay focused on ways to encourage systemic, pervasive change that results in changing a facility’s culture.


11 The Texas training manual is available on the NORC website, www.ltcombudsman.org

Identify and support provider best practices in the facilities in your area or state.
- Look for examples of practices that support person directed care or that are indicative of culture change. Give sincere positive feedback and encouragement acknowledging that changing processes and practices is difficult. Look for practices in assisted living facilities and board and care homes as well as nursing facilities.
- If there are few facilities where culture change has begun, initiate a dialogue with individual facilities about culture change and person directed care.
  - Use a survey instrument or a focused activity such as the Louisiana LTCOP used.
  - Remind certified nursing facilities that they received a copy of the video/training guide, “Bathing without a Battle.” Ask facilities if they have used it. If not, urge them to find it and use it or to order another copy. [www.bathingwithoutabattle.unc.edu](http://www.bathingwithoutabattle.unc.edu)
- If no dialogue or educational forum exists among providers, initiate one to promote culture change and to encourage the facilities that are changing even one are of practice.
- Apply these strategies to assisted living facilities. Create a dialogue with individual providers or offer educational opportunities focused on applying the person directed care practices to the assisted living setting. Refer to the resources section for ideas about content.

Make culture change one of the continuing topics in LTCO training.
- Use providers in your state who are implementing changes as presenters.
- Use state and national experts on occasion as appropriate and feasible.
- Provide resources for LTCO to use in talking with providers and consumers or in conducting training programs.
- Include this topic in training for volunteers and paid staff.
- Encourage all LTCO to participate in conference calls, webcasts, and training conferences on this topic.

Join or create a dialogue or a focus on culture change.
- Join your state’s culture change coalition if one exists.
- Serve on work groups or committees or other options that may be part of a larger organization, such as an effort related to a QIO’s project.
- Use opportunities to create visibility for culture change ideas and information, similar to the way that the Southwest Louisiana LTCOP used the health fair.
- Even if you are the lone voice, begin talking about person directed care, make something happen, such as the Northwest Louisiana LTCOP did. Be the initiator.
- Include person directed care and examples of culture change practices in your presentations and in conversations with others. Work to make the expectation of person directed care the norm.

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13 This idea is from Barbara Frank’s (B & F Consulting) plenary presentation at the NCCNHR Annual Meeting on October 17, 2005.
• Identify other individuals who might be allies from community groups, organizations or agencies, including provider organizations.
• If a citizen advocacy group exists, talk with them about culture change and the potential for collaboration.

**Share information on culture change with consumers.**

• Use some of the NCCNHR Fact Sheets or other resources for consumers to provide information about culture change. Consumers need to know what some individualized care practices look like or how staff and resident interactions might change.
• Help consumers articulate their concerns in a constructive way while a facility is learning and transitioning from an institutional culture to a culture of individualized care.
• In discussing what to look for in a facility, either a nursing home or an assisted living facility, integrate some indicators of culture change and person centered care.
• Use every opportunity to help consumers ask for and expect individualized care.
• Help resident and family councils have a voice during cultural transformation within facilities and on broader levels such as a statewide or regional task force, initiative, or committee. If needed, provide background information and resources so that residents and families are prepared to contribute to the discussion.

**IV. Culture Change and Ombudsman Advocacy**

**Support in the Older Americans Act**

The Older Americans Act lists the responsibilities of the Long-Term Care Ombudsman Program. Among the listed duties are several that support ombudsman involvement in activities such as culture change.

State Long-Term Care Ombudsman Program

(a) (3) Functions The Ombudsman [State Long-Term Care Ombudsman], …shall, personally or through representatives of the Office -

(A) identify, investigate, and resolve complaints made by or on behalf of residents…;
(B) provide services to assist the residents in protecting the health, safety, welfare, and rights of the residents;
(H) (i) provide for training representatives of the Office;
   (ii) promote the development of citizen organizations, to participate in the program; and
   (iii) provide technical support for the development of resident and family councils to protect the well-being and rights of residents.

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Although the Older Americans Act does not specify “culture change,” LTCO can promote person directed care and changes in facility processes as part of complaint resolution. The other listed responsibilities are opportunities to provide information about culture change approaches and individualized care. Ombudsmen must work with other programs, organizations, and providers to achieve widespread results. Promoting culture change can become integral to systems advocacy activities.

