
Implementing Culture Change in Nursing Homes: An Adaptive Leadership Framework

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Received June 26 2013; Accepted December 5 2013.

Decision Editor: Nancy Schoenberg, PhD

Purpose of the Study: To describe key adaptive challenges and leadership behaviors to implement culture change for person-directed care.

Design and Methods: The study design was a qualitative, observational study of nursing home staff perceptions of the implementation of culture change in each of 3 nursing homes. We conducted 7 focus groups of licensed and unlicensed nursing staff, medical care providers, and administrators. Questions explored perceptions of facilitators and barriers to culture change. Using a template organizing style of analysis with immersion/crystallization, themes of barriers and facilitators were coded for adaptive challenges and leadership.

Results: Six key themes emerged, including relationships, standards and expectations, motivation and vision, workload, respect of personhood, and physical environment. Within each theme, participants identified barriers that were adaptive challenges and facilitators that were examples of adaptive leadership. Commonly identified challenges were how to provide person-directed care in the context of extant rules or policies or how to develop staff motivated to provide person-directed care.

Implications: Implementing culture change requires the recognition of adaptive challenges for which there are no technical solutions, but which require reframing of norms and expectations, and the development of novel and flexible solutions. Managers and administrators seeking to implement person-directed care will need to consider the role of adaptive leadership to address these adaptive challenges.

Key Words: Nursing homes, Culture change, Leadership

In the context of persistent, pervasive, quality of care concerns (Castle & Ferguson, 2010), the culture change movement in nursing homes aims to transform institutional

models of nursing and medical care to create a person-directed, homelike care environment. Person-directed care occurs when staff and family support residents in directing

their own care, in contrast to a traditional, staff-directed model of care (Mueller, Burger, Rader, & Carter, 2013). The culture change movement is defined as “person-directed values and practices where the voices of elders and those working with them are considered and respected... where both older adults and their caregivers are able to express choice and practice self-determination in meaningful ways at every level of daily life.” (Pioneer Network, 2011). “Culture change” is the general term used to refer to this movement (Pioneer Network, 2013). To achieve these goals, providers in nursing homes are asked to consider changes across multiple domains of how care occurs, ranging from the physical environment, to staffing practices, to how input from residents, families, and frontline workers is incorporated into day-to-day practices.

The culture change movement in nursing homes is growing; it is estimated that 20% of nursing homes in the United States are affiliated with culture change groups (Banaszak-Holl, Castle, Lin, & Spreitzer, 2012) and that as much as 85% are engaged in some aspects of culture change (Miller et al., 2013). The U.S. Veterans Health Administration has mandated implementation of culture change and the Centers for Medicare and Medicaid Services likewise have included culture change as part of the “eighth scope of work” with state quality improvement organizations (Koren, 2010).

A variety of key barriers and facilitators to implementing culture change have been identified, such as cost (including physical structures and financial incentives), regulations, nursing home staff attitudes (Doty, Koren, & Sturla, 2008; Grant, 2008; Miller et al., 2010), legal concerns (Kapp, 2013), inadequate human resource, and staff development (Koren, 2010). A common theme across the identified facilitators and barriers is the critical importance of leadership practices (Burger et al., 2009; Rosemond, Hanson, Ennett, Schenck, & Weiner, 2012) and the need to develop practices to implement culture change. To change how an older adult relates to a staff member to ultimately “direct” his or her care, we require leadership practices that arise from a theoretical framework that acknowledges these relationships as the driving engine of the nursing home organization (Pioneer Network, 2011).

Complexity science may be a useful theoretical framework with which to consider how to change relationships within a nursing home. As complex organizations, care in nursing homes arises from formal and informal interactions occurring among people. These interactions are nonlinear and dynamic, occurring at all levels of the organization (Anderson & McDaniel, 2000). Therefore, effective leadership requires a focus on relationships; successful strategies for interacting with others provide the basis for effectively accomplishing care, rather than simply following rules and

policies (Anderson et al., 2005; Colón-Emeric et al., 2006). Complexity science proposes that leadership is an emergent property of an organizational system, rather than a management role or position of authority. Effective leadership to implement culture change, therefore, arises from the nature of the interactions of people at all levels of the organization.

Complexity science leadership theory distinguishes between technical and adaptive leadership challenges that arise in an organization (Lichtenstein et al., 2006; Uhl-Bien, Marion, & McKelvey, 2007). Technical challenges are problems or issues that are effectively addressed through the application of specific expertise, resources, or concrete technical skill. Often enacted with a policy or procedure by those in formal managerial roles, addressing these technical challenges requires the relatively straightforward matching of the correct expertise to the problem. For example, changing door handles to be easily opened by residents with mobility impairment is a technical solution to the challenge of making the environment more accessible to all residents. By contrast, adaptive challenges are those challenges that have no obvious, single solution, are more difficult to identify and describe, and require revising norms and belief sets. For example, improving satisfaction of residents, families, and staff with communal living areas such as dining rooms is an adaptive challenge. As these challenges cannot be addressed with a new rule or policy, novel solutions must be allowed to emerge from the interactions of people in the organization who face the challenges, referred to as adaptive work (Bailey et al., 2012; Thygeson, Morrissey, & Ulstad, 2010). Adaptive leadership is composed of the set of strategies and behaviors that are used to facilitate the adaptive work, arising from individuals in the organization who foster or allow the adaptive work to occur. Implementing person-directed care in culture change, therefore, requires recognizing and addressing these adaptive challenges as well as technical challenges.

