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# Strategies for Growth in Nursing Home Culture: Supporting Person-Centered Care

**Culture Change Overview**
The current culture in most nursing homes revolves around the tasks to be performed to satisfy survey requirements. Changing that culture means refocusing on people, and supporting them in thriving. By using the term "culture change" we mean to encompass the whole of life in a nursing home. The term "culture" captures the totality of life within a particular environment. Culture is, by nature, elusive, hard to pin down, hard to see, and even harder to change, because it is so much the culture that those in it are unaware of it, take it for granted – culture is the givens. The Pioneer Network defines culture change as a transformative change that is anchored in values and beliefs that return control to elders and those who work closest to them.

What most of us fear about going into a nursing home is that we will have to leave ourselves at the door. Our life as we have known it will be over. We will be an inmate in an institution, subject to its rhythms, routines, and requirements. In person-centered care, normal life is the goal. To achieve this goal, nursing homes adjust care and routines to the resident, instead of the other way around. For example, when a person moves into a nursing home, typically she is given the waking time, bathing slot, and dining room seating of the person whose death freed up a bed. In a changed, person-centered culture, the person who has just moved in is asked about her life-long patterns and a schedule is established to support their continuation. She, and her family, is asked about her accustomed routines for getting up and going to bed, eating meals, engaging in life activities, what helps her thrive. To change the culture from task-centered to person-centered, nursing homes need to re-orient their systems and structures to support staff in accommodating residents' needs and preferences.

The body of literature on the social and emotional well being of people living in nursing homes provides the context for what is today called *culture change*. *Culture change* is the current term for work over decades to humanize nursing homes. In the 1960s, practitioners expressed concern about the "depersonalization" of nursing home life. In the 1970s, the term was "custodial care." In the 1980s, a gerontologist comparing homelessness and nursing home life described residents' state of "psychic despair." Now Bill Thomas, through Eden, identifies it as loneliness, boredom, and isolation. An institutional model that provides basic medical care but does not address the human needs of connectedness and relationships is one that shuts down human beings. Impersonal and dehumanizing care that does not address the needs of the human spirit cannot succeed medically. The literature amply documents the indisputable link between psychosocial well being and clinical outcomes, between quality of care and quality of life.

Attention to quality of life became a matter of federal policy with the passage of the Nursing Home Reform Law of OBRA '87. OBRA required nursing homes to care for each resident's "physical, mental, and psychosocial well-being" using an interdisciplinary resident assessment and care planning process. Over the next several years, the federal government developed regulations, surveyor guidelines, and resident assessment protocols for quality of life and psychosocial well being. While the implementation of these regulations and guidelines has become fairly regimented, at their outset, they generated a rethinking of nursing home care.

One area that illustrates this is the rethinking of restraint use. While practitioners were already questioning restraints before OBRA '87, the law's focus on quality of life, residents' rights, and psychosocial well being accelerated this review. To reduce use of restraints, practitioners had to recognize the *iatrogenic* nature of restraints – not only were they damaging to the human spirit, they were actually *causing* declines in every aspect of physical care. Looked at in relation to the requirement for nursing homes to provide care "that attains or maintains the highest practicable physical, mental, and psychosocial well-being of each resident," restraints did not measure up.

Similarly, other care systems in nursing homes intended to meet residents' needs can instead be *iatrogenic*. Typical "toileting" occurs on a schedule built around staff routines. No wonder we have so much "incontinence." A social worker quoted a woman newly admitted to a nursing home that, in describing her despair, said; "You haven't lived 'til you've gone to the bathroom on someone else's schedule." In a changed culture, staff would be tuned in to

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residents' patterns and available to respond to residents when their needs occur. This is person-centered, *individualized care*. To individualize care, staff and residents need to be in a consistent caring relationship, and staff needs to be supported in accommodating residents' needs. Yet, in the highly impersonal medical model, care evolved that at its core dictates an impersonal touch. People who work in medical model settings were and are told not to form attachments to those they care for because such attachments are "unprofessional."

Care that dehumanizes an elder also dehumanizes the caregiver. The human spirit that resides within every one of us thrives on close connections to those around us. Most direct care staff come into care work to care for others. If they must force car wash type showers on residents who are pleading for them to stop, they must shut down some of their own humanity to complete the task. When aides are told to "pick up the pace" and to get the tasks done, they live with the dissonance created by a system that puts task over person. Many staff then operate in two realities, the one that adheres to the organization's rules, and the other guided by their human instincts as caregivers. In a changed culture, systems and structures support the relationship between staff and residents. Workers and residents work in tandem to find their way through the day, attending to needs with fluidity rather than routinization.

