Published in final edited form as:
Geriatr Nurs. 2013 ; 34(5): 388–394. doi:10.1016/j.gerinurse.2013.05.008.

A conceptual model for culture change evaluation in nursing homes

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Abstract

This article describes the development and particulars of a new, comprehensive model of nursing home culture change, the Nursing Home Integrated Model for Producing and Assessing Cultural Transformation (Nursing Home IMPACT). This model is structured into four categories, “meta constructs,” “care practices,” “workplace practices,” and “environment of care,” with multiple domains under each. It includes detailed, triangulated assessment methods capturing various stakeholder perspectives for each of the model’s domains. It is hoped that this model will serve two functions: first, to help practitioners guide improvements in resident care by identifying particular areas in which culture change is having positive effects, as well as areas that could benefit from modification; and second, to emphasize the importance in culture change of the innumerable perspectives of residents, family members, staff, management, and leadership.

Keywords

Culture change; Individualized care; Nursing homes; Quality of care

The case for a comprehensive model

Over the past decade, a growing number of nursing homes have adopted resident-centered care paradigms under the “culture change” rubric.[1,2] The ultimate vision of culture change is to improve resident and staff lives by centering facilities’ philosophies, organizational

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Conflict of interest: None.

Supplementary material

Supplementary material associated with this article can be found, in the online version, at http://dx.doi.org/10.1016/j.gerinurse.2013.05.008.

structures, environmental designs, and care and workplace practices around residents' needs and preferences.[1,3] Culture change efforts of varying designs have been implemented, and numerous models of culture change have been developed.[4,5] But there is a need for rigorous culture change process and resident outcomes evaluation with the continuing expansion of the movement.[5,6] However, culture change interventions cannot be adequately evaluated for their impact on specific resident populations and staff, improvements to interventions cannot be directed, and a clear understanding of what works when and how cannot be reached without a clear and specific conceptual framework to guide culture change assessment at the resident, facility, community, and national levels.

The numerous culture change models that currently exist lack the specificity to aid in outcomes evaluation. In the US, practitioners and researchers have access to information about Well-spring, Eden Alternative, Household (i.e., Action Pact), and Green House models of care, as well as theoretical models such as the Holistic Approach to Transformational Change (HATCh) for example.[7–12] Each of these models outlines general principles of culture change. Some, such as the Household and Green House models, have the basic frameworks available publicly but require contracting with a parent organization to receive comprehensive training. All have been described to varying degrees in the literature. Well-designed studies have been conducted on particular models, such as Kane et al's research on the outcomes of the Green House model[13] or Stone et al's evaluation of the Wellspring model.[8] But the models themselves do not readily point the reader to specific evaluation approaches. That is, they are useful if a nursing home commits to undertaking the full scope of the model's vision and has the time and resources to do so. However, most models do not provide guidance regarding intermediate steps, expectations, or assessment approaches for less than full implementation or for implementation with different resident populations. Models encompass much of the breadth of the culture change spectrum, but practitioners and researchers wishing to design or implement practical improvement initiatives or evaluate potential outcomes require more practical guidance. And the numerous, specific culture change-concordant toolkits[5] are not models, as they focus instead on particular, targeted issues (e.g., pressure ulcers, restraints, consistent staffing). They are helpful for directing change in one area, but they do not promote an integrated approach and often do not include information on how to assess multidimensional progress or outcomes.

Administrators, managers, clinicians, and researchers could benefit from a model that helps them understand the interplay of various culture change elements as more facilities implement culture change interventions. Ideally, such a model would provide explicit definitions within an overarching philosophical structure and also provide specific techniques for measuring progress and outcomes. There are two significant challenges to developing such a model. First, the types of possible changes are vast. Second, changes to the physical environment, leadership and management strategies, philosophical outlook, and care practices of nursing homes can occur in many ways: as small, independent "baby steps;" as part of a comprehensive, all-encompassing effort to redesign a system; or as any variation in between. Therefore, an assessment model must be broad enough to span all possible variants and yet detailed enough to help focus potential assessments and interventions on specific areas.

We combined constructs across published studies and models to help clinicians, managers, and researchers understand, implement, and evaluate culture change from multiple perspectives. We developed a comprehensive, detailed model of culture change elements for nursing homes' transformation efforts to address and included guidance on assessment methods. We describe development of the model, illustrating its components with examples based on our experiences in nursing homes at different culture change stages that serve residents with dementia as well as cognitively intact residents.

