Beyond the Medical Model: The Culture Change Revolution in Long-Term Care

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Culture change in long-term care facilities involves a shift in philosophy and practice from an overemphasis on safety, uniformity, and medical issues toward resident-directed, consumer-driven health promotion and quality of life. Fundamental to this shift is a focus on the importance of the relationships between residents and direct care staff. This review presents and discusses the key elements of culture change, including workforce redesign, resident-centered care, leadership, and the implementation process and evaluation. A case report describes how medical staff can participate in this grassroots movement and help foster the social, cultural, programmatic, and physical changes that can alter the culture of long-term care one home at a time. **(J Am Med Dir Assoc 2009; 10: 370–378)**

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The modern nursing home has evolved in part from changes in federal legislation over time. The Hospital Survey and Construction Act (Hill-Burton), amended in 1954, allocated funds for construction of long-term care facilities (LTCFs) that were tied to hospitals. The hope was that the success of the medical model would spill over from the hospital to the LTCF.[1] The passage of Medicare and Medicaid in 1965 further advanced long-term care toward a medical model.

The Omnibus Budget Reconciliation Act of 1987 (OBRA '87) led to standardized assessment, comprehensive care planning, reductions of restraint and Foley catheter use, and the development and reporting of quality indicators.[2] Although OBRA was developed with the intention of promoting residents' rights, its emphasis on quality of care and health outcomes had the unintended consequence of increasing the orientation of nursing homes on medical outcomes rather than on quality of life.

Since that time, a strong undercurrent within the field challenged the notion of LTCFs as medicalized settings. Several new care models have emerged: the Live Oak Institute,[3] the Eden Alternative,[4] the Wellspring Innovative Solutions,[5] the Beverly Culture Change Pilot,[6] the Greenhouse project,[7] and the HATCh model[8]: Table 1 provides a brief description of each. In 1997, a landmark meeting occurred where pioneers from across the country convened. This process led to formation of the Pioneer Network as the "umbrella organization" of this movement, whose goal became termed "culture change."[9]

Thirteen values and principles guide the mission of the Pioneer Network[10]; these are presented in Table 2. Through the advocacy of the Pioneer Network, federal regulators began to take notice of the concept of culture change. In 2002 the Centers for Medicare and Medicaid Services (CMS) hosted a session about the Network's practices and values. In 2006 CMS's eighth scope of work mandated that state quality improvement organizations (QIOs) develop long-term care-based initiatives in culture change.[11]

The process of culture change in long-term care involves a shift in philosophy and practice toward resident-directed, consumer-driven health promotion and quality of life. Fundamental to this shift is a focus on the importance of the relationship between the resident and direct care staff. Workplace and human resources support, nurture, and enhance the roles of LTC staff, particularly certified nursing assistants (CNAs). The success of culture change is dependent on education and "buy in" across all disciplines about the value of this approach and a commitment on the part of leadership to undergo a prolonged series of steps—a process that is often referred to as a "journey." This journey, however, has no final destination, as culture change is a method of continuous quality improvement.

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Table 1. *Models of Culture Change in Long-Term Care*

The Live Oak Institute (formerly Live Oak Regenerative Community) – Begun in the 1970s as a way to empower the disenfranchised in long-term care, this organization looked beyond the individual abilities of each older adult, and instead envisioned the crucial role of elder-hood in our society. An elder is defined as "a person who is still growing, still a learner, still with potential and whose life continues to have within it promise for, and connection to the future."

Eden Alternative – Developed in 1991 by Dr. William H. Thomas and colleagues, this model strives to transform long-term care facilities (LTCFs) into "lush, lively human habitats." Ten unchanging principles drive the ecology of a home with gardens, animals, and children.

Wellspring Innovative Solutions – Started in 1994, a collaborative effort of LTCFs in Wisconsin responded to the trend toward managed care and consequential poor reimbursement and decreased resources. Fundamentals to this model include collaboration among the facilities, staff empowerment, and consistent staff assignment to residents.