When we either ignore adaptive challenges or confuse adaptive challenges for technical challenges, we risk that a specific practice change (i.e., new carpet, permanent staffing assignments) will not result in fully realized person-directed care and will waste scarce resources. Rather, an adaptive leadership framework suggests that developing organizational capacity for culture change requires recognizing adaptive challenges and fostering adaptive leadership behaviors to address these adaptive challenges.

Fundamentally, culture change requires the transformation of an organization to develop new, normative values and behaviors congruent with person-directed care. Generating new rules and procedures alone will not result in new caregiver values and principles. For example, implementing person-directed care requires that direct caregivers

and residents know one another. A common approach to meet this requirement is to have staff permanently assigned to a set of residents. Enacting a new policy of permanent assignments is an example of viewing the need for caregivers and residents to know one another as a technical challenge and using administrative leadership alone to address this challenge. However, viewed as an adaptive challenge, we can see that for caregivers and residents to know one another is a challenge with no currently known, readily applied solution. Adaptive work is required of caregivers and residents to generate new ideas of how they will develop connections and strategies for learning about one another and sustaining positive relationships. Managers may need to talk with caregivers and residents and gain new insights into what kinds of interventions will nurture relationships. Perhaps permanent assignments will be one component of the solution, but perhaps not. Everyone will be asked to reframe how they may have thought about the caregiving relationship in the nursing home and develop new attitudes and beliefs. By acknowledging the adaptive challenges for caregivers and residents to know one another, we expand the opportunities to problem-solve, increase the probability of achieving our aim, and enrich our understanding of the leadership required to successfully implement culture change.

The purpose of this study is to describe key adaptive challenges and leadership behaviors to implement culture change for person-directed care. Therefore, we asked the following two research questions: (a) among barriers to culture change identified by nursing home staff, what are examples of adaptive challenges? and (b) among facilitators to culture change identified by nursing home staff, what are examples of adaptive leadership?

Methods

The overall study design is a qualitative, observational study of nursing home staff perceptions of the implementation of culture change in each of three nursing homes. A qualitative methodological approach was selected due to the descriptive, hypothesis-generating nature of the

research questions. Consistent with an interpretivist framework of qualitative research (King & Horrocks, 2009), we aimed to elucidate multiple understandings and experiences of culture change among nursing home staff. Focus group methodology was used to explore the range of opinions and perspectives among groups of people, allowing for ideas and perspectives to emerge from the interactions of group members that might otherwise not occur with individual interviews (Krueger & Casey, 2009). Approval for the study was obtained from the two Institutional Review Boards affiliated with the researchers.

Sample/Setting

The sampling design was organized in accordance with a "broad-involvement" focus group study design (Krueger & Casey, 2009), whereby multiple focus groups are conducted with one type of participant, supplemented with groups of additional key stakeholders in formal decision-making roles affecting the phenomenon of study. In this study, we conducted five focus groups of licensed and unlicensed nursing staff, exceeding the suggested minimum sample size of focus groups for which we anticipate achieving saturation of themes (Crabtree & Miller, 1999a; Krueger & Casey, 2009). These focus groups were supplemented with two additional focus groups of key stakeholders, including medical care providers, and nursing home administrators.

The participant sampling frame included all licensed and unlicensed nursing staff, medical care providers, and nursing home administrators in each of three nursing homes within a 50-mile radius of the university. We first identified a convenience sample of nursing homes with which we have had research, practice, or educational collaborations within a 1-hr drive (50 miles) of our affiliated institutions. From this set of nursing homes, we purposively selected homes for diversity in ownership and payment mix (see Table 1), based on previously cited findings of resources and regulations as key barriers to culture change; this ensured variability in each of these barriers. We did not sample nursing homes based on the degree of implementation of culture change; however, the

Table 1. Demographic Characteristics of Focus Groups, by Nursing Home and Participants

Focus group	Participant no.	Participants' positions	Nursing home (s)
1	4	Staff nurses, including RNs and LPNs	Nonprofit, Medicare, and Medicaid
2	4	Certified nursing assistants	Nonprofit, Medicare, and Medicaid
3	4	Staff nurses, including RNs and LPNs	Nonprofit, Medicare only
4	5	Certified nursing assistants	Nonprofit, Medicare only
5	5	Staff nurses, RNs only	Government owned, hospital based
6	10	6 MDs, 4 NPs	All three nursing homes
7	9	Nursing home administrators	All three nursing homes

nursing home administrators of all three homes described their organizations as actively engaged in culture change activities. Only one nursing home, however, had benchmarked progress using a reliable and valid instrument of implementation.

