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Why and How Do Nursing Homes Implement Culture Change Practices? Insights from Qualitative Interviews in a Mixed Methods Study

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Abstract

Objective—To understand the process of instituting culture change (CC) practices in nursing homes (NHs).

Methods—NH Directors of Nursing (DONs) and Administrators (NHAs) at 4,149 United States NHs were surveyed about CC practices. Follow-up interviews with 64 NHAs were conducted and analyzed by a multidisciplinary team which reconciled interpretations recorded in an audit trail.

Results—The themes include: 1) Reasons for implementing CC practices vary; 2) NH approaches to implementing CC practices are diverse; 3) NHs consider resident mix in deciding to implement practices; 4) NHAs note benefits and few implementation costs of implementing CC practices; 5) Implementation of changes is challenging and strategies for change are tailored to the challenges encountered; 6) Education and communication efforts are vital ways to institute change; and 7) NHA and other staff leadership is key to implementing changes.

Discussion—Diverse strategies and leadership skills appear to help NHs implement reform practices, including CC innovations.

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Keywords

Nursing Home; Culture Change; Resident-Centered Care; Leadership

Introduction

> "…we're meeting with the residents much more often, and if the residents say, 'We want to go fishing,' then we're going fishing, and we'll figure out a way to make it happen."

American nursing homes (NHs) remain plagued by the view that they are impersonal warehouses carrying out rigid routines on frail older adults. Spurred by the National Citizens' Coalition for Nursing Home Reform (Holder & Frank, 1985) and *Improving the Quality of Care in Nursing Homes* (IOM, 1986), NH reforms were enacted in the 1987 Omnibus Budget Reconciliation Act to personalize NH care. This federal directive spurred the "culture change" (CC) movement that organizations such as the Eden Alternative, began to undertake, loosely organized by The Pioneer Network (Guastello, 2011; Koren, 2010; Rabig, Thomas, Kane, Cutler, & McAlilly, 2006). Since the 1980s, multiple efforts have sought to reform care of NH residents though barriers to organizational change in NHs are complex and multiple (Scalzi, Evans, Barstow, & Hostvedt, 2006) (Wunderlich GS, 2001).

The overriding framework of CC principles is to personalize care for NH residents and transform facilities from hospital-like to home-like environments. NHs are advised to relax the hierarchical staffing structure, focus on continuous quality improvement and resident preferences, and honor staff contributions with cross-training, staff decision-making and teams. Approaches to reduce the institutional nature of the facility (Harris, Poulsen, & Vlangas, 2006) include reducing the prominence of the nurses' station and eliminating overhead paging systems. In 2007, 31% of NHs indicated they had adopted CC practices "completely" or "for the most part" (Doty, Koren, & Sturla, 2008). However, which CC practices are implemented in NHs, and in what order, vary considerably among facilities (Chapin, 2006; Sterns, Miller, & Allen, 2010). Some preliminary positive outcomes are associated with CC efforts, including higher resident, staff and family satisfaction levels and lower staff turnover rates (Anderson, Corazzini, & McDaniel, 2004; Bishop, Squillace, Meagher, Anderson, & Wiener, 2009; Kane, Lum, Cutler, Degenholtz, & Yu, 2007; Loe & Moore, 2011; Lum, Kane, Cutler, & Yu, 2008; Rahman & Schnelle, 2008; Tellis-Nayak, 2007).

Understanding the processes by which NHs institute CC is important to its successful implementation. The Diffusion of Innovation (DOI) theory (Rogers, 2003) and the innovation process in organizations were used as a framework to understand how healthcare organizations and individuals may adopt and implement change (Rahimi, Timpka, Vimarlund, Uppugunduri, & Svensson, 2009). DOI and the innovation process characterize stages of readiness and describe the traits of early and late adopters and the processes by which change is accepted and implemented. In initial stages, organizations may decide whether an innovation is needed and how the change will match their needs. While some organizations are more ready to adopt innovations than others (early adopters versus

laggards), they must be convinced by peers, regulators or others that innovation will be feasible and beneficial for the organization. Those who are late in adopting change are theorized to have less financial resources and tolerance for undertaking the risk of new ventures. According to the innovation process, applying innovations in a flexible and incremental way as well as having a champion as leader are important components of change. As changes become implemented, and more people learn about the changes, momentum may build within the organization such that the changes may become more widely accepted and eventually routinized into normal practice. Since the Centers for Medicare and Medicaid Services (CMS) has supported the adoption of CC practices (Doty, et al., 2008), we were particularly interested in how nursing home administrators (NHAs) perceive the need to implement reform practices in their facilities.

