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A stage model of culture change in nursing facilities

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In recent years, a movement to implement new organizational models through radical innovation known broadly as culture change (CC) has emerged in nursing facilities across the United States.

A variety of CC models such as Wellspring[1], Service House[2], Eden Alternative[3], Regenerative Community[4] and others are beginning to transform industry practices. The biggest challenge in evaluating CC stems from the lack of a common definition or nomenclature to describe the CC process. Because many different models of CC have emerged there is limited consensus about what CC is. What research suggests is that organizations attain different degrees of CC depending on contextual factors such as leadership or organizational resources.

We used an expertise elicitation method to develop a conceptual model of the CC process. We approach the question of how to assess the degree of CC from an organizational development perspective. Just as people progress through distinct stages of human development going from infancy to childhood to adolescence to adulthood to old age, nursing facilities undergoing CC progress through distinct stages of organizational change and development. Just as personality changes occur in individuals at different life stages, core systems change within organizations at different stages of CC.

Proposed stages of culture change

We propose four stages of CC:

STAGE I: Institutional model is a traditional medical model organized around a nursing unit without permanent staff assignment. Neither residents nor staff are "empowered" in this model, because the organizational power structure is "top-down" or hierarchical going from administrator to department heads to supervisors to frontline staff.

STAGE II: Transformational model is the initial period of CC implementation when awareness and knowledge of CC spreads among direct care workers and the leadership team. A key characteristics of many organizations at this stage is permanent staff assignment to the unit. Often, "symbolic" or minimalist (low cost) changes are introduced into the physical environment to make it less institutional (e.g., new furnishings, interior finishes, artwork, animals and plants).

STAGE III: Neighborhood model breaks up traditional nursing units into smaller functional areas and introduces resident-centered dining (without full kitchens). The role of a "neighborhood coordinator" is typically formalized at this stage and neighborhoods are given unique identifiers or names.

STAGE IV: Household model consists of self-contained living areas with 25 or fewer residents who have their own full kitchen, living room and dining room. Staff work in cross-functional, self-led work teams. The hierarchical organizational structure is "flattened" through the elimination of traditional departments.

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[1] Stone, R. et al., Evaluation of the Wellspring Model for Improving Nursing Home Quality. The Commonwealth Fund publication number 550, August 2002.

[2] Grant, L.A. Lyngblomsten Service House Demonstration. Research in Practice. Center for the Study of Healthcare Management, Department of Healthcare Management, Carlson School of Management. August 2001.

[3] Ransom, S. Eden Alternative: The Texas Project. Institute for Quality Improvement in Long Term Health Care. IQILTHC Series Report 2000-4, May 2000.

[4] Eaton, S.C. Beyond 'Unloving Care': Linking Human Resource Management and Patient Care Quality in Nursing Homes. International Journal of Human Resources and Management, Vol. 11, No. 3, June 2000.

Table 1 (attachment) shows a matrix that further delineates the four stages of CC. As organizations move from Stage I to Stage IV innovations occur in five organizational systems:

DECISION MAKING — Methods used to reach decisions become consensus oriented, more decisions are made based on group process, and decisional control ultimately becomes resident-directed.

STAFF ROLES — Staff assignment becomes more permanent and consistent. Staff work more autonomously in self-directed work teams that are multi-disciplinary. Staff roles change from those found in traditional departments (nursing, housekeeping, food services, activities, or social services) to roles that are multi-functional. More staff are cross-trained or work in blended roles. Cross-trained workers are those who can play several functional roles (e.g., a housekeeper or activity aide who can assist with CNA tasks because the worker is CNA certified). Blended roles involve job descriptions for positions that actually combine responsibilities of multiple departments (e.g., activities/social services, nursing/housekeeping or nursing/activities). At the most advanced stages of CC staff work as universal workers who function in multiple roles encompassing housekeeping, nursing, food service and activities. Universal workers function in roles that extent beyond those that can be completed by cross-trained workers and through blended roles.