Data

Description of Focus Groups

Within each nursing home, the director of nursing was contacted to disseminate information about the study to all licensed and unlicensed nursing staff, congruent with the focus of our research questions on staff perceptions. Interested participants contacted the study coordinator, who scheduled the focus groups onsite. Administrators and medical directors from the same nursing homes were contacted directly by the study coordinator. Because the nursing homes had nurse practitioners on staff with the medical directors, nurse practitioners and physicians participated in the medical provider focus group. To increase likelihood of disclosure (Krueger & Casey, 2009), groups were organized by licensure status, including one group of licensed and one group of unlicensed nursing staff in each of two homes, with one group of licensed staff only in the third home. This resulted in mean group size congruent with the suggested size for focus groups (Crabtree & Miller, 1999a) (see Table 1).

Focus groups were moderated by the first author of this study and the study coordinator (K. Corazzini and M. Weiner), reliability was established through observation of the moderator and review of audio recordings. Each focus group was conducted within a 1-hr time frame.

Focus Group Questions

Focus group questions were developed by the team as an open-ended, semistructured interview of perceived barriers and facilitators to culture change. To start, the moderator provided a working definition of culture change, congruent with Pioneer Network's definition of culture change (Pioneer Network, 2011), and provided a round-robin opportunity to share what participants believed relates to the term "culture change," to allow for multiple understandings of culture change. Next, open-ended probes (see Table 2) were used to elicit facilitators and barriers. These

probes included asking about unintended consequences that might present facilitators or barriers during the process of implementation. All seven focus groups were audio-recorded and transcribed by the study coordinator for uploading into the qualitative analysis programs Atlas.ti (Friese, 2011) and CAT (Texifter, LLC, 2011).

Analysis

Analysis of focus group data was conducted in accordance with a template organizing style with immersion/crystallization (Borkan, 1999; Crabtree & Miller, 1999b). For step one, we used our two a priori codes of "barriers" and "facilitators" to identify all text across all focus groups related to either a barrier or a facilitator. Pairs of researchers were assigned to code each focus group transcript for facilitators and barriers. All discrepancies were discussed within the pair for coding reconciliation. When discrepancies remained, they were presented to the full research team for discussion and reconciliation.

For step two, all coded text was reorganized into a set of barriers and a set of facilitators. These two transcripts were then read and coded inductively for themes or dimensions and for relationships among themes or dimensions by two members of the research team; they were then discussed first in the pair and then in the full group. Step one was designed to ensure consensus on what was a facilitator or barrier (i.e., reconciliation and coding discrepancies), whereas step two was conducted in an inductive process, whereby any two members of the team may have coded separately, discussed, coded again, talked as a full group, and coded yet again as new understandings and relationships patterns emerged among the dimensions of facilitators and barriers. Visual maps of the potential relationships among constructs also were generated for the purpose of discussion and refining our understandings (Stewart, Shamdasani, & Rook, 2007). Although this cyclical process of data coding is that of immersion and crystallization, the inductive approach to understanding and generating meaning from the data is congruent with a constant comparative method of data analysis, derived from grounded theory and common in focus group analysis (Krueger & Casey, 2009). As a result, this process allowed us to ensure that our data analysis was systematic,

Table 2. Sample Focus Group Interview Probes

What things in the nursing home could be different to make this environment more home-like and a better place to work or live?
What kinds of barriers do you see to making these changes occur?
What do you think would help make these changes occur?
Although culture change is generally thought to be a good thing, sometimes with change there are unintended consequences. What unintended consequences, either positive or negative, do you think might happen as the facility makes these changes?
Any other thoughts about this idea of "culture change" to make staff and residents feel better about the place where they live and work?

verifiable, sequential, and continuous (Krueger & Casey, 2009).

Results were summarized within each group and across groups, as the unit of analysis in focus group methodology is the group, and not the individual participant (Stewart et al., 2007). Once cross-group themes or dimensions of focus groups and relationships among these themes were finalized, themes of barriers and facilitators were read for examples of adaptive challenges and leadership by the first author. At least one coauthor reviewed each classification, and any discrepancies were discussed and reconciled.

To ensure rigor of the design, we addressed credibility, transferability, dependability, and confirmability (Denzin & Lincoln, 2005; Reid & Gough, 2000). Credibility was assured through purposive sampling and our iterative process of data collection and analysis to identify potential biases and ensure saturation of themes. Transferability was assured through purposive sampling, providing rich description of the data, and comparing emergent themes

to previous literature. Dependability was assured through written focus group protocols, first-author monitoring of focus group moderation, standard codes of barriers and facilitators, and double-coding with coding reconciliation for all codes. Confirmability was assured through rich descriptions of team meetings, audit trails of coding discrepancies, and group discussion of factors related to the phenomenon of study that may contribute biases.