Rationale for the study

The 64 qualitative interviews studied here were conducted as part of a mixed-methods study, and subsequent to a nationally administered survey of NH administrators (NHAs) and directors of nurses (DONs) which aimed to identify the prevalence of NH CC practices in US NHs in 2009/10 (Miller et al., n.d.). The purpose of the interviews was to understand ways that NHs go about implementing CC practices, from the NHA's perspective. Specifically, our research objectives were to 1) better understand which practices, if any, NHs choose to implement in their facilities; 2) learn about NHAs' motivations for instituting change; and 3) identify factors that aid and/or hinder the implementation of reform practices. The interviews help us to show how DOI is operationalized. From interview data we are able to describe how NHAs may introduce or resist practices associated with CC reform and the strategies NHAs use when implementing innovations. The findings emanating from this qualitative component of our mixed methods study helps us examine the implementation of CC practices given evolving resident needs, reimbursement constraints and policy requirements. Thus, it enriches our understanding of the opportunities, challenges, and practical strategies NHAs use when implementing CC practices.

After our survey of NHAs and DONs provided data about the prevalence of implementation of CC features, follow-up interviews provided insights regarding NHAs perceptions about the implementation of CC practices (Miller, et al., n.d.). Interview data reported here provide further insight into the applicability of DOI theory and help illuminate what motivates NHAs to institute reform practices. They provide NHAs' practical experiences regarding these changes.

Methods

Samples

This study consisted of a quantitative survey administered to DONs and NHAs from 4,149 U.S. NHs and follow-up qualitative interviews with a subset of 64 NHAs who had participated in the survey (Miller, et al., n.d.). The survey established a context of the growing prevalence of CC practices and the interviews illustrate dynamics of decision and implementation processes.

Quantitative survey

The survey questions were based on previously used questionnaires (Bott et al., 2009; Doty, et al., 2008; Mueller, 2007) regarding CC implementation. The questions were cognitively tested and revised before pilot testing and national fielding (D. A. Tyler et al., 2011) via online, mail, and telephone (Jobe & Mingay, 1989) (D. Tyler, Shield, R, Rosenthal, M, Miller, S, Wetle, T, Clark, M, 2011). The survey was sent to DONs and NHAs at a stratified, proportionate random sample of all Medicare and/or Medicaid certified U.S. NHs (N= 4,149); contact was achieved at 3,695 of these facilities. Cooperation rates (i.e., proportion of responses when contact with a NHA or DON was achieved) were 62.6% for NHAs (n=2,215) and 61.6% for DON (n=2,164), and 75% for either (Miller, et al., n.d.). CC scores were assigned to the NHA survey results to indicate the extent of CC implementation.

Interviews with NHAs

Our sampling strategy for interviews was to target NHs in states in each of the 4 major regions of the country, states with higher implementation rates of CC practices (Doty, et al., 2008), and included NHs with lower and higher levels of CC implementation and quality. We pilot-tested our semi-structured interview guide through interviews with three NHAs, following which we revised the interview guide. Questions in the interview guide were informed by the review of the CC literature. Using an interview guide ensured that the same questions were asked of each NHA in the same basic order. To start the interview NHAs were asked to relate what they had implemented to “improve the quality of care or life for their facility’s residents and/or staff, as well as any changes they had made to the physical environment.” By asking NHAs to tell their stories of these changes without specifying the subject of CC, we hoped to optimize the likelihood that NHAs would relate what was important to them instead of providing what they perceived to be socially desirable answers (Bernard, 2011; L. Curry, Shield, & Wetle, 2006). Interviewers were also blinded to the CC scores assigned to the NHA survey results.

NHs varied in size, ownership and chain status, and NHA tenure ranged in the length of time they served as administrators, with 20.3% of NHAs having less than 5 years experience and almost 16% with more than 25 years experience. NHAs reported an average length of tenure at the specific facility of 9 years (standard deviation 17.7 years). Half of the NHs were part of a chain, and 45.3% of the facilities contained 100 or more beds. The majority of NHAs worked for a for-profit facility (70.3%) (See Table 1). Almost 60% (110) of the 110 NHAs who were contacted completed the interview.

The interviewers asked whether and how changes were implemented; assistance received and corporate, staff, resident or other resistance possibly encountered; strategies in overcoming cost, physical plant or other obstacles; and whether changes were considered worthwhile. [See Appendix A for the interview guide.] Each interview lasted approximately 30 minutes. Three team members conducted the 64 interviews. Interviews were audio-taped, transcribed and reviewed by interviewers to ensure the accuracy of the transcription. The Institutional Review Board (IRB) of Brown University found the research to be exempt from IRB review since data collected contained no personal information, only information about the nursing home and its practices.

Analysis

In a modification of grounded theory analysis (Glaser BG, 1967), we devised a provisional coding structure based on our semi-structured interview guide to analyze the interviews (Crabtree, 1999). We modified the coding structure to reflect the content of the interview material elicited. First, two team members developed a preliminary code structure by which labels are applied to salient text. This structure was finalized by the full analysis team [see Coding structure in Appendix B]. Revisions to the coding scheme and decisions about codes were made by team consensus and previously coded transcripts were re-coded for consistency. Multidisciplinary team members (a medical anthropologist, health services researcher, two sociologists, and a social policy researcher) each separately read through and coded each interview transcript with codes that characterized segments of text, and then met to reconcile coding decisions in twice-monthly team meetings. The qualitative software program, Atlas.ti (www.atlasti.com), was used to help organize the interview data. As transcripts were analyzed, team members discussed preliminary themes from transcripts. We employed implicit interpretation and comparison to identify and determine themes from the coded material in an iterative process (L. Curry, Shield, R, Wetle, T, 2006). We then searched for competing interpretations to enhance the rigor of the choice and wording of themes. An audit trail of team decisions was kept throughout for the team to review coding and theme decisions.