**Support in the Institute of Medicine Report**

Support for LTCO leadership in culture change activities can also be found in the Institute of Medicine’s Report, “Real People, Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older Americans Act.”

Excerpts from “Systemic Advocacy Work, Exemplary Practices,” Table 5.8:

- “The program’s [LTCOP] systemic advocacy agenda includes items to improve the lives of residents and not merely to resolve identified concerns or problems in the LTC [long-term care] system. For example…improving the health care system’s overall standard of care…”
- “program’s systemic advocacy…is coordinated with others…so that broad-based coalitions, rather than the ombudsman program alone, seek systemic change”
- “Office has ongoing interactions with the full range of regulatory agencies with specific agendas to discuss plans for future actions at ‘pre-decision points,’ to plan and conduct joint trainings…and to maximize the different strengths, roles, and talents of each agency and the Office.” pp. 180-181

**The Role of the Ombudsman**

In deciding whether, and how, to become involved with culture change activities, LTCO have asked some significant questions about their role and the role of the program. Several of the primary questions are listed below along with responses from LTCOPs and other advocates who are very involved in working to promote best practices among providers. The following is a synthesis of dialogue from national meetings, conferences, and teleconferences. As you read the questions think about what role you have or want to have in advocating for culture change. What can you do?

**Leadership in culture change activities is the role of the State LTCO, isn’t it?**

To create and sustain change, efforts are needed at the state and local levels. State LTCO often contribute a policy perspective and work to create macro level changes, while local LTCO contribute specific examples of the needs of individual residents and families. Local LTCO typically have the strongest and most direct connections to consumers and to facilities.

*I have more individual complaints to resolve than I can handle, there is no time to work on culture change activities. Isn’t dealing with individual complaints more important than working on systems issues?*

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The Older Americans Act responsibilities related to systems advocacy pertain to both State and local LTCO. If LTCO wait until their individual complaint cases leave some extra time, systems advocacy will never occur. By changing systems, LTCO can have a positive impact on many residents. Culture change activities can impact many, or all, residents in each facility that begins with even one intervention or improved practice.

**If LTCO focus on culture change activities, who will address the problems in facilities? Is focusing on culture change the best use of our time given the chronic issues we deal with every day?**

All residents are entitled to quality services, not just the residents in facilities where culture change practices are being implemented. LTCOPs can continue to resolve individual residents’ problems and promote better provider practices that are consistent with individualized, person directed care.

**Is participating in culture change activities real advocacy? LTCO cannot force providers to change their practices.**

“The LTCOP is positioned to help providers see a situation from a resident’s point of view and thus make reasonable accommodations to promote their well-being. LTCO stand outside of the slow and arduous process of change and encourage it along. They can also get involved in ways that move it forward.”

Participation in culture change activities is systems advocacy. Unless LTCO participate, the resident’s voice may not be heard during the planning process. Consumer education and working with family and resident councils are all too often overlooked. LTCO can be encouragers, motivators, and a link between consumers and everyone else.

**Initiatives and campaigns come and go, yet problems with care remain. Why invest my time in something that probably will not last long enough to change daily life and care for residents in the worst facilities?**

Each public campaign offers a renewed opportunity for LTCO to promote lasting change while attention is focused on improving care practices. An initiative opens the door for LTCO to educate residents and families about good care, how to talk with providers about individualizing care, and to push to change public expectations about what can happen. As more facilities adopt person directed practices, the differences in facilities will become more visible. The long-term care system is complex, changing all of the facilities with chronic problems has not occurred despite numerous efforts. Withholding support until the worst facilities change is to deny the promise of the Nursing Home Reform Law to individuals in facilities where culture change can take root with encouragement and persistence. There is nothing wrong with seizing an opportunity to achieve or to create an expectation of receiving individualized care. LTCO work on multiple fronts.

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*LTCO Role in Culture Change*

*NORC, June 2007*
If the LTCOP becomes a leader or endorser of a culture change initiative that has providers as partners, won’t the LTCOP be viewed as “selling out” and losing its focus? The program’s credibility and public trust could be damaged.