Model development

We first searched the relevant peer-reviewed literature for (1) articles on all aspects of culture change and (2) models designed to help guide the cultural transformation process. We searched Medline and PsychINFO using the terms "culture change and nursing home," "person-centered care and nursing home," "household model and nursing home," "resident-centered care and nursing home," "Eden Alternative," "Green House and home" "Pioneer Network," and "Wellspring and nursing home," generating 104 results. Three research team members (CH, JP, AS) selected relevant articles and subsequently snowballed the search using references from these articles (including grey literature references). Five interdisciplinary research team members (RA, DB, CH, PP, AS) then iteratively evaluated the collected material. The goal was to survey the literature for how culture change is conceptualized. Thus, only materials that used the term culture change or similar systems-change-focused terms (e.g., person-centered care or cultural transformation) were selected for review, acknowledging that this necessitated leaving out numerous excellent culture change-consistent works that do not use the term culture change (e.g., the vast intervention literature on pressure ulcers, pain, nutrition improvements, activity programming, etc.). Specific culture change "domains" from the literature, defined as spheres of theoretical applicability or actual activity related to culture change, were entered into an Excel-based scoring matrix, using either verbatim phrases from the literature or paraphrasing. Frequency of appearance in the literature was not a criterion for inclusion. Some domains had been mentioned only once and some represented frequently recurring themes. Thus, considerable overlap in content initially existed. This redundancy was eliminated, and domains that fused theoretically distinct concepts were divided. This process resulted in a preliminary list of 36 domains. Next, the same five team members rated each domain on a scale of 0–2, with 0 indicating no direct relevance to culture change and 2 indicating extreme relevance. Team members discussed domains whose ratings did not achieve consensus. After three rounds of discussion, consensus was reached on all domains. Only domains with a final scoring of 2 were selected for inclusion in the model.

Team members also identified from the literature how a domain could be empirically assessed (i.e., verified through one of the following: direct observations, interviews or focus groups, surveys, or documentation review). For those domains where the literature did not point to potential assessment methods, team members used their extensive combined nursing home research and clinical experience to suggest potential methods. Literature- and team-originating assessment methods were added to the coding matrix and iteratively discussed for each domain, using existing program evaluation literature as a resource in this process. Methods on which consensus was reached were included in the model.

The final list contained 18 culture change domains, with assessment techniques for each. We then re-examined existing culture change models to identify any that might provide structure for these domains. Three categories of the HATCh model,[9] "care practices," "workplace practices," and "environment of care," closely matched most of the domains. Consequently, those tenets were chosen to provide overarching structure for our model. The remaining domainsdthose that did not fit specifically into one of these three categoriesdwere all overarching domains. We therefore created a fourth, "meta-constructs" category. The final model was called the Nursing Home Integrated Model for Producing and Assessing Cultural Transformation (Nursing Home IMPACT).

Model domains

The specific domains of the Nursing Home IMPACT are outlined and defined below. Potential methods for assessing the domains of the Nursing Home IMPACT are described in Table 1. Each method has advantages and disadvantages, and the ideal assessment method should be determined on a case-by-case basis. Table 2 links the domains to particular assessment methods, except for the Environment of Care category.

Meta-constructs

The domains in this category should be thought of as inter-twined with all other domains. They address broader issues applicable to the domains in the care practices, workplace practices, and environment categories, instead of encompassing a specific aspect of culture change (see Table 2 for domain-specific potential assessment methods).

Ownership of culture change efforts

This refers to the extent to which culture change is promoted by a broad spectrum of nursing home employees and residents rather than only by leadership or a single individual.

Assessment—In evaluation of this domain, one looks for evidence of a coalition of individuals, including residents and family members, supporting change. Assessment should involve purposeful information gathering, such as from residents, family members, and various types of staff, with deliberate efforts to include cognitively impaired residents and/or their families. For staff, a survey approach may be preferable to interviews, if the survey assures anonymity and thereby encourages frank responses. Evidence of the inclusion and equal valuing of both "top-down" and "bottomup" perspectives would indicate strides are being made in this domain, although, ideally, the distinction between top and bottom is eventually lost. Interview or survey questions should assess how residents, family, staff, and leadership define and support culture change, and how and whether they assume responsibility for it. How are particular changes implemented? Are changes described in the same ways by staff, leadership, residents, and family? Is support for change consistent through fruition? When assessing this domain, care should be taken to avoid leading questions and to allow room for open-ended responses.