Results

Seven overarching themes were devised to exemplify the major points from the interviews. 1) Reasons for implementing culture change practices vary; 2) NH approaches to implementing culture change practices are diverse; 3) NHAs consider resident mix in deciding to implement practices; 4) NHAs note benefits and few costs to changes of implementing CC practices; 5) NHAs describe challenges and strategies; 6) Education and communication are vital; and 7) NHA leadership is key to implementing changes (See Table 2 for list of themes). Quotes are selected to represent the themes below.

Theme 1. Reasons for implementing culture change practices vary

NHAs indicated various motivations for instituting changes, including their facility's mission, demographic changes, market factors, satisfaction surveys, and state-driven quality improvement efforts. Some NHAs spoke about systemic change while others focused on more superficial changes. A mission-driven reason more reflective of systemic change was:

> …we have a program…kind of like our culture change…which… helps integrate the staff more with the residents. And it helps us to become more resident center[ed]… we do a lot of things spiritually in the building, like having grace before meals…the mission in ministry... it sort of guides us in the direction that we go in.

Another NHA offered a "quality of life" rationale:

> I remember going in the shower room and there was more than one person in there. You know, dignity and privacy issues. I was always a private person and I thought, man, that's not right…

NHs responded to staff surveys and to resident council feedback, "focusing on satisfaction and what the residents want…not what is convenient for the organization." Others noted a financial motivation:

> … the basics… First rule is that we always take care of the resident… ask the question, "How is the resident going to benefit from this?" If they would benefit… then by all means, you do that… Second rule… is that we always take care of each other … everybody's needs are getting met… the owners' needs… the banks' needs…

NHAs noted a desire to modernize their facilities and institute state-required quality improvement efforts following sub-optimal inspections. This NHA spoke about physical improvements and teamwork.

> … our last survey since we've made these changes was very, very well. The surveyors saw a very big change in how the staff attitudes, the quality of care, you know, how the residents were reacting … you need to have teamwork and if you don't, I mean, you're really not going to be successful. Everybody has to be pulling at the same strings… which is a goal of making our residents happy...

One attributed dining improvements to "… what the state and federal government want…" Others cited state and corporation encouragement:

> …a corporation saying, you know, "This is kind of what our expectations are. This is a goal. You know, we want the facilities to you know, head into… the direction." Our state [is]…kind of hitting culture change hard.

One said, "Part of it is too is that the state regulations and stuff are driving a force to culture change to try to incorporate more of a homelike environment." Another added,

> … over the last couple years, our company, in general, has been really preaching and practicing resident centered care. And that's one of our goals that we've tried to implement and accomplish.

The variety of reasons that motivate change is complemented by multiple ways NHAs implement the process.

Theme 2. NH approaches to implementing culture change practices are diverse

Interviews indicate that new practices were not necessarily implemented as a whole package, following coordinated programs like Eden or Wellspring in which adoption of systemic change might be more likely; instead, practices were selected according to specific needs and desires of the NH.

Dining improvements and Physical Enhancements—Accounts describe various and incremental approaches to change in dining improvements, physical enhancements, activities or staff changes:

> Well, we've instituted a dining program ... we've purchased dining room tables and chairs that you know, go with it and have, we're updating our china… [also] we've

> redone our resident recreation area rooms … more homelike seating… a little more appealing.

One added artwork and comfortable couches, “to give the whole facility a more homelike appearance.” Another described ambitious physical changes:

> Like wall coverings and floor coverings, new ceiling tiles, updated call light systems. We now have a … page that’s sent through a wireless system to the nursing staff … I mean, just the noise level in the facility, that’s had a huge impact. We put in all new central bathing areas for our residents, new dining and activity areas, renovated nurses stations, lounge areas, so pretty much the entire facility’s kind of had a facelift.

Others reported smaller changes:

> Little things… not wearing bibs, using napkins instead of bibs, cloth napkins, improving some of the common space for families… for private visiting and playing games with their loved ones…

This NHA reported dining choices and expanded hours:

> … we’ve implemented the buffet breakfast… to have the French toast or the waffle or the whatever… and we’ve loosened up the hours… so they don’t have to get up at 7:00...

Staff changes—Others spoke about assigning the same CNAs to residents, or consistent assignment:

> … the biggest thing and the first thing that we did was to implement consistent assignment for the CNAs, the Certified Nursing Assistants.

Benefits of this CC practice which embodies the person-centered essence of culture change, in which the individual is “known,” were cited:

> …we maintain as much as possible, consistent assignments, particularly with team leaders, so the same staff is with the same group of residents week-in, week-out… you develop a personal relationship with the residents… and identify changes in conditions that would be possibly more subtle than it would be if you were rotating staff.