Golden Gate National Senior Care (formerly Beverly Enterprises) – The first for-profit facility to pilot a resident-centered model as a strategy for quality improvement. A Commonwealth Fund study revealed that although there were no short-term financial gains, the long-term gains of improved quality of life for residents, better working conditions for staff, and improved leadership may all argue for a competitive model in the marketplace.

Greenhouse – The first of this model was built in 2003. Individual houses of 8–10 elders per home are cared for by an elder assistant who is a "universal worker." Decisions regarding menus, activities, and routines are decided by the residents, and residents have full access to the entire house.

HATCh – Holistic Approach to Transformational Change. Created by the Quality Partners of Rhode Island, this model consists of 6 domains, or circles, with the resident at the center of the work being done. Three circles that most affect the resident are workplace practices, care practices, and the environment. Workplace practices connote activities and procedures that affect residents through their influence on staff. Care practices refer to the manner in which residents receive care in the facility. The environment circle refers to promoting a place of home.

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KEY ELEMENTS OF CULTURE CHANGE

Workforce Redesign

In a traditional LTCF the leadership model is top-down. There is a "chain of command" in which nursing assistants are tightly regulated under licensed nurses' orders, and nurses are tied to onerous documentation that is required for reimbursement.[12,13] Because this model can often lead to tension among staff,[12,14] culture change promotes a redesign of the workforce where the goal is to "flatten" the hierarchy. This can be done by creating self-directed work teams.

Self-directed work teams are associated with higher job satisfaction, improved self-esteem for workers, increased efficiency, and reduced staff turnover.[13] Often these teams are made up of 3 to 15 members, and they manage both care practices and management issues.[13] Unlike an interdisciplinary team, where the members are primarily established as a task force and working toward an end-goal, a self-directed team will work on the same neighborhood (group of rooms or residents) and decide within itself what work needs to be done for that day. Supervisors act as facilitators, but they do not hand down orders to be carried out.[13] Instead, the tasks are decided within the group.

For example, imagine that a resident council raises concerns about soiled linen baskets in their hallways. The self-directed work team meet to problem-solve a solution, and each neighborhood identifies a place to store the linen. Each team decides, independently and with different protocols, how this would work best with their neighborhood. One team may have a team member on each shift volunteer to have it be part of his/her job to monitor and clean the hallways; another may have a rotating schedule of monitors. Regardless, the outcome is the same—the halls now allow easy access for the residents, and odors and unsightliness are eliminated. Instead of being task driven, these teams are outcome driven.

Resident-Centered, Individualized Care

Judith Carboni, a nurse, described home as "a lived experience that possesses deep existential meaning for the individual" and homelessness as "the experience of the negation of home." She identified 7 aspects of home: identity, connectedness, lived space, privacy, power and autonomy, safety and predictability, and the ability to journey out into the world. Unfortunately, through her research, she found that the institutional elderly fall more on the homeless side of the continuum.[15]

There are many resident-centered activities that can potentially reverse feelings of homelessness. Allowing residents to dictate bedtimes, eating schedules, and menus promotes residents' abilities to re-create actions that they would do at home. For example, Hoeffer et al[16] designed a resident-centered bathing plan for older adults with dementia. They identified the function a bath was to serve, and then determined how often this bath was needed to meet this function. This resident-centered planning resulted in significantly fewer physically and verbally aggressive behaviors. Nursing assistants also felt less

Table 2. *Pioneer Network Values and Principles*

- Know each person
- Each person can and does make a difference
- Relationship is the fundamental building block of a transformed culture
- Respond to spirit, as well as mind and body
- Risk taking is a normal part of life
- Put person before task
- All elders are entitled to self-determination wherever they live
- Community is the antidote to institutionalization
- Do unto others as you would have them do unto you, the Golden Rule
- Promote the growth and development of all
- Shape and use the potential of the environment in all its aspects: physical, organizational, psycho/social/spiritual
- Practice self-examination, searching for new creativity and opportunities for doing better
- Recognize that culture change and transformation are not destinations but a journey, always a work in progress

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frustrated after the experience, leading one to hypothesize that staff-resident relationships were nurtured through this experience. Sloane et al[17] evaluated usual care versus resident-centered showering or towel bath; results indicated that agitation and aggression could be significantly lowered without compromising quality care. Skin condition improved and there was no increase in pathogenic bacteria colonization.

