

What is culture change and person-centered care?

WHAT DO THE WORDS “CULTURE CHANGE” AND “PERSON-CENTERED CARE” MEAN?

To understand these concepts, first think of some words that describe the typical nursing home. If you're like most people, you're thinking of words like “institutional,” “hospital-like,” or even “cold and sterile.” Unfortunately, despite the good care that is provided, this is the image that most people have of nursing homes. In contrast, what words do you think of when you think of your OWN home, the house or apartment where YOU live? If you're like most people, you think of your own home as being “warm and inviting,” “relaxing,” or even “cozy” or “safe.”



KEY CONCEPT

Culture change in nursing homes refers to a shift from that cold, sterile, hospital-like environment, to an environment that is more centered on the individual needs and unique preferences of the people who live and work there. Culture change is viewed in nursing homes as the movement from a “traditional” model of care, characterized as hospital-like in nature, to a new model that emphasizes person-centered care and “home.” In a nutshell, culture change is about transforming the nursing home into not just a “home-like” environment, but actually making it “home” for the residents.

HOW IS PERSON-CENTERED CARE DIFFERENT FROM TRADITIONAL CARE GIVEN IN NURSING HOMES?

Person-centered care empowers residents to direct their own care and empowers the caregivers to be responsive to the needs of the residents. Person-centered care takes the decision-making of everyday activities away from the institution and places it in the hands of the residents and the staff who care for them. Implementing person-centered care concepts usually requires a transformational change in the culture of the nursing home, hence the term “culture change.”

Most of us have become accustomed to the traditional model of care, where we tell residents when they have to get up in the morning, what they'll have for breakfast, and when they'll take their medicine and when they'll take their shower, not to mention who will care for them and who their roommate will be. The daily lives of the residents are directed by the routines of the nursing home; often the care of the residents becomes a “task” that has to be done by the staff. This type of task-oriented care takes control away from the residents, possibly contributing to such outcomes as depression, weight loss, ADL decline, dependency, incontinence, etc.

While many of us who have worked in long-term care have accepted the traditional model of care, and even believed it was “good” for the residents, the exciting news is that there are now alternative models of care that are gaining more attention and exposure. These alternative models have sprung up in recent years in response to the growing realization that there is a better way to provide care for our nation's elders.



TIP: These new models of caring for nursing home residents have a number of variations and a number of names to go with them.

Here are some examples:

THE EDEN ALTERNATIVE was developed by Dr. William Thomas at a nursing home in upstate New York. This model of care was designed to address the three plagues of nursing home life: loneliness, helplessness, and boredom. This can be done, Dr. Thomas believed, by developing “human habitats.” Plants, pets, and children in the nursing home are usually associated with the Eden Alternative.

THE GREEN HOUSE is another model of person-centered care in which small groups of 10-12 residents live in actual residential houses within a community. This model is very similar to that of residential group homes in the MR/DD setting.

THE NEIGHBORHOOD MODEL is being used by many nursing homes that are moving toward resident-centered care. These are smaller units of residents with their own consistently dedicated support staff; neighborhoods usually have their own living, dining, and other common areas.

THE WELLSPRING MODEL is comprised of a number of specific elements, and is designed to achieve two general goals. The first goal is to enhance the quality of resident care. The second is to enhance the quality of work life, particularly for front line workers. Both goals are reached through the facilitation of organizational culture change to a person-centered care model.

THE PIONEER NETWORK sees culture change in long-term care as an ongoing transformation based on person-directed values that restores control to elders and those who work closest with them. This transformation includes changing core values, choices about the organization of such things as time and space, relationships, language, rules, objects used in every day life, rituals, contact with nature, and resource allocation.

HISTORY

So, how did nursing homes evolve into the institutional places that they are today? Looking back at the past provides a clearer understanding of why long-term care operates the way it does. Some of the earliest examples of homes that cared for the elderly were known as almshouses.

In the 1800's older people with chronic illnesses were housed in hospitals. Healthy older adults (who couldn't afford alternative care) lived in almshouses, sometimes called poor houses. The people who lived in the almshouses were usually put to work. These homes frequently turned a profit, so they were taken over and managed by the government. Many of you may still remember the "county poor farm." During this time, there was a belief that if you were old and poor it was because you were morally corrupt.

Poor houses were purposely unpleasant; they were used as a way of making people choose to be good – so that they might avoid them. In fact, legislators at this time found the old poor houses so objectionable that they banned the use of Social Security to provide the housing. With the enactment of Social Security, healthy older people had the ability to pay for other, less aversive forms of care. Custodial homes developed.

In the 1960's Medicare funding was limited, so older sick people could no longer stay in hospitals indefinitely. Elderly sick people were moved into the custodial nursing homes. Because these custodial nursing homes had only cared for *healthy* elders prior to this time, they had no idea how to care for the *sick* elders that were being transferred from the hospitals. With no other options to choose from, they adopted a medical model of care, complete with buildings that were laid out to be efficient like hospitals. Government-subsidized loans were offered to build huge numbers of these facilities. That is why so many of them look so much alike.