Starting the change process—How the changes were instituted also varied. One NHA “pull[ed] together a culture change committee with residents and staff” for input. Starting small was a common mechanism.

> Paint is such a fast easy way to clean something up… if you do a small project, one room, not every single room… make it your model. Then everybody can see it, and buy into it and… then suggest changes and then you can do another room…You have to get everybody onboard.

Starting with the simplest items was also noted.

> …we changed the easiest things first. Like five people wanted to get up on the 11 to 7 shift … [and] whether they wanted the bath or shower. The CNA is now aware… it's given at the day and time that they prefer… it was a big process… when you have a hundred people to do but that was one of things that was easier to do.

Theme 3. NHAs consider resident mix in deciding to implement practices

NHAs noted a mix of residents, including short stay residents with dementia, those with subacute and rehabilitation needs, and baby boomers. This NHA explained the facility's philosophy for dementia care:

> …our mission is to try to maintain the abilities and quality of life of our residents for as long a period time as possible… toward the end of life… with palliative treatments to keep the resident as comfortable as possible up until… the good Lord takes them away… we're different in what we do…

A continuing care retirement community NHA related CC practices to their "wellness" goals:

> … we are constantly triaging family members from the independent side of the house to the health centers that we operate as assisted living and skilled, and there are people in transit all the time… [this is] a continuation of our wellness philosophy that really creates the opportunity to live as well as you can for as long as you can.

One NHA explained the facility's more flexible bedtime hours was "keeping up with the culture change movement" with "a lot more alert, oriented, short term residents… [who] don't want to go to bed at 7:00 and watch Wheel of Fortune." Another said,

> … with the baby boomers coming around…they're going to want Wi-Fi… not a bathroom, but a spa… if you're not moving forward, you aren't going to get much of the pie.

Some were explicit about their financial motivation for resident mix:

> You have to attract the Medicare Part A resident because the Medicaid rates don't even cover our cost, so that's it in a nutshell. And the better marketing you can do… to bring in… the Medicare, then you will have… a better cash flow, to do things… to make it more attractive.

Another respondent noted the importance of the private pay client:

> …they're demanding customers. They're writing us a hefty check every month and I want to please them. You know, they're my first class… passengers on the airplane. We want them to be happy… they get to sit first and they have a drink in [their] hand while we're still waiting in the line …The first class people is all the profits...

One NHA summed up the rationale for instituting CC practices for the short stay and private pay resident by saying, "What I mean, part of the culture change is just market conditions..."

Theme 4. NHAs note benefits and few implementation costs of implementing CC practices

NHAs revealed that implementation of some features was relatively easy, while others noted fewer costs than they had expected. The following change was not costly and had an immediate positive impact:

> We've implemented happy hour lately, and the residents said to me … when we had the first one, "This is the best thing we ever did"… Just doing simple things like getting the grill going outside and the weather permitting, we can get out there and cook some hamburgers or some hotdogs… it's really driven by resident choice…

Regarding financial concerns, one NHA said, "Most of its cost has been pretty negligible." Another said:

> …you just take money and use it for different things so one month, you know, we'll spend a little more money on paint and white boards and you know, that comes from maintenance and office supplies funds. So just creative use of your budget...

An NHA described how costs were equalized in replacing bibs with napkins:

> Like we changed our, what was called a clothing protector, which looked very much like a bib and… we actually bought napkins and we used the budget that we had for our bibs… we actually bought *linen* napkins… so a lot of the budget was there.

Steam tables for the skilled unit had the added benefit of reducing waste:

> …all I had to do is buy some, you know, $10, $12,000 dollars worth of equipment. We set it up like a steam table… they can smell the food, they can see it on the steam table … they feel like hey, I really do get a choice... And there's not as much waste of food and, and then… it looks better because they can smell it already…

On the other hand, some noted that costs and physical plant constraints were considerable, a theme addressed next.

> … there's a lot of the newer nursing homes… they've got different facilities on each wing where they would have a kitchenette or something, and we don't have the finances, nor do we have the room … so all we can do is work with what we have and try to improve …

Theme 5. Implementation of changes is challenging, and strategies for change are tailored to the challenge encountered

Challenges—NHAs recounted difficulties in implementing changes and tactics they used. Challenges included staffing and resident issues, the physical plant, costs and union pressures.

Staffing and resident issues—One NHA said that state, NH associations and CC organizations were not always realistic in their recommendations:

> … you always get the feeling that they haven't really been in the trenches. Or they don't quite understand when implementing these specific areas or different tasks… working with human beings, it just isn't like when you're writing some kind of thesis in a book. That human factor is never accounted for…

Another said:

> It's hard to get there. And sometimes you feel like you don't have the resources… you know, nursing homes get staffed lean and mean, and administrators and managers are all expected to do a lot of things. And then you go, okay, well, now let's do culture change on top of regulatory compliance and keeping our families happy and keeping our residents happy. It's hard to fit it all in, and it doesn't always work the way you want it to.