Unlearning established practices

Sustainable changes are institutionalized, and mechanisms for helping staff unlearn established practices exist.

Assessment—Data collection should assess whether and the way in which culture change has impacted how staff, management, and leadership do their jobs. Is there congruence of information collected from different groups? Do individuals advocate for the resources they believe are truly needed to enable successful change? Can staff and residents describe examples of successful and unsuccessful culture change innovations? Can they explain what the facility learned from failed attempts? How did leadership and staff initially learn new ways to do old tasks and, over time, did they fall back into the old way of doing things or establish work-arounds? Longitudinal assessment of this domain is ideal. Alternatively, when longitudinal observation or repeated interviewing is not possible, conducting in-depth interviews at a single point in time, asking respondents to reflect on current versus former practices, may be considered.

Prioritizing both safety and a home environment

This domain highlights the importance of integrating culture change and safety, for the benefit of both residents and staff.

Assessment—What are staff, residents', and family members' impressions of the impact of culture change on staff and resident safety? Ideally, all groups should be aware of specific issues and how culture change and safety are addressed simultaneously within the facility. For example, how does the facility ensure culture change happens alongside the need to monitor and prevent potential infection control issues, such as influenza or methicillin-resistant Staphylococcus aureus? How is the equipment necessary to transfer residents safely incorporated into the culturally transformed environment? What creative techniques do staff use to improve the autonomy of and quality of life for residents with dementia while still maintaining safety, and how does leadership empower staff to do so? For instance, for a resident with mild cognitive impairment who loves fresh coffee and being in the kitchen "cooking," but who is a safety risk with a full coffee pot, how have staff and residents worked together to minimize the risk? For example, have they tried using an electric hot water boiler that automatically turns off after boiling and providing single-serving instant coffee and heavy-bottom mugs? Documentation of safety concerns and methods implemented to alleviate them in culturally transformed ways is central to assessment of this domain.

Aligning culture change goals and resources

Leadership receives the support and resources it needs from the parent organization to facilitate culture change. Additionally, leadership, management, and staff goals for culture change are aligned.

Assessment—Information should be sought regarding resource allocation and processes relating to culture change. For example, are resident-, family, or direct care staff-initiated culture change ideas considered and prioritized by leadership? How does leadership support

staff members' efforts in enacting resident-centered care? Are requests from leadership embraced by residents and staff as being congruent with their own vision for culture change? Are the opinions of cognitively impaired residents actively solicited? How do various stakeholders view each other and what do they see as opportunities for improvement? What discrepancies (i.e., possible opportunities for intervention) exist?

Care practices

This category's domains have to do with practices that directly impact residents, such as waking, meals, bathing, meaningful activities, and delivery of medical care. These practices frequently overlap across several domains. Ideally, all care practices should be resident-centered and designed to empower all residents with as much control, choice, and normality as possible, based on their individual preferences and strengths. Again, Table 2 provides details on potential assessment methods.

Promoting residents' voices

Staff actively and regularly solicit resident preferences on all matters of living—activities of daily living, meaningful activity, medical and psychosocial decision-making, and unit operational matters—and a resident's cognitive impairment is not seen as an impediment to soliciting preference.

Assessment—Across shifts and settings, how do staff solicit resident preferences to optimize the chance that all residents will actually voice their own preferences? Does staff use leading or yes/no answer questions as substitutions for actual solicitation of residents' opinions? How and in what venues is resident input solicited and documented, during both the intake process and daily life in the nursing home? Are residents encouraged to attend treatment team meetings? Are there resident members on unit- and nursing home-level committees? To what extent are resident-led committees empowered with the authority to institute changes? Ideally, because priorities vary across individuals,[14] residents and family members should be actively empowered to speak up about all aspects of their lives, without fear of dismissal, reprimand, or retribution. These changes often cannot be achieved without education and training provided to leadership and management, to help them support staff in responding to residents' desires. In some cases training may be considered for staff as well, to assist them in better recognizing opportunities for resident self-promotion across individual residents.