That's not to say that the medical model is inherently flawed; certainly the place for the medical model of care is in the acute care setting. Florence Nightingale is known for setting the environmental standards of caring for the acutely ill. Thus we have hospitals where health is promoted by the medical and nursing staffs who direct the routines of the patients in a carefully controlled environment. The problem with this model of care in nursing homes is that people actually reside in the nursing homes. Therefore, they need to retain control over their lives, at least to the extent that they are able.

Now that we have that historical perspective of the culture of nursing homes, we can begin to understand how things got to be the way that they are. Understanding the past has an important role in changing the future.

CHANGE

Change seems inevitable. Because many people (nursing home residents, families, staff, stakeholders and the younger generations) no longer find the traditional nursing home model appealing, change must happen. It's not a matter of "if," it's a matter of "when."



KEY CONCEPT

Advocates of nursing home culture change have defined broad objectives in these areas to promote culture change.

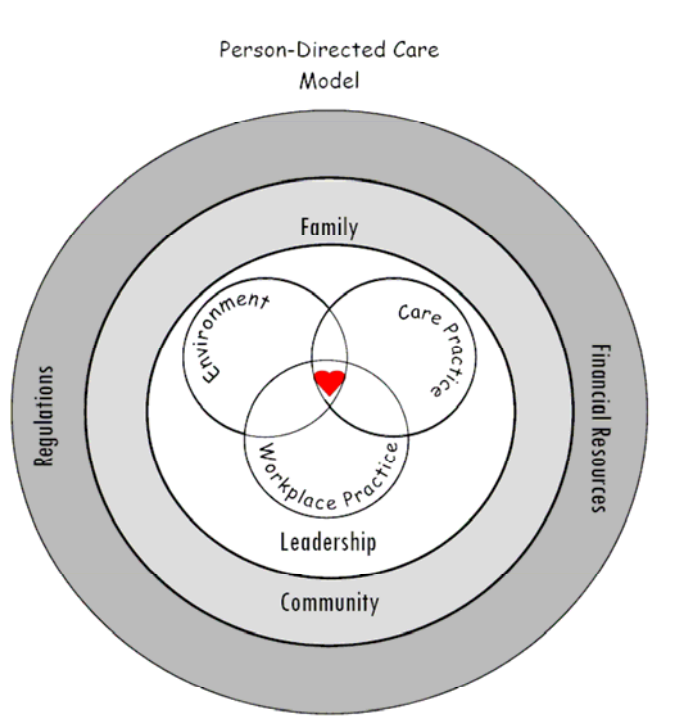
1. *Return decision-making control to residents.* To do this we need to assist residents in determining their own daily schedules. Do they really want to get up at 6:00 a.m., or would they rather sleep until 9:00 or 10:00? We need to allow them to make their own decisions about what and when they'll eat and how they'll bathe. We also need to

remember to not create dependency; rather we should promote all remaining capacities for self-care and mobility, as well as supporting continence for as long as possible. End of life care is also an area that needs more attention, with a focus on quality.

2. *Enhance front line staff's capacity to be responsive.* Here, we're talking about the concepts of consistent staffing and self-managed work teams; self-scheduling for the nursing staff, and cross training are other concepts that are working well in some homes already. We also need to remember to involve the nursing assistants in care planning, as they are truly the eyes and ears of the residents and typically know what the individual needs and preferences are of the elders. By enhancing our hiring and retention practices and developing pro-active relationships with surveyors, we give the staff the essential components they need to be responsive to the needs of the residents.
3. *Establish a home.* Some homes have begun to re-design their institutional structures; for some, this means remodeling or even brand new construction. The idea is to create a holistic environment by creating residential spaces and places for privacy. Family members need to be involved in any decision-making, so as to truly promote a sense of community within the nursing home.

THE PERSON-CENTERED CARE MODEL

The Person-Centered Care Model considers six inter-related domains that lead to personal, organizational, community, and systems changes, all of which are necessary for a transformation from institutional to individual care. The center domains are overlapping areas of Workplace Practice, Care Practice, and Environment. Leadership surrounds them most immediately. Each nursing home is of course encircled by Family and Community, and then by Regulatory/Government domains. Changes are necessary within each domain to achieve this level of transformational change.



FREQUENTLY ASKED QUESTIONS

Everybody has questions about culture change, and there are common myths that keep some homes from making changes. The intent of this manual is to help answer some of the questions that you have, and hopefully to throw light on some of those myths.

Question: “Can we incorporate culture change practices, given the federal and state regulations? Don't the regulations prohibit us from these practices?”

Answer: OBRA '87 serves as the foundation for person-centered care, as we are responsible to promote the well being of the residents to their most practicable level.

Question: “Can we incorporate culture change concepts, even if we don't have the finances to remodel or rebuild?”

Answer: Incorporating culture change doesn't have to be a financial liability. In fact, many homes are far along in their journey without spending any money at all. Culture change simply requires a shift in our paradigm, thinking outside the box about how we care for our residents.

Question: “How can we incorporate culture change when most of our residents have some form of dementia?”

Answer: Residents with dementia and most other types of cognitive impairment respond well to person-centered care. When communicating with these residents is a challenge, consult their families to learn more about their individual needs and unique preferences.

Some homes have already fully embraced the concepts of culture change and person-centered care; some are hearing these terms for the first time. No matter where you are on your journey of change, it is our hope that this manual will serve as a resource where you can find guidance as you make changes, or to give you ideas about what changes to make.