Consistent assignment of direct care staff facilitates resident-centered care. Consistent assignment is a concept whereby each CNA cares for the same residents every shift that they work for as long as those residents remain at the home. This fosters deep relationships between direct care staff and residents, which is accompanied by improvement in personal appearance and hygiene.[18] Furthermore, CNAs with consistent assignment tend to have a higher job satisfaction. Researchers theorize that because the direct care staff person is with the resident every day, he or she is better able to identify subtle changes in condition much quicker than with rotated assignments.[19]

By changing the philosophy of the traditional LTCF from institutional to home-like, the effects of homelessness can potentially be reversed.

Resident Choice

Maintaining autonomy continues to be very important to older adults, and this autonomy greatly impacts health. Langer and Rodin[20] first commented on this in a study looking at the effects of choice and enhanced personal responsibility in older adults in a LTCF. Two groups were compared; one was given more choice and opportunity to exert personal responsibility; the other received usual care. The choice/responsibility group was rated by their nurses to be 93% "improved" within 3 weeks, although the study does not go into specifics as to what these improvements were. The choice/responsibility group also found themselves engaging in significantly more active interpersonal activities, such as visiting with other patients or people from outside the nursing home. Similar studies have revealed that even very impaired residents can participate in self-care, and that they develop higher self-esteem as a result.[21,22] De-centralized dining (Figure 1) and eating family style have been shown to

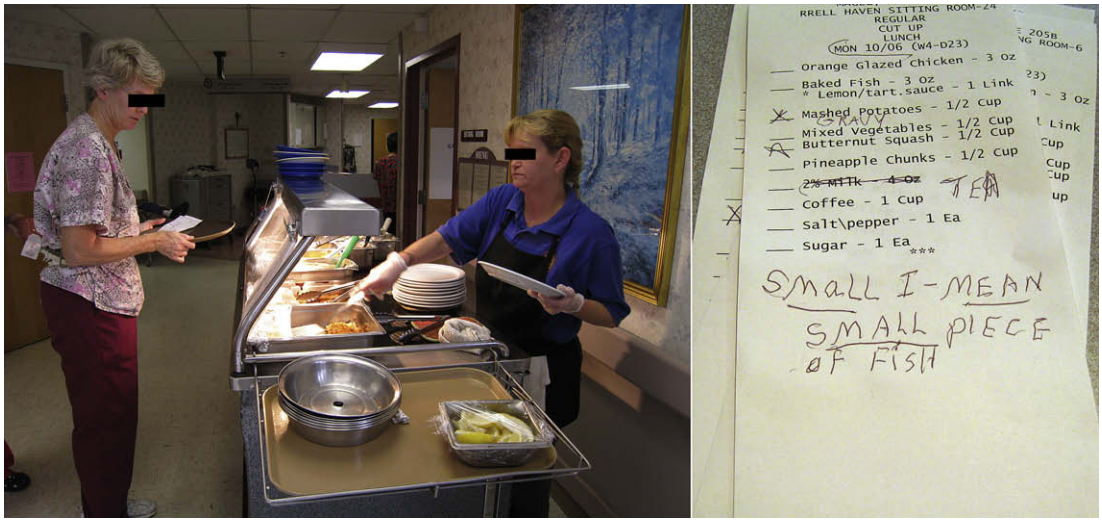

Fig. 1. Buffet-style dining and menu choice. *Left: St. Camillus heat-and-serve cart. Food is cooked in a large kitchen and brought to the floor in a serving cart. Residents are able to walk or wheel up to the cart and look at the food before ordering on a menu. Residents select on the menu the items they want and staff bring the menus to the cart; dietary service serves the requested food. Right: St. Camillus lunch menu, on which a resident has advocated for his/her choice.*

encourage food choice, promote food intake, lead to desirable weight gain, and reduce the need for dietary supplements.[23,24]