Improving residents' quality of life

This domain includes resident choice and autonomy regarding daily living, privacy, comfort, functional competence, dignity, meaningful activity, relationship building, food enjoyment, spiritual well-being, security, and individuality.[15]

Assessment—Specific areas for focus should be solicited through input from all residents on an individual level. Similar to *Promoting residents' voices*, the objectives for this domain often require management and leadership education and training, as well as changes in facility systems and structures, to promote and support improvements in resident quality of life at the front lines. Staff training may be desirable in some cases, to mentor staff on

creating opportunities to promote resident autonomy, but it is important to realize that leadership and management support and accommodating systems is key to enabling staff to culturally transform their care.

Meaningful use of time for residents

This domain encompasses any activitydwhether solitary or group, silent or audibledproviding engagement, meaning, enjoyment, and peace or comfort to a resident. The components of this domain support both *Promoting residents' voices* and *Improving residents' quality of life*.

Assessment—Ideally, meaningful activities (group and individual) should be available to all residents at any time, including during evenings, nights, weekends, and holidays, and regardless of cognitive impairment. Residents and staff should indicate who initiates group activitiesdis it only activities or recreation staff, or do direct care staff and other residents take the lead as well? Additionally, how and when are individual residents' inputs solicited about what constitutes meaningful use of time? Do residents have excessive "down time," when they are not meaningfully engaged? Are residents with dementia less targeted for engagement than other residents? It may be most practical to use very simple, structured, observation checklists to create *ratios*. For example, because being in a common area such as a day room does not automatically result in meaningful engagement, a ratio such as "time engaged in meaningful activity" over "time in day room" for individual residents may help provide a sense of life from a resident, not staff, perspective. More specifically, after soliciting residents' definitions of meaningful activity, a staff member might observe and note, at five-minute intervals, whether particular residents are engaged in self-defined meaningful activity over the period of time these residents are in the day room. Conflicts in information gathered from various stakeholders should be noted as potential discussion points.

Resident-centered medical care

This domain entails individualizing clinical protocols to increase their effectiveness. It includes but is not limited to empowering all residents and encouraging them to voice their opinions during medical decision-making, regardless of cognitive status.

Assessment—What structures or processes exist to support the practice of person-centered medical care? Do residents and family members feel the care provided is simultaneously respectful of the resident's privacy and self-determination and consistent with good clinical practices? How are resident and family choice solicited about the type and nature of medical care, e.g., during the intake process, during the discussion of advance care planning, or during treatment team meetings?[16] Is a shared decision making model[17] used?

Workplace practices

Domains in this category have to do with practices directly affecting staff, for example, staff assignment, empowerment, communication, and decision-making processes. As indicated above, suggested assessment methods are outlined for each domain in Table 2.

Decentralization of authority and new organizational processes

The nursing home's organizational processes are revamped to ensure, reffect, and accommodate resident- and staff-centered outcomes.

Assessment—Who speaks up during meetings and how are decisions made? Do meeting minutes reffect the input of all members? Do self-generated, formal, or informal committees for direct care or ancillary staff exist, and are these empowered to achieve meaningful change within the organization? Do direct care staff have actual, day-to-day decision making authority regarding routines and care delivery? Blurring of the traditional distinction between residential care and the greater community is also important. Do committees comprise staff members from all disciplines, residents, family members, and community members (as appropriate)? Assessment should allow for distinguishing between theoretical and actual practices. That is, does the facility's organizational documentation match the facility's practice as observed? Any disconnects between theory and actuality should be considered opportunities for discussion and potential intervention.

Consistent staffing

Consistent staffing has been shown to facilitate meaningful, caring, respectful, and clinically observant relationships between residents and care staff and to foster positive resident outcomes.[18,19] This domain entails residents having the same direct care staff consistently work with residents for the length of their stay.

Assessment—Use of a consistent assignment calculator, such as that available from Advancing Excellence,[20] is the most straightforward means of assessing this domain. It is additionally valuable to assess the longitudinal impact of consistent assignment from staff, resident, and family member perspectives. Discussion (e.g., via learning circles) of points of variation, facilitators, and barriers should be fostered among all stakeholders to understand obstacles and design ways to overcome them.

Prioritizing both culture change and quality

The nursing home ensures that traditional foci on quality of care are maintained when transitioning to and supporting a resident-centered culture. Culture change and quality should not be presented as "either/or;" rather, quality of care should be *integrated into* cultural transformation processes.