PHYSICAL ENVIRONMENT — The functional areas where residents live and staff work become smaller as nursing units are broken up into "neighborhoods" and "households." A neighborhood breaks up the typical nursing unit with 25 to 35 resident rooms into smaller functional areas usually without the need to make large capital expenditures. Nursing units are broken into smaller functional areas that are not self-contained. Neighborhoods share ancillary services (e.g., dining, laundry, activities and bathing) with other neighborhoods. A household represents a self-contained area with 16 to 24 (or fewer) residents. Core services are decentralized. Each household has its own full kitchen (with cook top, oven, microwave, refrigerator, freezer, dishwasher, sink, cupboards, dishes, and utensils). Personal laundry is typically done within the household. A common dining room and living room are provided on each household. Households are sometimes provided individualized entrances within a larger facility or can be in located freestanding facilities.

ORGANIZATIONAL DESIGN — Organizational functions become less compartmentalized in traditional departments (such as nursing, housekeeping, food services, activities and social services). These "silos" disappear as new organizational structures emerge to provide core "support services" for neighborhoods and households. This redesign makes the organization flatter and less hierarchical.

LEADERSHIP PRACTICES — The composition of leadership teams changes as teams become more decentralized, autonomous and multidisciplinary. Core competencies of leadership teams in critical management skills improve. These core competencies include conflict management, communication, visible presence or "modeling the way," supporting change and process management (including supporting a learning organization and problem solving in operations).

We are now pilot testing a CC Process Map and Staging Tool that can be used to classify nursing facilities into one of these four stages. **Figure 1** (attachment) shows a decision tree that describes the logic underlying the staging scheme[5]. **Table 2** (attachment) shows the results of our pilot tests using the staging methodology in three facilities.

Dover Health Care

Using our staging methodology, Dover Health Care (DHC) is classified as a Stage II facility operating predominantly through a transformational model. This facility has environmental features of a neighborhood model; however, it lacks the operational features of this model (e.g., multi-disciplinary or cross-functional neighborhood teams; resident-centered dining; and neighborhood team decision-making authority). In terms of the physical environment, DHC has features of a neighborhood model. It divided two nursing units on two floors into six neighborhoods: 1) White Birch (22 beds); 2) Norway Evergreen (22 beds); 3) Spruce (18 beds); 4) Elm (11 beds); 5) Willow (22 beds); and 6) ACU (24 beds). Although this facility has Stage I features when it comes to staff leadership behaviors, overall this facility is operating under a transformational model (Stage II).

Spring Health Care

Spring Health Care (SHC) is a Stage III facility operating under a neighborhood model. It divided two nursing units on two floors into four neighborhoods with roughly 30 beds each: 1) Harmony Gardens; 2) Serenity Springs; 3) Willows Way; and 4) Country Corners. SHC maintains a centralized dining area for most residents on the first floor and currently provides limited dining opportunities on its neighborhoods. SHC does not offer a "true" neighborhood dining experience. SHC is predominantly a neighborhood model (Stage III).

Compton Health Care

Compton Health Care (CHC) is classified as a Stage I facility. It has a single 84-bed nursing unit on one floor with four wings which are organized within a traditional institutional model. CHC has the operational characteristics of a Stage I facility which is not surprising given that it is not a CC facility.

This model delineating the four stages of CC is potentially useful to providers and researchers. It offers a roadmap to provider organizations undergoing CC so they can assess their progress from Stage I to Stage IV. For researchers, the model allows more precise measurement of organizational innovations that are part of the CC process. The model has been successfully pilot tested in a small number of CC facilities across the U.S. The preliminary results are promising but limited due to small sample size. As the staging methodology is tested in a larger number of facilities, and it will be validated against other measures of CC. (We are pilot testing a set of CC scales to measure change in the five core organizational systems). As new knowledge about CC becomes available, it should lead to a better understanding of the CC process.

[5] A Culture Change Staging Questionnaire with questions and coding conventions is available upon request from the first author on this paper.