Long-ingrained habits and attitudes inhibit provision of more choice and control in many long-term care settings. Kane et al[25] interviewed more than 100 long-term care residents and nursing assistants from multiple states. Whereas cognitively intact residents cited the importance of control over daily matters (bedtime, food, use of money, and so forth), nursing assistants thought the residents would desire more control over visitors and formal nursing home activities. Furthermore, neither the residents nor the staff were optimistic about the possibility of residents obtaining control. This disconnect self-perpetuates the cycle of residents not being heard and staff misunderstanding their desires.

Mechanisms to promote more choice and control include resident councils, learning circles, and resident and family feedback for quality improvement. Resident councils are groups of residents that meet to implement change in their quality of care, the facility's activities, or other concerns that they may have.[26] The group is made up only of residents and is self-directed; it can aid communication between residents and staff. One study suggested that a resident council, in conjunction with other quality initiatives, significantly reduced adverse events, such as incontinence, pressure ulcers, and behaviors.[27]

Learning circles go one step further in collaboration between residents and staff. A learning circle is based on the premise of building community through thoughtful collaboration and equal weight to all participants.[28] Depending on the purpose of the circle, it is made up of residents, family members, staff, and even community members. A maximum of 15 members sit facing one another in a circle and one person facilitates. A question is posed, cross-talk is prohibited, and each person takes a moment to respond to the question. Quieter participants are encouraged to speak, but are not obligated to do so. Unfortunately, there are no data on the learning circle's efficacy. Anecdotal evidence supports its instrumental use in culture change initiatives and resident empowerment.[29]

Family members often feel left out of the caregiving process once their loved one moves to LTC.[30,31] To improve the facility-family relationship, facilities have implemented strategies with mixed results. For instance, a written partnership agreement improved the family's sense of care giving for their loved one, but it did not diffuse conflict between family and staff.[32] However, training for both family members and staff in conflict resolution, along with a collaborative meeting with administrators to sway facility procedures, improved family satisfaction with care and family-staff relations overall.[29,33] Web-based instruments, such as "My Innerview," allow resident and family feedback to drive quality improvement.[34] Regardless of the strategy implemented, facilities agree that families are an essential member of the care team and can be instrumental in empowering residents' lives.

Transition Away from the Medical Model while Still Focusing on Quality Health Care

The medical model involves the use of medical jargon, which can be problematic for residents and families. Physicians and nurse practitioners can serve as role models to families and staff by changing the language used in daily life. Table 3 provides examples of how medical model language and approaches can be made more empowering.[35] Although critics may discount this process as euphemistic, words can be a powerful agent for change.[36,37]

Some researchers and geriatric experts are concerned about the potential negative impact of culture change on quality health care. If resident choice and autonomy are paramount, what will happen if a resident refuses to engage in exercise or healthy eating? What if the resident refuses care for a pressure ulcer and insists on lying in bed? This may be perceived as "residents' rights" by the staff. Because resident-centered care involves the resident being a team member, careful collaboration with the resident can prevent such pitfalls. These issues need to be addressed and strategies put in place so that the tenets of culture change are not misrepresented or misinterpreted.

Outcome studies on the impact of culture change and CMS measures have yielded mixed results. A longitudinal study of the first greenhouse model revealed higher scores on quality of life measures and fewer residents with depression, on bed rest, or engaging in little or no activity.[38] However, compared to one of the traditional LTCFs, there was a higher prevalence of bladder incontinence. Another study evaluating the use of antipsychotics during third shift nursing suggested that facilities with resident-centered culture had a greater reduction in antipsychotic use than in traditional facilities.[39] Two separate evaluations of the Eden Alternative (EA) yielded starkly contrasting results. A 1-year study of 2 EA nursing homes found a higher incidence of falls, problems with nutrition, and higher use of hypnotic prescription, although staff and family satisfaction were improved.[40] A 2-year study of 5 EA nursing homes revealed large reductions in anxiolytic and antidepressant use, pressure ulcer rates, and behavioral incidents.[41] A quality improvement observational study of the Wellspring model suggested a marked reduction in deficiencies and deficiency severity after implementation of the model.[42]