Assessment—In assessing this domain, it is important to understand that culture change may in some cases lead to a temporary drop in resident-centered quality indicators as new processes are implemented. For example, the incidence of pressure ulcers may rise temporarily as staff grapple with how to interpret culture change messages that are seemingly (but not actually) contradictory, such as "letting residents do what they want" (inaccurately interpreted as "just let residents stay in bed"). However, culture change does not negate responsibility for good care; it simply provides a different path for getting there. Therefore, any drops in quality indicators should not be tolerated long-term. If a resident with dementia continually tries to get out of bed without assistance because she can't remember that she hasn't been able to transfer independently since she broke her hip, staff

can proactively devise a plan to support her independent mobility by building her core strength and balance and by providing in-room hardware to assist her in getting around independently. They can integrate the resident's right to take risks with their obligations to provide high quality care. Devising documentation methods to collect data consistently and longitudinally on the relationships between changes in nursing home culture and the incidence of established quality indicators is key to assessing this domain.

Existence and functioning of interdisciplinary teams

Truly interdisciplinary teams exist, both formally and informally, fostering strong teamwork and efficient, effective provision of care.

Assessment—Information should be gathered on whether and how some or all of the following take place and participants' impressions of them: standup meetings to address emergent issues, help resolve daily issues, and achieve unity of mission; action teams focused on specific, measurable, and time-limited objectives; teams in which direct care staff members hold leadership responsibilities; and learning circles (providing structured conversations with some combination of leadership, staff, residents, and family that allow everyone an opportunity to speak). During assessment, care should be taken to represent the views of various staff types, to assess participation and inclusion and to distinguish practices that are encouraged but not practiced from those that are actively pursued.

Staff communication

Leadership, management, and staff communicate with one another effectively and respectfully and interact with residents in a respectful, non-infantilizing manner, with the goal of delivering customized, high quality care.

Assessment—What communication processes do leadership and management model for staff? Are leadership and management taught new, nonhierarchical ways to communicate? How do staff interact with residents and with one another? How do these interactions "feel" to a neutral observer? Do different staff have different impressions of their communication processes? What are residents' and family members' impressions of staff-resident and staff-staff communication processes? What trainings are held on which subjects and for which participants?

Staff empowerment

Staff at all levels, especially direct care staff, feel and are empowered; there are mechanisms in place to ensure that their voices are heard and that they have the ability to collaboratively make decisions and take action, as well as to show responsibility for those choices and actions.

Assessment—What are direct care staff members' impressions of their own empowerment? What concrete examples can staff point to? What impressions do leadership and management have? Are there discrepancies among the various stakeholder perspectives? What concrete policies or practices have been enacted to promote staff empowerment? Does training along the following lines take place: positive mentoring & guidance rather than

"culture of blame" and punitive orientation to staff errors; training of management staff (e.g., unit managers) to accommodate and embrace a less hierarchical structure and the empowerment of direct care staff; having coaches/mentors/guides advise and provide feedback to direct care staff to facilitate their development and continued growth and on-the-job learning; training of leadership and management to include all staff in decision making processes and to facilitate teamwork?

Environment

This category has to do with the physical environment in and around the nursing home, such as the configuration and content of rooms, access to the outside, lighting, and ambient sounds. Ideally, the environment should feature supportive design, in order to promote as much independence and engagement as possible. Many facilities begin culture change with physical modifications, because these are relatively easy to conceptualize, and previous studies and reports have detailed numerous components of environmental change.[21–26]

Assessment—There are multiple means to assess an environment: post occupancy evaluation, observation, behavior mapping, survey, interview, etc. One common method is direct observation, ideally using a checklist. The list presented in supplementary material incorporates the elements listed in previous studies and reports, eliminating redundancies. While the list is therefore relatively comprehensive, it is nevertheless incumbent upon a facility or researcher to decide on the relative importance of each component. It should also be noted that there is no particular threshold at which cultural transformation of the environment can be said to have been completed. In addition, it is important to note that multiple methods should be used to fully evaluate any environment.