Results

Themes of Facilitators and Barriers

Six key themes emerged, including relationships, standards and expectations, motivation and vision, workload, respect of personhood, and physical environment. Within each theme, participants identified barriers that were adaptive challenges and facilitators that were examples of adaptive leadership. Brief definitions of each theme, with sample adaptive challenges and leadership behaviors, are summarized in Table 3.

Table 3. Themes of Facilitators and Barriers With Sample Quotations of Adaptive Challenges and Adaptive Leadership

Theme	Definition	Sample adaptive challenge	Sample adaptive leadership
Relationships	The quality of the staff–staff and staff–resident/family relationships	<ul style="list-style-type: none"> • Incorporating CNA knowledge of residents into care decisions • CNAs feel no one “has their back” when overwhelmed 	<ul style="list-style-type: none"> • Managers pitch-in to cover direct care tasks during care plan meetings so CNAs can attend • MD/NP learns names of all staff • CNAs recognize and take turns caring for challenging residents
Standards and expectations	Meeting patient, family, coworker, and regulators’ expectations for care	<ul style="list-style-type: none"> • Difficult to quantify and thus demonstrate value of the quality of caregiving beyond task completion 	<ul style="list-style-type: none"> • Supervisors explicitly value caring attitudes and behavior • Allow natural leaders to emerge and develop peer–peer accountability
Motivation and vision	Individual and shared staff motivation and vision for caregiving	<ul style="list-style-type: none"> • Staff perceived to be “just doing this for the paycheck” 	<ul style="list-style-type: none"> • Encourage shared responsibility, relationships with residents, pride as motivation for good care • Encourage individual growth and professional development
Workload	Direct caregiver workload, including case-mix, and staffing ratios	<ul style="list-style-type: none"> • Finite time and staff to accomplish both regular tasks and manage unexpected problems 	<ul style="list-style-type: none"> • Allow staff choice and flexibility • Empower frontline staff to develop their own schedules and assignments together
Respect of personhood	Respect of the residents’ dignity, individuality, and choice	<ul style="list-style-type: none"> • Resident choice may conflict with facility policies meant to promote safety or encourage activity and socialization 	<ul style="list-style-type: none"> • Interpret rules and regulations with attention to their underlying rationale
Physical environment	Physical structure and furnishings of facility	<ul style="list-style-type: none"> • Homelike furnishings may be impractical for residents with functional or mobility impairment 	<ul style="list-style-type: none"> • Permit/facilitate customization and adaptation

Note: CNA = Certified Nursing Assistant.

Relationships

Relationships were defined as the quality of the nursing home staff–staff and staff–resident/family relationships. All groups discussed how poor quality relationships were barriers to culture change. One administrator described how detrimental poor relationships are to frontline caregivers, “The CNAs (Certified Nursing Assistants) want teamwork. Who has their back? Who is going to help when they are overwhelmed and have too much to do”? This was echoed by the CNA groups, “We...need someone to have our back. That’s all.” Seen as an adaptive challenge, this barrier is not removed by applying managerial expertise and enacting a rule or policy about teamwork. Rather, staff describe the need for responsibility for one’s peers and mutual support of frontline caregivers, which requires shifting norms about how to provide care and creating new behaviors.

Poor quality relationships among staff were seen as barriers to resident-centered care planning. Both nurses and CNAs described how knowledge they held of resident preferences and needs were ignored by those in the position to develop care plans. As one CNA summarized, “as a CNA, you know what the resident needs...but [licensed providers talk] to everybody except for [us]. We’re in there for thirty to forty minutes when [the residents are] telling us these things.” Another CNA explained the consequences of not sharing information directly:

By the time the word is passed on so many times, it is not at all what we said, you see what I’m saying? You can make a person better if you talk to the person who is with them the most.

A nurse described, “Care plan meetings happen and we aren’t involved.” The challenge of how to incorporate the knowledge of direct caregivers into the care planning process, which may temporally conflict with their other caregiving responsibilities, is an adaptive challenge as it requires valuing observations and knowledge of frontline caregivers and developing new ways of exchanging information than may currently exist in a nursing home.

All groups except the administrators provided examples of adaptive leadership facilitators to high-quality relationships. Medical care providers described strategies to allow high-quality relationships to develop with nursing staff, such as bringing in homemade food to share with staff. One provider described how he learned the names of all of the nurses in a large home by carrying a notebook, “It was tough to remember all the names but it meant something to them and I was able to do a better job.” In each of these cases, the providers demonstrated adaptive leadership by creating connections that allowed new ways of relating to develop among staff.