One NHA noted how staff members perceived a need for more staff:

> Challenges that we've probably had immediately after we said we were turning the switch and going towards more resident centered care or culture change… I guess the challenge I kept hearing from the staff was, "I thought we were getting more help."

Among the most difficult CC tasks reported is staff empowerment and job restructuring, and the quote illustrates the basic challenge of doing more than superficial change:

> … we've thought about changing some jobs… one of the concepts now is that you have people that work on the unit that are all things; you know the nurse, the CNA, the housekeeper, the dietary, in these sub-units. But we haven't really got to that yet. We're thinking about it, but I can't see my way through to that, clearly see how I would do that.

Staff resistance was another barrier:

> We have a lot of long term employees, which is good and bad because they've done the same thing, the same way all the time… nobody really likes change. So that was a challenge, but I think we had enough people and we took our time doing it.

Residents were also cited as sometimes unwilling to change though they may have been disagreeing with specific practices:

> And I still work with the residents because they had what we call cover-ups with bibs. I tried to get rid of those and that didn't go… I tried to go with the linens and napkins and things; nope, they still wanted those cover-ups [laughs].

One challenge was accommodating residents during physical renovations:

> Throughout the year-long project, we renovated the entire facility. A huge undertaking when … it's occupied construction… this is their home and trying to relocate them while we did the renovations to their room [was difficult] but well worth it. It's a huge impact for the facility.

Facilities with a large resident and staff population pose unique obstacles:

> …it was a very large facility, and if you picture a large boat that's trying to make a turn in the water, you can't just make a sharp turn.

Union difficulties and "a certain mindset about…my job description and you're not going to change me" were claimed as reasons for the lack of progress in instituting change:

> … The union contract doesn't allow universal workers… we can't have nurse aides who help with laundry because in the contract it states that the nurse aide can only do their own duties.

NHAs also related their strategies for overcoming barriers. This NHA was motivated to re-imagine staff jobs because of funding constraints.

> … I really expect everybody to think outside of their own job description, and there has to be overlap between what everybody does… this is a tough regulatory environment, and you know, the majority of my residents are still Medicaid residents so there's… a limit to the funding available. So we all have to pitch in and cross over the line. Get comfortable with going out of our job description in order to keep the building running as smoothly as we can for our residents.

Strategies for change—In response to staff resistance to instituting consistent assignment this NHA reported a mechanism that helped overcoming staff reluctance:

> We had the CNAs for the residents' care needs; we had the CNAs draft up the assignments for the parties, not knowing what assignment that they would get… there was some ownership in that process…Now we're two plus years past… most of the CNAs like it…

Some NHAs were financially supported by their corporation or received assistance from state and other organizations. One suggested,

> …you can maybe get a grant, find a grant writer… I know the state of Minnesota has some grants; they're like $200,000 or community nursing homes or community health care improvements… you could get some grants, you know, do some fund raising.

Another received a grant, "to make some improvements related to improving quality of life," and,

> … we acquired a 12-passenger van; we call it "wheels to the world" and we use that to take the residents shopping, out to lunch, Christmas lights, Wal-Mart trips, anything that's really kind of a normal function of life. And we have a little trust fund set up that families donate money for gas and for buying a meal…

Beyond financial considerations, NHAs spoke about the advantages of taking small steps. One said, "Look for the small wins and begin with a strategy that gets you wins where your staff can see the benefits of doing it." Another said,

> It's not like you have to go out and buy everything at once, and do everything at once. You just slowly do it. You know, we got a steam table for that dining room… a used one at first… from another campus. And then, you know, you start picking

> up the things you need… maybe it might cost a little bit over the long-run, but short-term, it doesn't affect you that badly.

A strategy was to include key people at all staff levels in planning.

> Make sure you have the right players sit around the table. That's probably the hardest part. You can't just go change a practice of care or change an activity without involving the other disciplines. Because really everything we do is interrelated, and it all affects the other departments… make sure you have the right players sitting at the table.

In emphasizing broad and empowered staff involvement, NHAs cited the primacy of education and ongoing communication, described next.

Theme 6. Education and communication efforts are vital ways to institute change

NHAs recommended including all levels of staff in ongoing communication and education regarding CC: "I think number one, it starts off with having a good relationship with your staff."

> … Everybody from the administrator to the housekeeper to the lobby worker that all understand the concept, what you're trying to do. That's number one… And then you know, meetings and that's fine, but they got to understand the whole concept at first.

Another stressed:

> … you need the input and the feedback from the CNAs. You know, you have to involve them, you need to.

NHAs talked about input from residents and families. One said, "There's no bad ideas, you know, there's always ideas to consider." Another noted,

> … if you listen to the residents… Culture change is from the people that live here, work here. That's where your culture change really is.

Another said,

> … so many times we try to put programs out there of what *we* think they want, and it would save a lot of people's time and headaches if they would just go to their residents first. I mean it has to be resident-driven.