Conclusion

Nursing home culture change mirrors the model long used in hospice and palliative care.[27,28] It is a multi-faceted, longitudinal process that emphasizes a resident-centered, quality of life approach. It is a process that can and should take place to benefit all residents and staff. Therefore, we developed the Nursing Home IMPACT, a comprehensive model built on existing work to help practitioners and researchers assess culture change processes. This model provides explicit definitions, examples, and potential assessment methods for specific culture change domains. It has the potential to help guide improvements to resident care by identifying particular areas in which culture change is having a positive effect (i.e., areas to recognize and maintain) and areas that could benefit from modification (i.e., areas for change initiatives), because it merges features of previous models and outlines practical assessment methods. Additionally, it emphasizes the need to regard culture change progress from multiple perspectives: leadership, management, staff, residents, and family members. It is neither location nor discipline specific and can and should be used from the perspective of valuing all residents' input and abilities. Its value over existing models also stems from the specificity of the domains' assessment suggestions and from the inclusion of the meta-constructs category, which highlights interwoven culture change aspects that are sometimes lost when a more narrow approach is taken.

Culture change can neither be well-understood nor systematically improved without rigorous assessment. And incorporation of resident and direct care staff perspectives is critical to ensuring changes have their desired effects in the moment as well as over time.[5] The Nursing Home IMPACT has many possible applications, and future research should focus on pilot and feasibility testing. In practice, a facility interested in making changes in the *Promoting the resident's voice* domain, for example, could have leadership and management support direct care staff to conduct periodic, time-limited observations of life in the facility from the perspective of residents with advanced dementia. These baseline data could then be used as the foundation for conducting a series of learning circles with leadership, management, direct care staff, residents, and family members to discuss the results, highlight strengths, and assess opportunities for improvement. After improvements have been initiated, data could then be collected in a follow-up period, with the cycle repeating indefinitely. In such a case, the assessment and evaluation processes themselves actually become the tools for culture change, with little to no monetary cost. This may increase the potential reach of the Nursing Home IMPACT, as not all skilled care facilities committed to improving resident-centered care have the financial resources to modify physical facilities or enter into contractual arrangements with existing culture change organizations. This example also highlights the utility of the model for evaluating how care is impacting particular subgroups of residents.

As the above example shows, specific tools designed to facilitate culture change can be placed within the framework of the Nursing Home IMPACT to provide a larger context for particular techniques and to help stakeholders conceptualize related areas for observation, assessment, or intervention. It has particular relevance to dementia care, where the voice of residents is often neglected. Additionally, the Nursing Home IMPACT can help facilitate culture change research by providing standard domains and definitions to assess progress on explicit outcomes. Finally, use of the Nursing Home IMPACT can extend beyond skilled nursing to assisted living facilities, because the domains and assessment approaches apply similarly in both environments. In sum, the Nursing Home IMPACT provides a heretofore-lacking component in the culture change movement and has numerous potential applications. Research is needed to substantiate its ability to help practitioners and researchers facilitate positive changes.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgements

The authors would like to acknowledge Barbara Frank, MPA, co-founder of B&F Consulting, for her valuable comments on the manuscript.

Funding: This material is based upon work supported by the Department of Veterans Affairs, Veterans Health Administration, Office of Research and Development, Health Services Research and Development (PPO 09-266). Dr. Hartmann was supported by a Department of Veterans Affairs, Veterans Health Administration, Health Services Research and Development Career Development Award (CDA 08-008). The funders played no role in the design, execution, analysis or interpretation of data, or writing of this paper.

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Table 1

Potential Culture Change Assessment Methods.