Staff also provided examples of how adaptive leadership could occur. For example, several CNAs talked about how administrators and nurses could step in and help with some direct resident care when CNAs are clearly busy with other resident care, which might free CNAs to participate more fully in decision making. This behavior was an example of adaptive leadership because it would facilitate the opportunity for CNAs to incorporate new perspectives on resident preferences in care plans.

Standards and Expectations

Standards and expectations were defined as meeting patient, family, staff, and regulators’ expectations for care. All groups identified barriers in this theme, largely focused on how meeting standards and expectations for care did not result in resident-directed care in one of two ways.

First, rules and policies sometimes directly conflicted with strategies for providing resident-directed care. A medical care provider described how the nursing home used to post a picture of each resident when he or she was younger, as a strategy to promote better staff knowledge of the resident. “One thing I really liked...was that outside the room they had...a picture of the resident from a younger age. They had to take them down because of confidentiality.” In this example, simultaneously meeting confidentiality and privacy regulations while sharing information about residents can be seen as an adaptive challenge, because existing regulations conflict with the proposed strategy. As a nurse described, “It’s hard to individualize when you have the state making mandates...You have to go by what the state says.”

Second, traditional metrics did not fully describe the qualities of caring necessary for culture change. As another medical care provider described, “Most important is care. But you’ll never put a check mark in that box so you can’t quantify.” This provider describes the adaptive challenge inherent in trying to capture elements of caring in ways that are concrete and measurable; current technical knowledge of how to measure care processes via checklists and charting does not capture staff caring and provision of resident-directed care.

A nurse described the barrier as

It’s a different way of thinking about our...residents... you have to change the thought process of those coming in...you gotta get more input and more activities and not just from the activity department. You have to get all the disciplines to work on this together.

This nurse identified the new ways of thinking and normative value shifts required to establish standards and expectations that are congruent with culture change.

All groups identified adaptive challenges in standards and expectations, but not all groups identified adaptive leadership to address these challenges. Specifically, no examples of adaptive leadership were described by the administrator group to address these barriers of standards and expectations. In one example of adaptive leadership, a CNA described the need for administration to be clearer with residents and families about standards and expectations of how care is provided by talking with them rather than expecting written admissions policies to be adequate. As an example of adaptive leadership, such discussion would facilitate residents, families, and staff to shift mutual expectations of care to figure out how to accomplish resident-directed care. In another example, a Director of Nursing (DON) was described by a medical care provider as exhibiting adaptive leadership, "The staff respects [the DON] and she fixed the staff attitudes. She tells people they can work there as long as they care about the residents." Her approach exemplified adaptive leadership by reshaping explicit standards to be congruent with culture change; this approach allowed standards and expectations to be reframed for congruence with this shift in values.

Motivation and Vision

Motivation and vision was defined as the individual and shared staff motivation and vision for caregiving. All groups described barriers to culture change within this domain, which included barriers that were coded as examples of adaptive challenges. Nurses spoke about colleagues who lacked the motivation to make the effort to provide resident-directed care, "So many here don't want to go the extra mile." Nursing assistants similarly described, "we have some (staff) who just do what they have to and then they're done." The challenge was coded as adaptive because changing motivation requires shifting underlying values and beliefs about one's job.

This adaptive challenge was echoed by medical providers and administrators. Providers described encountering nurses who were talking on their cell phones instead of supervising resident care, which was viewed as a lack of motivation to take responsibility for the residents. Administrators and medical care providers alike described the challenge as staff being motivated by their paycheck alone, "staff has no vested interest except coming for a paycheck." As one administrator summarized, "If you're doing it...just for a paycheck...that causes a conflict...when you come into a job that you truly love, you do extra." How to motivate and create that vision among staff for the "love" of providing resident-centered care as part of culture change, therefore, is an intrinsically adaptive challenge.

All groups provided examples of adaptive leadership facilitators. Administrators emphasized how increased

staff choice in how care is provided yields increased staff commitment or "ownership" of a vision of culture change. One administrator described allowing staff to select which unit they would work on, as well as choice in other care routines, "...empower staff to set some of the routines. If the staff owns it, they don't say, 'It's not my job'." Another administrator talked about, "ownership for everyone" of person-centered care, and this occurs by, "let[ting] people be in on the ground level of making some choices."

Direct care providers described examples of adaptive leadership that were behaviors that facilitated new perspectives on commitment and motivation to develop. A nurse explained how she encourages staff to "ask yourself, 'would you want someone like yourself to care for your parents?'" Another nurse described how to put the resident first to begin to change motivation:

I think if we could incorporate it to where we are more focused on the resident than getting our 8 hours in and doing the tasks. If we could focus on the resident, it may take a bit more on our part but it would make be less of a burden in the long run. We have to re-learn how to do things.

These are examples of adaptive leadership because such approaches open up the opportunity for individuals to do the adaptive work of reconsidering their vision of resident-centered care.