Because culture change is varied and typically contains multiple components, evaluation of clinical outcomes can be inherently difficult. Several variables—such as consistent staffing, enhancing the green environment (eg, with gardens), enriching activities planned by the residents—make it challenging to determine exactly what is being measured and compared. Is it resident quality of life, clinical outcomes, or improved working conditions for staff? Rahman and Schnelle[43] recently completed an appraisal of the research base of the culture change movement. This appraisal revealed that the movement is advancing faster than the research may support it. The authors propose several questions to address this deficit and hopefully strengthen the empirical base.

In an effort to standardize the definitions and concepts surrounding culture change, Grant and Norton[44] proposed a conceptual model of the culture change process. Key concepts that emerged were consistent staff assignment, neighborhood models, cross-training of staff, and "flattening" of the hierarchical department structure. In addition, Grant and Norton[44] describe the 4 stages of culture change—traditional nursing

Table 3. *Examples of Language and Treatment De-Medicalization*

Medical Model Term	Culture Change Term
Patient	Resident's Name (eg, Mr/Ms. Smith)
Feeder	Needs Assist at Meals
Wheelchair Bound	Wheelchair User
Diaper	Pad/Brief
Disabled	Needs Support
Agitated	Active
Difficult	Determined
Aggressive	Assertive
Noncompliant	Preferring not to be treated
Manipulative	Resourceful
Demented	Forgetful
Elopement Risk	Likes to Walk
Fall Risk	Wants to Walk

Medical Model Behavior Interpretation	Culture Change Treatment
Noncompliant	Re-address resident-centered goals of care
Depressed	Empower resident to engage in what they consider to be meaningful activities
Angry	Change approach to resident's treatment; develop meaningful relationships
Needs restraints	Schedule walks
Needs Psychiatric Consult	Needs 1:1

Source: Holme A, Newbauer S, Wandersee M. Presentation: "Do more than look at me – involve me" - Pioneer Network Conference, Washington, DC, August 20-22, 2008. Used with permission.

home, culture change emerges, neighborhood model, household model (Table 4).

ROLE OF ADMINISTRATIVE LEADERSHIP AND MEDICAL PROFESSIONALS IN FOSTERING CULTURE CHANGE

Leadership is a central theme in culture change. Without leadership to translate the abstract philosophies into tangible practices and provide encouragement and direction, the process can lose momentum and implementation may fail. Furthermore, change is a continuous, ongoing process requiring lasting leadership for sustainability.

Successful LTCF leadership emphasizes both staff and resident empowerment.[45] Empowerment has been shown to be instrumental in maintaining low turnover rates of direct care workers.[46] Other aspects of leadership associated with low turnover rates are recognizing staff's work, providing opportunities to give feedback, and making staff feel valued. Wages alone are not a strong motivator, and in fact have been shown to be inferior to managerial practices, consumer commitment, and flexibility in motivating staff.[47,48] Direct care workers feel more empowered when they are trained to work with difficult families, have managers that engage in the work during stressful times, feel empowered to speak up for their residents and be a part of the change process, and have the tools that they need to do a good job.[47]

Barriers to culture change abound. Scalzi et al,[49] in a study of 3 nursing homes undergoing a culture change initiative, reported that one barrier to change was when nurses felt excluded from the culture change process; however, homes that had a "critical mass of change champions" were enabling. Unfortunately, many LTCFs cling tightly to the hierarchical model, thinking that the authoritative "top-down" approach will prevent survey deficiencies or fines.[44,50] As part of the empowerment process, the human resource department of the facility can play an instrumental role in terms of both management philosophy and quality improvement.[51]