Assessment method	Tools needed/focus of assessment
(1) Direct observation of	
(a) Residents' daily life	(a) Structured, facility-generated observation tool to capture residents' lived, longitudinal (if possible) experience or brief notes from multiple, timed, unobtrusive observation of residents (again, longitudinal may be preferred)
(b) Residents' medical care	(b) Notes from unobtrusive, respectful shadowing of clinical staff during residents' medical care
(c) Treatment team meetings	(c) Notes from silent observation of treatment team meetings by non-participating observer
(d) Staff[a] meetings	(d) Notes from silent observation of staff meetings by non-participating observer
(e) Tesident committee meetings	(e) Notes from silent observation of resident committee meetings by non-participating observer
(2) Interviews	(a), (b), and (c): pre-formulated list of non-leading interview questions (open-ended *or* a mix of open- and closed-ended) with interviews conducted by someone not directly involved in resident's care or staff member's performance evaluation
(a) With residents	
(b) With staff[a]	
(c) With family	
(3) Focus groups	(a), (b), and (c): pre-formulated list of non-leading focus group questions (open-ended *or* a mix of open- and closed-ended) with focus groups conducted by someone experienced in listening and group facilitation who is not directly involved in residents' care or staff members' performance evaluations
(a) With residents	
(b) With staff[a]	
(c) With family	
(4) Surveys	(a) and (b): survey tool with non-leading questions (closed- and/or open-ended) with responses collected by anonymous method (e.g., no name on survey, deposit in sealed drop box in common area; Web-based)
(a) Of residents/family	
(b) Of staff[a]	
(5) Review of documents relating to	
(a) Treatment team meetings	(a) Brief notes taken on standardized template, from review of treatment team meeting notes from pre-identified time period, with focus on particular topic of interest (e.g., evidence of resident/family member participation and team's follow-through on resident/family member requests)
(b) Notes in residents' charts about specific issues	(b) Brief notes taken on standardized template, from review of pre-identified, specific areas of resident chart for pre-identified time period, with focus on particular topic of interest
(c) Records of residents' use of time	(c) Standardized template used to record information (e.g., numbers or words) about residents' meaningful use of time from relevant document sources for pre-identified time period; template should have space to note lack of documentation
(d) Facility organizational structure and processes	(d) Standardized template used to record information from facility records; template should have space to note lack of documentation
(e) Staff[a] meetings	(e) and (f): brief notes taken on standardized template from review of documents pertaining to these meetings for pre-identified time period, with focus on particular topic of interest
(f) Resident committee meetings	
(g) Quality and safety concerns	(g) Standardized template used to collect data consistently and longitudinally from relevant documents on implementation of culture change and incidence of established quality indicators or other safety concerns; ideally, baseline period should be established for incidence rates prior to new culture change intervention initiation
(h) Staff training	(h) Standardized template used to record information about type, quantity, frequency, duration, attendance, availability, quality, etc. of staff trainings on particular topic of interest

[a]"Staff" refers to any or all of the following, as appropriate for the needs of the assessment: leadership, managers, direct care staff, other.

Table 2

Suggested assessment methods for Nursing Home IMPACT domains.

Domain	Suggested assessment methods[a]																				
	Observation					Interview			Focus group					Survey		Document review						
	1a	1b	1c	1d	1e	2a	2b	2c	3a	3b	3c	4a	4b	5a	5b	5c	5d	5e	5f	5g	5h
Ownership of culture change efforts						X	X														
Unlearning established practices	X					X	X		X	X											
Ensuring both safety and a home environment						(x), (y)	X	(x), (y)	(x), (y)	X	(x), (y)	Y	Y							X	
Aligning culture change goals and resources				(x)	(x)	X	X														
Promoting the resident's voice	X		X			Y	Y	Y	Y	Y	Y	Y		(x), (y)	(x), (y)				Y		
Improving the resident's quality of life	X					X	(x)	X	X	(x)	X										
Meaningful use of time for residents	X					Y	(y)		Y	(y)						X, Y					
Resident-centered medical care		X	X			X		X	X		X				(x)						
Decentralization of authority and new organizational processes				X		(x)	(x)		(x)	(x)							X				
Consistent staffing[b]	Y					Y	Y	Y	Y	Y	Y				(y)		X				
Prioritizing both culture change and quality							(x)			(x)										X	
Existence and functioning of interdisciplinary teams							X			X								X			
Staff communication	X					(x)	(x)	(x)	(x)	(x)	(x)							X			X
Staff empowerment							X			X			Y					X, Y			X, Y

X, Y = potential assessment strategies; Xs represent one method/group of methods and Ys represent an equally viable, *alternative* method/group of methods.

(x), (y) = possible complementary strategies to X or Y–(x) or (y) may not be sufficient by themselves.

1 = direct observation of: a = residents' daily life; b = residents' medical care; c = treatment team meetings; d = staff meetings; e = resident committee meetings.

2 = interviews with: a = residents; b = staff; c = family.

3 = focus groups with: a = residents; b = staff; c = family.

4 = surveys of: a = residents/family; b = staff

5 = review of documents relating to: a = treatment team meetings; b = notes in residents' charts about specific issues; c = records of residents' use of time; d = facility organizational structure and processes; e = staff meetings; f = resident committee meetings; g = quality and safety concerns; h = staff training.

[a] Numbers in the column sub-headings represent suggested assessment methods and are defined as follows (note that "staff" refers to any or all of the following, as appropriate for the needs of the assessment: leadership, managers, direct care staff, other; also note that the numbers in the column sub-headings also correspond to the numbers presented in Table 1).

[b] Use of a structured calculation for consistent assignment is the preferred strategy listed as X.