Workload

Workload was defined as the direct caregiver workload, including case-mix and staffing ratios. All staff described adaptive challenges arising from the workload. Two key types of adaptive challenges were described. The first type of challenge was how to provide resident-directed care in the context of current staffing ratios, whereby nurses and CNAs felt incorporating resident preferences required too much additional time. As a CNA described, "If we had more help, we would have time to do it their way. We can't even figure out what they want...because it is so busy. You don't know if the person wants a bath...You just do the job." How to provide resident-directed care in the context of current staffing ratios is not exclusively an adaptive challenge; having too few care staff is a technical challenge that is readily addressed by increasing staffing. However, given fixed resources with limited ability to substantially change staff ratios, what may be considered an adaptive challenge is how to incorporate the process of eliciting and honoring resident preferences into care routines in the context of extant staffing ratios. CNAs described managing inadequate time by prioritizing what care to give, "We can't even meet their basic needs...forget about their preferences." Therefore, the adaptive challenge is how to allow residents

to direct their care for what is feasible to provide. Another CNA describes this adaptive challenge as such, “It doesn’t really take longer to do it the way the resident likes it, it just takes time to give the care [the resident] needs.”

The second type of workload barrier coded as an adaptive challenge was that of staffing assignments. All staff groups described adaptive challenges in implementing consistent staffing assignments. A medical care provider described how nursing staff are not willing to agree to consistent staff assignments, which impedes the development of relationships for resident-directed care, “If the nursing staff would agree to permanent assignments, it would be easier...[to develop the relationship for care]...but you never know who will be the caregiver that day.”

Both nurses and CNAs also discussed how consistent assignments may facilitate relationships to know resident preferences, but that rotations are also important to avoid burnout with challenging residents, and to ensure staff ability to cross-cover for one another. A nurse described, “I...like the...idea but when ...somebody calls out and...people in the other village are saying ...we’re not crossing over to help.” This was coded as an adaptive challenge because the implementation of a set of policies or rules about assignments cannot solve this challenge; rather, adaptive work is required to develop new ways of simultaneously promoting continuity in caregiving, yet ensuring staff avoid burnout and are able and willing to help on other units or with other residents.

Examples of adaptive leadership to address adaptive challenges in workload were described by all groups except the medical care providers. Facilitators coded as examples of adaptive leadership were behaviors and strategies that could facilitate direct caregivers developing ways to balance consistency and workload. As a CNA summarized, “I think it’s good to be consistent *and* it’s good to rotate.” An administrator described how allowing staff their own choice and flexibility in scheduling would facilitate accomplishing this adaptive work, “let staff choose which neighborhood they work in...[the organization] gets better job satisfaction and better [care].”

Respect of Personhood

Respect of personhood was defined as the respect of resident dignity, individuality, and choice. All groups identified barriers to culture change related to the respect of personhood that were coded as adaptive challenges. Staff provided examples of how resident preferences were in direct conflict with nursing home policies related to promoting resident safety or socialization. For example, CNAs and nurses described how residents in two of the nursing homes were required to go to the dining room to eat, even if a resident did not wish to go. Whether following from a safety issue (e.g., risk for choking), or a desire to increase a resident’s

social interaction, the direct conflict between the policy and desire of the resident was seen by staff as violating the autonomy of the resident, “when they wanna just lay around... but no, you [must go to the dining room]. To me, that’s ... forcing them to do something they don’t want to do.” This challenge is adaptive as the technical application of a new rule or policy (e.g., follow resident choice) does not simultaneously address the need to allow the resident to dine in his or her room, yet reduce risk for choking, or increase physical or social activity. New ways of configuring care to meet these multiple goals would be required of staff. In fact, one CNA noted how her organization clearly discussed with direct care staff that residents have a right to refuse. She noted the inherent (adaptive) challenge following from this, as she found that procedures that were enforced in the nursing home did not support a right to refuse:

[The residents] have the right to refuse, but that’s only on paper to me. This resident can say, ‘[I don’t want to get up]’, but having two or three people in your face saying, ‘No! [you] can’t lay there! You have to get up!’... [how] is it their right to say no? I don’t understand.

An administrator in another nursing home echoed this challenge, “What if someone wants to stay in their PJs until noon? Most of the time, they’re encouraged or pushed to get dressed.”

Other examples of this adaptive challenge related to aspects such as how to address residents. A nurse in one nursing home described how surnames were required to address residents, even when a resident explicitly preferred otherwise, “Here, we must call them Mr. or Mrs. We have to be very formal. Sometimes, the residents would prefer to be more casual and go by their first name.”