LTCO are the voice of the resident, many times LTCO are the only participant whose sole focus is the consumer perspective. To make substantive changes in systems, the LTCOP needs to be a full participant in the dialogue. In some cases, the advocate or LTCO perspective has had a significant impact on the process. NCCNHR’s participation in the Advancing Excellence Campaign resulted in the adoption of a measure regarding consistent assignment of staff and another one on workforce retention. In Wisconsin, the State LTCOP’s insistence on consumer representation resulted in the addition of some consumers to the Local Area Networks for Excellence.17

The LTCOP always needs to be careful regarding its role and how that is publicly portrayed to gauge the potential impact on the program’s credibility. There are many ways to work with others, especially providers, without compromising the program’s ability to be a staunch advocate for residents. LTCO cannot significantly impact culture change and more widespread individualized care on a systems level without working with providers and others.

No one wants to talk about culture change. Everyone is focused on having enough staff. What difference does culture change make if there aren’t enough trained staff to provide care?

Culture change and workforce issues (staffing) are integrally connected. A stable workforce is a precursor to enabling individualized care. Several studies have shown that addressing workforce issues supports moving toward individualized care. See the resources section of this paper for more information. In New Orleans, Louisiana, workforce retention issues is the focal point for a discussion that the SLTTCO believes will ultimately benefit residents by allowing for a stable workforce and therefore better care practices.18 LTCOPs can continue to work on staffing standards and other related issues as they work on culture change.

It seems that I am the only one in my area who cares about individualized, person directed care. If providers are not being cited for deficiencies, there is no motivation to change. Where do I begin?

It takes just one voice to begin raising issues and pushing for change. Without that voice, change may never occur. Speaking out may lead to connections with other people who have similar interests but have remained silent. There are many available resources; several primary ones are listed in this paper. You begin by learning about person directed care practices, how they are supported in law, in regulations, and even by the survey process for nursing facilities. You can also talk with other LTCO who are involved to

17 Notes from the Advancing Excellence all for State LTCO, February 2, 2007. NORC.
18 Linda Sadden, Louisiana SLTCO. Conversation on February 17, 2007.
gain ideas in addition to looking at the tips contained in this document. Share the available resources with providers, licensing, the QIO, and residents and families.

*The assisted living and board and care regulations in my state do not require practices that are consistent with culture change. Isn’t talking about culture change in those settings futile?

No. Currently some assisted living facilities and board and care facilities are implementing the principles of culture change such as knowing each resident, building relationships between residents and staff, responding to the spirit as well as to the mind and body, and putting the person before the task. Because the principles of culture change are consistent with basic human dignity and rights, it is appropriate for LTCO to advocate for such actions in the absence of specific regulations. There are many ways to accomplish a goal. Refer to the Section V, Resources, of this paper for more information.

*Our program has no additional resources to support culture change activities. How can I be expected to add another “unfunded mandate” to my responsibilities? I would participate if someone else started the work and if there is sufficient time.

Start with small steps. Refer to the Sections II and III of this paper for specific ideas. If possible, seek additional funding to support a specialized effort. If LTCO wait until there is enough time and resources to support a major endeavor, many residents and families will not learn about better approaches to care and experiences of daily life.

*Is there one proven method of culture change that is best to use? What is the best process?

There are numerous models for implementing culture change. A few that are well known include Eden, Greenhouse, and Well Spring. The purpose of culture change is not to adopt “a model” but for a facility to engage in its own process of learning, analysis, and change. Culture change is frequently described as a journey.

Barbara Frank, a co-founder of NCCNHR, a long-time advocate for quality care, and a consultant with B & F Consulting, offered some comments to NCCNHR members about how to move forward with culture change. Her remarks, related to dining services and long-term care models in general, address the question about what approach works. Barbara offers tips for making sure that culture change results in substantive change.