Changing the caregiving culture to center on the care-giving relationship requires reorganizing work, and a reorientation of the workplace culture. Long-term care, like many workplaces, generally has a command-and-control culture. Decision-making occurs at the management level and staff members have limited opportunity for input. Staff learn to keep their ideas to themselves and do as they are told, while management is frustrated that staff do not take up opportunities to participate in committees or offer opinions at meetings. To change the culture, nursing home leaders need to change the way they lead. There is an emerging body of literature that the key to effective leadership is the ability to grow the leadership capacity of others. Leadership, when it is most effective, is inclusive. What has traditionally been labeled as resistance or opposition is often actually necessary information for successful implementation of any initiative. Successful culture change initiatives have a collaborative approach that involves those residents and staff affected by the change in designing, thinking through and troubleshooting what it will take to put changes in place. This engagement in shaping where they live and work, in itself humanizes the culture, and also ensures it is remade in a way that will work for everyone involved.

**Person-Centered Care**

In person-centered care, relationships between staff and residents are at the heart of care. Homes honor those relationships through consistent assignments in which teams of staff work together with groups of residents on a steady on-going basis. Homes that have created "neighborhoods" often include non-nursing staff from housekeeping, food services, social work and activities as part of the consistent team working with the same residents in one area of the home. In supporting normal life for residents, staff help people get up according to their life-long patterns, eat their meals, as they have been accustomed to at home, and go about their daily activities in a way that feels and is "at-home" for them.

This requires a complete reorientation of systems of care. The current systems of care are efficiently producing the current results. So, to shift to a person-centered culture, homes must reorient their systems of care. For example, in the current system, the night shift awakens residents not because they are early risers but because they need to get a start on getting everybody up, clean, dressed, and fed by a certain time in the morning. For people to awake of their own accord requires a reorientation of the systems for the nursing staff, housekeeping, food service, and laundry. Homes will likely experience a reduction in anti-anxiety meds when people have a better start to their day, a reduction in incidents among residents and between residents and staff, better nutritional status, and numerous other health improvements associated with going with people's natural rhythms instead of against them. Each change will generate others.

Some critical areas for focus in shifting from task-centered to person-centered care include:

Resident assessment and care planning – some homes use "I" format care plans written from the resident's point of view. For example, instead of "ambulation 2X/day," a care plan would say, "I like to walk. My favorite times for walking are after lunch and dinner. I usually walk about 15 minutes, but on nice days, I like to stay out longer."

Consistent assignment – rather than have staff rotate, staff are assigned consistently to the same group of residents and the same co-workers, so that they all get to know each other and can work well together as a team.

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Decentralization of decisions, resources, and routines – such as country kitchens or other means on the unit for accessing food for snacks and meals so that residents can eat when and what they feel like. Activities are done individually and may be coordinated by staff other than the activities staff.

Localized communication systems – regular meetings on the units or neighborhoods among those who live and work there to discuss what is relevant to daily life for those who live and work there.

Inter-shift communication – so that the hand-off enables each care team to stay in tune with the rhythms and needs of residents.

Participatory leadership that fosters open, honest relationships – recognizing that opening the lines of communication nurtures human connections and is central to good care.

**Transformative, Inclusive Leadership**
Leadership is essential to the success of a culture change initiative. For the past thirty years there has been a growing body of knowledge about leadership, and the leadership skills needed to make organizational changes. We can extrapolate from this growing body of work, and apply the concepts to the long-term care setting. Changing any organization's culture can be done, but it is a challenging task, and takes extraordinary leadership abilities. Changing the culture in a nursing home is exceptionally challenging, as there are strong and persistent outside forces that have pushed homes into the box that they now find themselves in.

James Kouzes and Barry Posner found that exemplary leaders had in common five qualities; they (1) challenged the process, (2) inspired a vision, (3) enabled others to act, (4) modeled the way, and (5) encouraged others. They said that a key component to leadership is the ability to challenge what is currently happening – to challenge the culture. A leader who challenges systems that are not working must have followers who also want to make changes. To follow, people must believe in the person leading. In culture change, a leader who challenges systems that put task over people will find the support and trust of those who work there because they see the value and feel the pull of the rightness of it.