Nurses and CNAs provided examples of adaptive leadership that would allow such adaptive work to occur, including more flexibility in how to apply policies, through understanding the underlying rationale for it. One CNA gave an example of how she modified her morning care routine to be able to sit with a resident in her room to allow her to eat her breakfast in her room. A nurse suggested asking the resident directly what he or she prefers to tailor care plans to be person directed, “Maybe we need to include them more in their care plan meetings or just, ‘what do you think we ought to do about this today, Mr. John Doe?... This is how we see it. Are we missing something?’” This latter suggestion exemplifies adaptive leadership because it is a mechanism for the caregiving staff and resident to do the adaptive work of reorganizing care policies and procedures in alignment with the resident’s choice while respecting the resident’s innate personhood as an expert on him or herself.

By contrast, although medical care providers and administrators described barriers of respect of personhood

that were coded as adaptive challenges, we did not code their descriptions of facilitators as adaptive leadership. Administrators, in particular, described the use of technical expertise to address adaptive challenges of the respect of personhood. For example, one administrator discussed the need to “weed out people” who do not demonstrate respect of the resident, either in the initial hiring or orientation process. This application of technical expertise (i.e., careful human resources screening to “weed out” uncaring potential staff members) is indeed an important component of ensuring staff respect residents’ personhood. However, it does not address the adaptive challenges of personhood faced by currently employed staff.

Physical Environment

Physical environment was defined as the physical structure and furnishing of the nursing home. Adaptive challenges that emerged from this set of barriers related to the adaptive work required to identify a balance between making the environment personalized and home-like, yet maximize resident function. The selection of furnishings or other physical attributes of the interior or exterior were often described by staff as selected for how, “home-like” they were, without regard to whether they simultaneously maximized resident comfort and function. As one nurse described, “Here it looks ...home-like, [but the residents]... can’t [get out of a chair] because it’s too low.” Second, staff identified specific, homelike physical environmental characteristics of how residents could personalize their space, such as bringing in items from home, or how administration could have furnishings or colors that were less institutionalized and more typical of a private home, but that this was not actively encouraged among residents and families.

Example of facilitators coded as adaptive leadership occurred among nurses and CNAs who provided suggestions for how to begin the adaptive work to create a better balance between home-like and accessible. As one nurse described, “Disabilities should not interfere with making it more homelike...we have ramps and accessible bathrooms and kitchens. You can do more.” They described a preferred future whereby “home-like” could exist without ignoring the accessibility needs of the resident. Another nurse gave an example of how administration allowed maintenance, direct care staff, and a resident to develop a novel solution to balance home-like with function, by cutting the table legs of a dining room table to fit the resident.

Discussion

This study highlights the importance of recognizing adaptive challenges to culture change and applying adaptive rather than technical solutions to them. We found many

barriers to culture change identified by nursing staff, medical staff, and administrators included elements of adaptive challenges, rather than technical challenges alone. Even themes that may appear to be readily addressed through technical solutions or expertise, such as workload or physical environment, also can be framed as adaptive challenges that require adaptive leadership to address.

Sterns, Miller, and Allen (2010) classified culture change practices related to workload aspects such as consistent staffing assignments, and all physical environment practices as “least complex” (Sterns et al., 2010, p. 514), with complexity defined using a complexity science framework. Yet, all groups in our study described adaptive challenges in both of these two domains, as well as our other key domains of barriers and facilitators. A recent review of the effects of permanent staffing assignments on care found inconsistent relationships between assignments and outcomes (Roberts, Nolet, & Bowers, 2013). We might hypothesize that this finding may be explained in part by whether implementing consistent staffing assignments was considered solely a technical challenge or whether staff acknowledged and addressed the simultaneous adaptive challenges. Therefore, an important implication of our findings is that successful implementation of all aspects of culture change may require identifying and addressing both adaptive challenges and technical challenges.

Thus, our findings suggest that recognizing the critical importance of adaptive challenges in all aspects of implementing person-directed care is an important first step in developing the necessary leadership practices for culture change. As adaptive challenges are only addressed through the use of adaptive leadership, failing to develop and support adaptive leadership practices among all levels of staff will result in the mismatch between problem and solution, wasting scarce resources, and not realizing person-directed care. Burns, Hyde, and Killett (2013) identified “wicked” versus “tame” (p. 515) problems arising in nursing homes, comparable to our distinctions between adaptive and technical challenges. Although both wicked problems and adaptive challenges arise from similar theoretical frameworks of complexity science, the choice of the term “wicked” emphasizes the potentially harmful effect of adaptive challenges left unacknowledged and addressed with technical solutions. Indeed, Burns and colleagues (2013) provided examples of how wicked problems addressed with tame solutions resulted in resident abuse and neglect. Adaptive leadership has been shown to be a successful leadership approach to addressing “wicked” problems in non-health care sectors (e.g., Haubold, 2012); our findings provide preliminary support of this leadership approach to addressing such challenges in nursing home care.