Ongoing communication helped maintain involvement and keep everyone posted.

> Tell your story every time you get a chance, you know, and then keep people updated, you know, that's the other piece because, like I said, out here sometimes things take a long time, and then they're wondering what's going on. You've always got to keep people updated.

Another emphasized communication to "keep them excited about it."

NHAs also reported that they learned from educational seminars, conferences and materials. One "purchased some training materials from the Pioneer Network… for everybody, the

staff, the residents, the families… to promote and try to keep them as informed as possible." Another said,

> I've been to conferences on culture change, and I'm now sending my staff. I've got six staff members who have been to Eden Training.

Another recommended going to, "seminars put on by the state to discuss culture change initiatives and to come up with ideas." An NHA said,

> In fact, this particular state is doing some very good work around advancing cultural change and so… our leadership staff has been to conferences. These strenuous communication and education efforts seem to be components of successful leadership.

Theme 7. NHA and other staff leadership is key to implementing changes

In their accounts, leadership and attributes of receptivity, flexibility, partnership and decisiveness are central to implementing NH reform. An NHA echoed others: "Get staff involved on day 1, day 1." Another said, "You just have to jump in":

> … what helps is the style of leadership that you have with your staff and you know, I've always been a firm believer in that team approach.

Leadership can be fostered in all, some indicated:

> …we have a leadership team, which is comprised of front line staff, us, most of the CNAs… trying to make their workplace a better place to work… my staff, my LPNs know that, you know … we stand behind them in their decision making… frontline staff… also know … if a family asks something of them, they don't have to get approval before they can do something if they know that it's the right thing to do.

Another NHA stressed aspects of leadership, such as flexibility, taking ownership and utilizing creative thinking:

> You have to truly think outside the box because a lot of these things are doable, you just got to be willing to take change and accept change, and somebody's got to be willing to be the driver to see that these things happen because it's so easy to fall back in that trap of, "oh, we can't do that because," or, "that won't work because" … and just try it, and then you'll be so impressed because you'll be, like, "man this did work, let's do something else," and then you begin to get excited...

Other NHAs spoke about the necessity of adaptation.

> I guess the best thing that I was, and this is something that I had to learn, is to be flexible and to kind of allow the process to guide you versus you coming up with a preconceived notion of how it should be. And kind of set goals and to be fluid that and allow you know, what the residents and staff are telling you to be incorporated into that plan.

Another's advice emphasized a step-by-step approach:

> … be patient, think things through, and let your staff kind of guide the way. You know, if they're ready to make a big change then make it, but if they're not ready to make the big change, you know, do small things first… set realistic goals… go from one thing at a time until your staff is ready to make the big plunge into it. You know, because if you have to force somebody to do something, it's just not… going to work. Everybody has to have a say in it; that way they're comfortable going through that door. So.

Discussion

The interviews with NHAs describe their approaches to improving quality of care and life suggested by the CC movement. Interviews reveal how NHAs implement changes in the face of increased regulations, tightening reimbursements, and a diverse and frailer elderly population. Interviews provide insight into their varied and practical approaches to change. This account solidifies the observation regarding the numerous ways NHs implement reform and other preliminary mixed methods research (Chapin, 2006; Rosemond, Hanson, Ennett, Schenck, & Weiner, 2012) that indicates leadership and facility-wide communication are vital to successful change efforts.

As suggested by the framework inspired by DOI theory (Rogers, 2003) and the innovation process in organizations (Rahimi et al., 2009), NHA interviews reflect a range of approaches to CC implementation and surveys indicate considerable acceptance of these practices (Miller, et al., n.d.) While some NHAs seemed to be early adopters of the innovation (Rogers, 2003), wholeheartedly embracing the philosophy and practice of CC, others used incremental implementation to carefully fit new practices into their facility routines within specific needs and constraints of their organization. Their approaches reflect a refining and restructuring process typical of the first stage in the implementation of innovations in organizations (Rahimi et al., 2009). The strategy to be flexible and selective seems integral to their acceptance by the organization. Interviews also provide evidence of how successful implementation can be aided by external expertise and financial support, whether from states, corporations and outside leadership, to foster the more wholesale adoption of CC practices and change.

The interviews are also revealing in topics that NHAs did not address. Though asked about employment changes, staff empowerment and resident decision-making, their lack of content about these areas may indicate the difficulty in making systemic change that challenges the fundamental institutional nature of NHs and the existing patterns of conducting NH care. Some staff members as well as NHAs may also be resistant to job restructuring efforts that may diminish their authority or require more responsibility. Though some NHAs in this study note that union presence may be a barrier to some change, unions do not always resist innovation (Rosenberg, 2005) and job satisfaction from reorganized work practices aligned with culture change has also been reported (Bishop, et al., 2009). NHAs also noted the changing population of NH residents, including those with cognitive impairments, those who are of the Baby Boomer demographic and the Medicare skilled population. They reported that short stay and private pay residents are more financially attractive to NHs than long stay residents, and many attempt to maximize the financial

opportunities in these populations. In addition to their sensitivity to these financial incentives, interviews document NHAs' perceptions that today's residents are more technologically proficient and demanding as consumers.