TABLE 1

The Four Stages of Culture Change

STAGES	RESIDENT-DIRECTED DECISION MAKING	STAFFING ROLES	PHYSICAL ENVIRONMENT	ORGANIZATIONAL REDESIGN	LEADERSHIP PRACTICES
There are four basic stages of culture change. An organization can be at a more advanced stage on one attribute and less advanced on another attribute. In general, these attributes cluster together by stage of organizational development.	*From Stage I to Stage IV, decision-making becomes more dependent on group process, and decisional control becomes more resident-directed.*	*From Stage I to Stage IV, staff assignment becomes more permanent and consistent. Staff work more autonomously in smaller work teams that are multi-disciplinary. Roles change from those found in traditional departments. More cross-trained staff, more staff in blended roles and more staff who can function as universal workers are examples of how staffing roles become more integrated.*	*From Stage I to Stage IV, the size of the functional areas where residents live become smaller, and more differentiated, personalized, and self-contained (i.e., decentralized into smaller functional areas).*	*From Stage I to Stage IV, departmental functions and staff roles become less compartmentalized into departmental silos. The organizational structure becomes flatter and less hierarchical. The traditional departmental structure (e.g., nursing, housekeeping, activities, food service, social services, etc.) disappears.*	*From Stage I to Stage IV, the composition of leadership teams changes. The competence of leadership teams in areas such as conflict management also improves. Leadership teams are more decentralized, autonomous and multidisciplinary.*
STAGE I: INSTITUTIONAL MODEL					
This is the traditional model that is found in most nursing facilities. It is organized around a functional area known as a nursing unit (with a nurses' station with medication and chart storage, and clean and dirty utility areas).	Decision-making involves top managers (primarily administrator and director of nursing with input from other department heads) with little input from frontline staff, residents or family members. Group process such as a "learning circle" is *not* used in decision-making. Instead, top management makes most decisions affecting the daily lives of residents or staff. The round of daily activities is determined by the needs of the staff and the institution with limited input from residents.	Nursing staff are not permanently assigned to nursing units but rotate across units based on organizational policies or depending on need. If one unit is short-staffed, staff from another unit are used to fill that position on a day-to-day basis. Staffing patterns are determined by policies and procedures centrally controlled throughout the facility. Staff roles reflect traditional functions defined by organizational departments (e.g., nursing, food service, housekeeping, activities, and therapy).	Centralized dining in a large common dining room serves residents from multiple units. Kitchen access is limited primarily to food service workers or others who have authorization to be in kitchen areas. The decor (e.g., interior design, furnishing, finishes, lighting and materials) is institutional (as opposed to home-like). The typical nursing facility with an institutional model is divided into three to four nursing units with 25 to 35 or more residents each.	This is the typical hierarchical organizational model with a board of directors and administrator at t he top. There are department heads for key functions such as nursing, rehabilitation, social services, food services, activities, building maintenance and business office.	A broad range of leadership skills are found at this stage. The leadership team primarily involves the administrator, the director of nursing and key department heads.

STAGE II: TRANSFORMATIONAL MODEL

STAGES	RESIDENT-DIRECTED DECISION MAKING	STAFFING ROLES	PHYSICAL ENVIRONMENT	ORGANIZATIONAL REDESIGN	LEADERSHIP PRACTICES
This is the initial stage when culture change begins to show itself in terms of key culture change attributes. This model is similar to the institutional model in terms of organizing services around a functional area known as a nursing unit.	Group process such as a "learning circle" *is* used to elicit input into decision-making. Group process leads to a greater "equality of values" (i.e., leveling of social status) within the organization between top management, supervisors, frontline staff, residents and family members. Although input is sought from diverse stakeholders, its impact on decision-making is minimal and more *symbolic* (i.e., contributory) than real. Group process is used, but has limited impact on actual decision-making.	Nursing staff are permanently assigned to the unit. Staff do not rotate across units. Staffing patterns are determined by policies and procedures that are centrally controlled throughout the facility. Staff roles reflect the traditional functions defined by organizational departments (e.g., nursing, food service, housekeeping, activities, and therapy). Some self-scheduling is allowed by unit staff, but is usually limited to the day shift.	This stage of introducing change into the physical environment involves minimalist (low cost) interventions to change the ambiance on the nursing unit to make it less institutional. Changes in decor are made through new furnishings, artwork, interior finishes, plants, and animals. Increased personalization in resident rooms and common areas are used to make the setting more homelike. Removal of institutional clutter from hallways (e.g., lifts, laundry carts, wheelchairs, trash cans, and so forth) is another strategy to make the environment more homelike. A breakfast buffet may be introduced into the centralized dining room to give residents greater flexibility and choice at mealtimes.	Department heads no longer work strictly within their departmental roles, but are assigned to nursing units. Department heads may be assigned to individual residents through a "guardian angel" program (e.g., to serve as an advocate for a particular resident or group of residents). Department heads "model the way" and become involved in the daily tasks and activities on the unit (e.g., helping with meals or activities, and answering call lights).	At this stage the first signs of change in leadership practices are seen. Members of the existing leadership team begin to grow in their ability to involve others in critical thinking and decision-making. Team leadership begins to emerge through more frequent use of group decision-making processes. "Natural" leaders (i.e., workers with strong leadership abilities who do not hold formal leadership positions) begin to emerge, so new leaders are found on the unit. Mentorship training programs are introduced. Other leadership training programs are offered at this stage (e.g., person-first training, community leadership training and conflict resolution training).