“1. Let’s not push ideas on nursing homes. One size does not fit all. It’s more important for a nursing home to find out from those who live and work there what is working and not working about food service as it currently is, and what they would like to have happen. CAG’s [citizen advocacy groups or LTCO] would do better to promote a process of inquiry and collaborative decision-making where the people who live and work in the home figure out together what they can and should do differently.
2. Within each nursing home, it is more important to expand the possibilities than to substitute one rigid system for another. A 5-meal plan might work for some people and not others, may answer some people’s concerns and not others. What we are really looking for is individualized options for eating. So we would encourage the nursing home staff to find out for each resident who can tell us or who has someone who can tell us, what do you like to eat and when do you like to eat it? Eating is connected to other parts of the daily cycle, like when people like to wake up in the morning and go to bed at night. For some early birds, having coffee available early is going to be important, and maybe the ability for the staff on the unit to provide toast or muffins, something light to get the day started. For people who like to sleep late, can the unit make breakfast foods after the kitchen is finished with breakfast? Does the unit have a coffee maker, a refrigerator stocked with foods the residents like, a microwave and a George Forman grill? To have any of these things on the units requires electrical adjustments and that the standards for food handling and preparation are able to be met on the units. Same issues during the day and at night — are snacks that residents like available on the unit?

3. This requires decentralizing some aspects of food service and is a very challenging process for most nursing homes to undertake. It’s best to start slowly, pilot test the mechanics, trouble-shoot the safety considerations, and build up over time a capacity to undertake the transformation. This includes learning what people want and learning how to provide it and maintain oversight of all the issues relevant to safety and well-being.

4. Finally, change is most successful when there is a good process, that involves everyone, goes slowly but solidly forward, and meets the real needs of the people there with real ideas from them about what would work.”

V. Resources
There are numerous resources on culture change. The following list contains several primary sources of information. This is not a comprehensive list.

- National Long-Term Care Ombudsman Resource Center. (202)332-2275. A section of the web site is devoted to Culture Change and another section highlights Culture Change News. This site has numerous examples of LTCOP activities, best practices, other tools and resources for LTCOP, and links to other sources of information. A section of the Gazette features culture change activities. Issues are archived online.


- NCCNHR: The National Consumer Voice for Quality Long-Term Care. (202)332-2275. Information, fact sheets, and tools for consumers and advocates on multiple quality initiatives, resources from consumer calls discussing quality care, and links to many other resources. [www.nursinghomeaction.org](http://www.nursinghomeaction.org)
• The Pioneer Network. Learn about culture change in nursing homes and other aspects of long-term care, find resources, culture change information from states, and links to other resources. (585)271-7570. www.PioneerNetwork.net; blog: www.PioneerExchange.org

• Quality Partners of Rhode Island. Training tools and resources which are being used nationwide with QIOs and providers. An “Individualized Care Training Curriculum” is one of the resources on this site. www.riqualitypartners.org. Click on the nursing home section.

• Paraprofessional Healthcare Institute. Training materials to grow leadership and supervisory skills among staff. www.paraprofessional.org

• The Commonwealth Fund in New York City has a video on its website that explains culture change and offers visual examples of the change in progress. www.cmwf.org/topics Click on Care of the Elderly.

• Centers for Medicare & Medicaid Services, Sharing Innovations in Quality. The “Artifacts of Culture Change Tool,” is helpful in assessing an organization’s status on the culture change journey in addition to provoking ideas about next steps. http://siq.air.org


• Centers for Medicare & Medicaid Services. A four part series of broadcasts targeted to providers and surveyors is entitled, “From Institutional to Individualized Care.” This series began in October 2006. Each broadcast features national experts and has handout materials available to download. Previous broadcasts can be viewed for several months following the actual presentation. To view a broadcast, go to the CMS Survey and Certification Online Course Delivery System and register at: http://cms.internetstreaming.com

• North Carolina New Organizational Vision Award. The provider manual is a template for culture change focusing on workforce issues. Addresses care practices in nursing homes and in other long-term care settings. http://www.ncnova.org

• Eden Alternative. Tools can be found at http://edenalt.com/edentols.htm

• “Board & Care Quality Forum. A newsletter for small board and care homes.” Has published a series of articles on provider best practices in areas that parallel the culture change practices in nursing facilities, includes practical tips from providers. Reisacher Petro and Associates. (412)563-7330. www.bcqf.net; email: bcqf@msn.com
• Promoting Excellent Alternatives in Kansas Nursing Homes Education Initiative. (PEAK-ED) This site has newsletters and a variety of educational materials on culture change. Center on Aging, Kansas State University. http://www.k-state.edu/peak/