As NHAs market to the short stay population, the CC movement strives to institute person-centered care and "homelikeness." While the creation of a homelike setting can contribute to a therapeutic environment to aid transition home, our respondents did not bring up this point in interviews. The growing recognition of the benefit of good relationships between older adults and those who care for them (Piercy, 2000) are thought by participating NHAs to be aided by practices such as consistent assignment. Narratives also show that while individualized care practices and amenities align with the CC movement, they may spring from different motivations. While the CC movement seeks to make the NH more of a home, strategies to maximize the short stay and private pay sectors enhance an amenity-driven model more like a "hotel" than a "home". Since NHAs sometimes labeled their new initiatives as CC practices, it is worth asking whether motivations for person-centered practices matter when derived from CC principles or from financial considerations if processes of care improve as a result.

Interviews showcase successes of varied and incremental changes, with some NHAs incorporating new paint colors in corridors, others instituting flexible dining choices and bathing or sleeping hours, and some adding Happy Hours (Brannon, Kemper, Heier-Leitzell, & Stott, 2011). NHAs describe their challenges and their responses to hurdles. While narratives describe positive responses by staff, residents and families, more qualitative and mixed methods research is recommended to help illuminate which specific practices lead to which outcomes, and how. More research is also needed to understand obstacles NHs face in staff turnover and impediments to resident decision-making (Robinson & Rosher, 2006). Prime among NHA approaches is the importance of education and ongoing communication with residents, families, and staff members. Finally, the importance of vision in administrative and team leadership seems key to successful implementation of change. How decisions were instituted depended on the leaders being communicative, responsive and flexible in adapting to unforeseen circumstances, inevitable in the change process.

While a concerted attempt was made to sample NHAs from throughout the US, 64 NHA interviews are ultimately not representative of all NHs in the US. In addition, by agreeing to speak with us, NHAs may have been among the more successful in implementing reform measures. The interviews are a robust number by qualitative standards, and in conjunction with the national quantitative survey (Miller et al., n.d.), their in-depth exploration of the attitudes, experiences and perspectives of NHAs afford us insight into why and how NHAs implement CC practices in NHs. We elicited only the NHA view of CC implementation within the NH; interviews with residents, families and staff would enhance insight into the complexity of introducing NH reform as well as the impact on teams and jobs (Yeatts & Cready, 2007). Finally, it is not possible to judge the extent of success by NHA account alone since asking respondents to relate practices of which they are proud may not elicit their stories of failures. Nonetheless, in asking for the obstacles they encountered, respondents described multiple barriers in their quest for improvement.

Overall, interviews illuminate motivations, obstacles and strategies by which NHAs respond to the CC movement, and describe practical application of implementing reform. These narratives provide insight into creative strategies that NHAs have marshaled to overcome human resistance and practical hurdles, and they underscore necessary leadership traits to emulate. Their words can provide example and impetus to help overcome hurdles to improve care and enhance life for NH families, staff members and most importantly, for NH residents.

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Appendix A. Administrator Interview Instrument

INTRODUCTION

As we mentioned in the email/fax we sent you, we are asking you about some of your facility's practices. We want to know how you decided to implement these practices, what

helped, and what the hurdles were—and finally, whether you feel it was worth it to make these changes. Most of all, we're interested in hearing *your story* and in showcasing the practices you're proud about. I want to stress that there are no right or wrong answers.

INTERVIEW

We're following up on the survey you and/or your DoN completed a little while ago. In this interview I am particularly interested in hearing about any important practices your facility has implemented to improve quality of care or life for your facility's residents and/or staff, including any changes made to the physical environment of your facility. **Would you describe any practices or changes you have implemented to improve quality and tell me what it's been like?**

If the following related to resident-centered care are NOT addressed in story:

- How were the changes implemented? Who was mainly responsible?
- Why were changes implemented?
- Who helped? Outside workshop? Consultants? Other training? For whom? Using a model?
- Were there changes in staff jobs, including supervisory roles?
- How did long-employed CNAs respond? What about new CNAs?
- Is CNA supervision different since the changes? What about changes for staff empowerment?
- What has happened to make for more resident-centered care?

If practices WERE IMPLEMENTED, what helped FACILITATE the changes and what BARRIERS did you encounter? PLEASE TELL THE STORY.

If the following NOT addressed, add, you didn't mention…

- The training needed' Whether there was resistance, from staff, board, chain, or from physicians; The costs involved
- The physical structure you have; The kinds of units (e.g., sub-acute, dementia)
- What about regulations?

For these, What was it about [e.g., **THE TRAINING]** that made it easier or harder to do?

If mostly positive or negative… You've mentioned a lot of (e.g.) **barriers**; have there been any helpful things you want to mention? (or vice versa)

Was there something that stood out overall that HELPED or HINDERED your efforts?