STAGE III: NEIGHBORHOOD MODEL

STAGES	RESIDENT-DIRECTED DECISION MAKING	STAFFING ROLES	PHYSICAL ENVIRONMENT	ORGANIZATIONAL REDESIGN	LEADERSHIP PRACTICES
This model represents one way of breaking up the typical nursing unit with 25 to 35 resident rooms, into smaller functional units (called neighborhoods). However, these neighborhoods are not self-contained as is the case with the household model. They share core services (e.g., dining, laundry, activities, and bathing) with other neighborhoods.	Group process such as a "learning circle" is used to elicit input into decision-making. The input of frontline staff, residents and family members is no longer symbolic, but real. Decisions around daily life or "spirit and identity of the neighborhood" are determined through group process. These decisions typically involve "minor" aspects of daily life such as special celebrations, parties, group activities, staffing assignments or food choices. For example at this stage, residents may be given control over how to spend funds allocated to an activities budget for the neighborhood. The boundaries of decision-making are established for each neighborhood.	Nursing staff are permanently assigned to one or more neighbor-hoods within the same unit. Staff do not rotate across units. Staff work in self-directed teams with a neighborhood coordinator as the team leader. Non-nursing staff are also permanently assigned to the neigh-borhood and work as part of the team. Some of these non-nursing staff work in blended roles that cross cut the departmental functions of the typical nursing home. CNA (Certified Nursing Assistant) Certification for non-nursing staff is not required but encouraged to develop cross-trained workers. Some workers have blended roles that combine responsibilities of multiple departmental functions (e.g., activities and social services, nursing and house-keeping, or nursing and activities). The admini-strator, director of nursing and department heads may begin to work evening shifts and weekends at this stage. Staffing schedules become more flexible.	This model offers decentralized dining in the neighborhood without a full kitchen (i.e., without kitchen amenities such as a cook-top, oven, microwave, refrigerator, freezer, dishwasher, sink, cupboards, dishes and utensils). Lacking a full kitchen, food preparation on the neighborhood is limited to the use of crock-pots, toasters, coffee makers, waffle makers, griddles, bread makers and similar small electrical appliances. Nursing stations and medication carts are still used on the unit, which is subdivided into smaller neighbor-hoods. Downsizing of excess bed capacity often happens at this stage.	The role of "neighbor-hood coordinator" is formalized. This position may be filled by any staff that is part of the self-directed work team such as a certified nursing assistant (CNA), activity aid (AA) or a department head. The role of "neighborhood coordinator" is a new role that gets added to a worker's primary role on the self-directed work team. Neighborhoods are frequently given names at this stage (e.g., Balsam Lane or Cedar Grove) to differentiate them from their former unit names (e.g., One North or Two South).	Leadership becomes more decentralized as consensus decision-making occurs in self-directed work teams. Leaders begin to develop skills in conflict management.