This recognition of the importance of adaptive challenges in implementing culture change also means that current approaches to how we prepare and develop staff in nursing homes will need to move beyond hierarchical, rule-based management strategies. In a sector where the majority of staff are prepared at less than bachelor's degree, with few professional nurses (RNs) and even fewer medical care providers (AHCA, 2013), the move toward widespread implementation of culture change represents a powerful opportunity for leadership and management development among all levels of staff. Our findings, therefore, indicate the importance of ensuring that development emphasizes how to facilitate the creation of new normative values and novel solutions for how to provide person-directed care—that is, strategies and behaviors for adaptive leadership. The adaptive leadership framework, therefore, provides a leadership approach that helps to clarify what administrators and managers can do versus what they must facilitate other staff and residents in the nursing home doing (i.e., the adaptive work) to accomplish culture change.

This idea is consistent with [Banaszak-Holl and colleague's \(2012\)](#) finding that nursing homes with high developmental cultures are more likely to have a greater degree of implementation of culture change. Such homes are those that are characterized, in part, by administration and management that are supportive and foster staff flexibility in responding to environmental demands. Findings from this study suggest that the mechanism of change that explains what [Banaszak-Holl and colleagues \(2012\)](#) found is what we have defined as adaptive leadership. Similarly, [Sterns and colleagues \(2010\)](#) found that elements of culture change dependent on the nature of relationships were the least likely to have been implemented by nursing homes and to have been implemented largely by nursing homes that had been undergoing culture change for a longer period of time. Our study suggests that the degree to which these relationship-focused changes occur arises from the use of adaptive leadership practices in the nursing home.

Implications for Policy and Practice

How to create policies and regulations that support and recognize culture change is a critical need identified by this study. The barriers and facilitators identified in the domain of standards and expectations illustrated the frequent conflict faced by staff attempting to adhere to policies or regulations that would impede the delivery of resident-directed care by ignoring adaptive challenges and treating care as technical challenges. Measures of care, therefore, must take into account adaptive leadership to address adaptive challenges in culture change, rather than relying on measuring the application of technical expertise or behaviors that

only apply to addressing technical challenges. For example, Centers for Medicare and Medicaid Services' Artifacts of Culture Change tool is meant to generate a score indicating how person-centered the care delivered by a facility is; nearly all of the items in this instrument reflect the implementation of technical solutions, such as whether closet rods are adjustable, whether CNAs self-schedule their work shifts, or whether the home has a cat or dog ([Bowman & Schoeneman, 2006](#)).

By contrast, measures of direct care staff empowerment have been related to staff implementation of person-centered care ([Caspar, Cooke, O'Rourke, & MacDonald, 2013](#)); empowerment provides staff the ability to do the adaptive work necessary to address adaptive challenges. Further, [Shura, Siders, and Dannefer \(2011\)](#) have used participatory action research as a mechanism for residents and direct care staff to be able to shift normative values and develop novel solutions (i.e., engage in adaptive work) for person-centered care. Both examples provide measures of the quality and nature of interactions that facilitate adaptive work among staff and residents required to address adaptive challenges for culture change and provide a starting point for how to revise our measures of care.

These studies also provide concrete examples of the specific types of behaviors administrators, practitioners, and nurse supervisors can use for adaptive leadership, such as bringing together staff and residents, empowering them to collaboratively identify barriers to care and to generate novel solutions, and to support the implementation of new ways of providing care. For example, in our findings, several staff noted that residents were not allowed to remain in their pajamas, even if a resident expressed a preference not to dress. How might a nursing home administrative team support residents in identifying the challenges related to dressing, and staff and residents to collaboratively propose novel ways to address these challenges? One could imagine the administrative team successfully coaching direct care staff in conflict management skills, as well as doing their own adaptive work in collaboration with surveyors to develop mutually agreeable ways of documenting this process to demonstrate adherence to regulations.

There were multiple limitations to our study. First, although all staff discussed how the three nursing homes were engaged in culture change, neither did we benchmark relative progress in implementation of the homes nor did we select based on implementation stage. As a result, we do not have the ability to describe how views of adaptive leadership may evolve or co-occur with differing degrees of implementation. Subsequent research can address this limitation to generate and test hypotheses of the effects of adaptive leadership on implementation by measuring the developmental trajectory of the implementation of culture

change, using the adaptive leadership framework. Second, we did not specifically probe for adaptive challenges and adaptive leadership in our focus group guide. Rather, we elicited facilitators and barriers that were coded in relation to adaptive leadership. Thus, the occurrence or nonoccurrence of adaptive leadership in a group may not relate to differences in the actual use of adaptive leadership; such potential differences by staff position require further study. Third, we did not include a for-profit, chain-owned nursing home, representing the majority of nursing homes in the United States. Nonetheless, this study provided an important first step to move us beyond the simple enumeration of facilitators and barriers, to link to the complexity science framework of leadership, and to inform the development of effective leadership strategies for culture change.

Funding

Partial support of this research was provided by National Institutes of Health/National Institute of Nursing Research (1P30NR014139-01; PI: Anderson).

Acknowledgment

This work was presented at the 2012 Annual Meeting of the Gerontological Society of America.

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