HAS IT BEEN WORTH IT? Please elaborate on why or why not. Please give EXAMPLES…

- Has resident care and/or quality of life improved? Did any costs increase/decrease?

- By about what percent did costs increase/decrease overall?
- Has staff retention been affected (CNAs or licensed)? Has it affected recruitment of new staff?

Note any documentation of changes; e.g., turnover rates, cost data, problem lists…

_____ _____

_____ _____

What advice would you give to a nursing home wanting to implement quality improvement initiatives, or what some people refer to as culture change practices (perhaps something you didn't know before you started)?

Is there anything else special you'd like to tell me about how your facility improves resident care or quality of life? How did it happen? Were there challenges/facilitators?

We appreciate what you've told us. It sounds like you have some great practices.

If interviewer believes there are any practices related to resident-centered care, staff empowerment and/or home-like environment, ask the following:

To conclude, on a scale of 1 to 5, where 1 is not at all, 5 is very much, and 3 is neutral:

1. Have the practices you've described in this interview helped you achieve regulatory compliance?
2. Have they helped you reduce costs?
3. Have they helped you increase the number of Medicare patients here?
4. Have they helped you acquire a bigger market share?

Thank you so much for participating in this interview. Talking with you today has been tremendously helpful.

Interviewer assessment of the facility's culture change practices:

1= not at all, 5= very much

DOMAIN	RATING
Resident-centered care	
Staff empowerment	
Home-like environment	

Appendix B CODING STRUCTURE

I. Decision factors for quality improvement practices (General, not below; e.g., cost, mission, physical plant)

- **a.** Market-driven (e.g., marketing, competition)
- **b.** Responses to nursing home populations (e.g., short-term/rehab, dementia, bariatric)

II. Implementation & management strategies & styles (General, not below; e.g., meetings, satisf. surveys)

- **a.** Process of implementation (e.g., first steps, role of individuals, leadership factors)
- **b.** Educational resources (e.g., training, conferences, consultants, literature, toolkits)
- **c.** Financial, regulatory strategies (e.g., grants, policies, waivers)
- **d.** Communication (e.g., obtain input, share decisions, share progress)
- **e.** Physical plant
- **f.** Next steps

III. Barriers & ongoing challenges of implementation or impact (General, not included below)

- **a.** Individuals (e.g., staff, family, residents, physicians, other)
- **b.** Regulatory barriers
- **c.** Costs
- **d.** Physical plant
- **e.** Resident mix (e.g., short-stay, rehab, dementia, bariatric)

IV. Facilitators of implementation or impact (General, not included below)

- **a.** Individuals (e.g., staff, family, residents, physicians, other)
- **b.** Financial, regulatory barriers (e.g., grants, policies, waivers, other)
- **c.** Corporate/ownership/management group
- **d.** Physical plant
- **e.** Resident mix (e.g., short-stay, rehab, dementia)

V. Resident practices (General, not included below; e.g., activities)

- **a.** Dietary
- **b.** Personal care (e.g., ADLs, bathing, scheduling)
- **c.** Resident-centered/directed practices

VI. Staff practices (General, not included below; e.g., empowerment strategies)

- **a.** Changes in job design (e.g., cross-training, responsibilities, supervision, new jobs)
- **b.** Staff advancement (e.g., remuneration, training)

VII. Physical environment changes (not considered culture change; e.g., interior, exterior; carpeting, vans)

- **a.** "Culture Change" enhancements (e.g., remove nursing stations, private rooms, names)

VIII. Impacts (pos., neg., expected, unintended, lack of; e.g., physicians, administrators)

- **a.** Residents/families
- **b.** Staff (e.g., recruitment, turnover, retention, satisfaction)
- **c.** Costs
- **d.** Market (e.g., marketing, competition)

IX. Good quotes (General, not included below)

- **a.** 1st mention of culture change and/or resident-centered practices in interview
- **b.** Philosophy
- **c.** Advice to NHs

Table 1

Nursing home and administrator characteristics

Survey Question	Response	
	N (64)	Percentage
Total number of beds in the facility		
Less than 50 beds	10	15.6%
51 to 100 beds	25	39.1%
More than 100 beds	29	45.3%
Nursing facility is for profit		
Yes	45	70.3%
Nursing facility is part of a chain		
Yes	32	50.0%
How long have you been a nursing home Administrator?		
Less than 5 years	13	20.3%
6 to 10 years	10	15.6%
11 to 15 years	11	17.2%
16 to 25 years	17	26.6%
More than 25 years	10	15.6%
*How long have you been the Administrator at this nursing home?**		
In Years (Mean ±SD)	9.0 (±17.7)	

Table 2

THEMES

NUMBER	NAME OF THEME
1	Reasons for implementing culture change practices vary
2	NH approaches to implementing culture change practices are diverse
3	NHs consider resident mix in deciding to implement practices
4	NHAs note benefits and few implementation costs of implementing CC practices
5	Implementation of changes is challenging, and strategies for change are tailored to the challenge encountered
6	Education and communication efforts are vital ways to institute change
7	NHA and other staff leadership is key to implementing changes