STAGE IV: HOUSEHOLD MODEL

STAGES	RESIDENT-DIRECTED DECISION MAKING	STAFFING ROLES	PHYSICAL ENVIRONMENT	ORGANIZATIONAL REDESIGN	LEADERSHIP PRACTICES
This is the final stage in the culture change process. To achieve this stage, renovations to the physical environment are usually necessary. Since most units in the typical nursing home have been designed to support an operational model that was taken from acute care hospitals, most lack the architectural and interior design amenities needed to support a household model.	Learning circle (or other group process) is used to make most decisions that affect life in the household. For example, decisions about food choices become more resident-centered. Residents have "refrigerator rights" (i.e., access to a refrigerator with food that is theirs). Residents are given much greater influence about when and what to eat. Decisions about daily household activities become more resident-centered. Residents are given more control over their daily routines and activities (e.g., when to get up, when to go to bed, or how to spend the day). Household boundaries for decision making expand beyond "minor" aspects of daily life (at Stage III).	Staff are permanently assigned to a single household. There are full-time, part-time and casual staff (i.e., those without regularly scheduled hours) that are assigned to each household. Household teams create their own work schedules, so scheduling is no longer centralized within the facility. As a result, both shifts and staffing ratios begin to vary across households over time. Staff are no longer working within traditional functional departments. Staffing mix moves towards having more "universal workers" (staff who serve in multiple roles encompassing housekeeping, nursing, food service and activities). So, CNA certification for all staff working within each household becomes increasingly vital.	This model represents a self-contained area with 16 to 24 (or fewer) residents. Core services are decentralized. Each household has its own full kitchen (with cook-top, oven, microwave, refrigerator, freezer, dishwasher, sink, cupboards, dishes and utensils). Personal laundry is typically done within the household. A common dining room and common living area are provided to residents in the household. Staff work areas are better integrated into common areas for residents, so the nursing station and medication carts are eliminated. Most daily activities occur within the household, so staff no longer have to transport residents to centralized activity areas that are outside the household.	This is a smaller organizational unit with 16 to 24 beds per household. At this stage the traditional departments (e.g., nursing, housekeeping, food service, activities) have been largely eliminated from the facility. Services offered by departments such as food service, building maintenance, contract therapy and business office are restructured so that they function as support services for each household. The administrator oversees these support services. Each household has a "nurse leader" who reports to a "clinical mentor" (similar to the former director of nursing or DON). Each household has a community coordinator who reports to a "social mentor" (a new role that combines the roles of activities director and social services director).	A new leadership team emerges at the facility level and includes the administrator, the clinical mentor, the social mentor, nurse leaders from each household and community coordinators from each household. Conflict management skills are fully operationalized. Leadership skills are improved.

TABLE 2

Pilot Test Results: Stage of Culture Change for Three Facilities

CULTURE CHANGE ATTRIBUTE	HEALTH CARE CENTER		
	DOVER	SPRING	COMPTON
	STAGE II	STAGE III	STAGE I
QUESTION 1: Permanent nursing staff assignment	Yes	Yes	No
QUESTION 2A: Staff awareness of culture change	Yes	Yes	No
QUESTION 2B: Staff leadership behaviors	No	Yes	No
QUESTION 2C: Resident-directed behaviors among staff	Yes	Yes	No
QUESTION 3: Leadership team obligations	Yes	Yes	No
QUESTION 4: Neighborhood features in the environment	Yes	No	No
QUESTION 5: Multi-disciplinary or cross-functional neighborhood team	No	Yes	No
QUESTION 6A: Resident -centered dining (food choices)	No	No	No
QUESTION 6B: Resident-centered dining (social experience)	No	Yes	No
QUESTION 7: Neighborhood team decision-making authority	No	Yes	No
QUESTION 8: Self-contained household	No	No	No
QUESTION 9: Refrigerator rights and daily life choices	No	No	No
QUESTION 10: Multi-disciplinary or cross-functional household team	No	No	No
QUESTION 11: Empowerment of household within facility leadership team	No	No	No
QUESTION 12: Self-led work team	No	No	No