Culture change leaders promote creativity in others by giving others "permission" to lead. By seeing the best in others and expecting excellence, they transform the workplace culture. The idea of a lonely leader at the top charting a course that others follow because they are told they must, has been replaced by a growing body of evidence that a more effective style of leadership is one in which the leader involves others in the organization, finding out from people who will be doing the work what they think will work, and bringing them into the design and decision-making of the change process. Leaders must have a vision of what they want to happen and the ability to share that vision and allow others in their organization to help shape it. They must also allow for mistakes and learn from them. Fear of mistakes keeps real change from happening.

Putting in practice anything new is hard, but changing the very culture of an organization takes special leadership skills. Warren Bennis, noted writer and researcher on leadership, concludes that no leader sets out to be a leader. Rather effective leaders are people compelled to follow a course. In long-term care, culture change leaders then are their most effective when setting out to do the right thing, feeling within themselves the value of what they are doing. He also found that effective leaders bring their whole selves to the process and withhold nothing. Commitment to what they are doing and valuing the people around them are essential ingredients.

Such leadership requires skills and systems that support relationships. Skills include group process, teamwork, and interpersonal skills. Systems include communication among staff and decision-making that gives staff authority that coincides with their responsibilities for care. To be a transformative leader requires innovation and original thinking, the ability to see how current systems and structures perpetuate problems and enlist participation in reshaping those systems and structures from those who must live with them. Leaders focus on people; inspire trust; maintain a long-range perspective; and keep their eye on the horizon. Rather than aim for "buy-in" they share ownership, and are willing to be changed by the process of engagement with others. A culture change leader changes "how" change happens, so that everyone is involved in putting systems in place that are congruent with nurturing the human spirit.

**Workplace Practices that Value and Support Staff**
High turnover has plagued long-term care. Long-term care has tended to attract people who look for a caring

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connection to others—they enjoy being of service. But the reality of the job often is quite different than the worker's expectations. Too many people to care for, too much overtime, working in isolation, low pay and a feeling of being unappreciated are some of the reasons people give for having left the field. In general this has been a field that has not been very supportive of its workers. Nurses complain of mountains of paperwork that keep them from the work they love and frontline workers complain of the increasingly heavy load they are carrying.

In culture change, all the people who live and work in the nursing home are valued and supported. Consistent assignments provide a structural support for the caring relationships that give meaning to the work. Front line staff is highly involved in care planning, and in the daily decisions that affect resident life. Because they work with the resident's own rhythms instead of trying to make the resident fit into a facility schedule, their work is more rewarding. They are doing the work that drew them in, and so they feel the value of their effort. In a culture change home, workers' input is sought and they have a say in most decisions that affect them. As one administrator put it, "I try to abide by the input of staff on most decisions, most of the time."

Another way that staff know that they are valued is that their personal and professional lives are not ignored. A worker whose child is ill is not penalized for being a concerned mother, and the worker who wants to improve by taking classes is supported. Workers are shown that they are valued when they are recognized as full human beings. Supportive approaches to supervision, teamwork, opportunities for professional development all make a difference in the work culture.

Many homes are sterile environments in which conversation about tasks and procedures are abundant but real conversation where people ask questions, say what they really think, or engage personally is in short supply. There is an abundance of superficial conversation but little of the real conversations that ground relationships. The very nature of these superficial conversations contributes to the dehumanizing feel of nursing homes. This lack of real conversation makes the task of trying to change the culture daunting. For many homes that start down the path of deep change, one of the first things that they have to address is the way people relate to each other. Years ago, a home that was looking at how it engaged residents came to a bigger revelation: before they could begin the dialogue on how to change the way they talked with residents they needed to learn how to talk to each other. It is not uncommon to have rules about what can be talked about. For instance, it is not uncommon to have as a general rule, that conversation that is not upbeat and positive is not allowed because it is considered "negative." This is just one way that real conversation is shut out and people are shut down.

Integral to this is the notion that real relationships are not allowed. So they occur underground. There is the above ground system that supports the remote professional touch and there is what really happens: front line workers who keep their caring underground. Culture change integrates the two systems into one. The caring and trust that is the hallmark of healthy relationships is supported, nurtured, and recognized by the system as elements of good care. It is not only residents who become institutionalized; staff do as well. A culture change home is one that seeks to de-institutionalize and re-humanize the environment for all who spend time there.

The primary objective is to facilitate the implementation of strategies for growth in nursing home culture that support Person-Centered Care. Innovative strategies include interventions that will address: workplace practice, environment, and care practices.