Medical directors and nurse practitioners are also instrumental to promoting culture change via their roles as change agents within their facilities. Kotter's[52] 8 steps to transforming your organization provides a model for how they can do this. One way to exert influence, according to Kotter, is to help create a "sense of urgency" (step 1). This can be done by citing the literature and appealing to the institution's staff to make life better for the residents. Furthermore, medical directors and nurse practitioners should not underestimate the teachable moment. By working with sympathetic staff at all levels, a medical director or nurse practitioner can "form a powerful guiding coalition" and "communicate the vision" (steps 2 and 4). Together, such a group may have enough power to help facilitate change. Physicians and nurse practitioners can also advocate for facilities by making themselves a part of the survey process. As mentioned earlier, CMS has mandated that culture change be part of the state QIOs. This can contribute to helping develop the "sense of urgency" and also advocate for the changes. Last, documentation of the residents' choices is important, and theoretically helps to prevent deficiency citations.

Rigorous outcome studies examining clinical outcomes, quality of care, quality of life, and resident satisfaction are needed to demonstrate the effects of culture change.[43,51] A recent editorial in the *Journal of the American Medical Directors Association* highlighted the need for clarification of definitions of resident-centered care, the difficulties of evaluating resident-centered care in those residents suffering from dementia, and the paucity of appropriate measurement tools.[53] It also urged the medical staff to foster culture change by supporting administrative attempts to change and backing the needs of residents and families. Training of medical providers in culture change principles is also needed. To that end, the

Table 4. *Stages of Culture Change at St. Camillus*

Stage Model of Culture Change	St. Camillus' Progression through Stages
Stage 1: Traditional Long-Term Care Facility • Organized around traditional nursing unit • No consistent assignment • Top-down hierarchical structure that lends itself to disempowerment in residents and direct care staff	• Nurses delegated tasks to CNAs and documented care plans for reimbursement • CNAs did not manage their own schedule • Nursing staff floated from unit to unit, dependent on task need • Central dining area provided residents with pre-made meal trays • Residents had no input on when to wake up, when to go to bed, or in meal planning
Stage 2: Culture Change Emerges • Leadership and direct care staff become more knowledgeable of culture change • Learning circles develop amongst staff and residents • Low-cost changes in decor to a more home-like environment • Consistent assignment is implemented	• Leadership and staff educated themselves about culture change via education sessions: - Sessions occurred across all shifts over a 9-month period - Topics included "encouraging residents to dictate their morning routine," "feelings of home vs homelessness," and "we create people's behaviors" - Residents were included as case examples to put a familiar face on the issue
Stage 3: Transition to smaller "neighborhoods" • Traditional nursing unit broken into smaller neighborhoods • Dining area decentralized • Neighborhood identity emerges in both name and actions	• One unit piloted changes, such as gentle awakening • ***Direct care staff*** concluded that they needed consistent assignments and assigned neighborhoods • Grant received for heat and serve carts to de-centralize dining and enhance resident choice • Medical director and nurse practitioners were always informed of changes that were occurring
Stage 4: Final Stage – Household model • Hierarchical model is "flattened" - Staff is cross-trained for multiple tasks - Self-directed teams in neighborhoods - Each neighborhood is now autonomous	• Self-directed teams have emerged • Staff is cross-trained (eg, dining service assists with setting residents up for meals and housekeeping assists with clean-up). • Resident- councils give feedback that leads to real change • St. Camillus continues to evaluate itself—acknowledging that culture change is "not a destination, but a journey"

Adapted from Grant LA, Norton L. A Stage Model of Culture Change in Nursing Facilities. The Commonwealth Fund; 2003. Presented at GSA Meeting, San Diego, CA, November 22, 2003.

American Medical Directors Association is currently collaborating with the Pioneer Network to develop core physician competencies in resident-centered care.[54]

CASE EXAMPLE

St Camillus Health Center of Whitinsville, Massachusetts, serves as an example of a facility transformed by culture change. A nonprofit, 123-bed facility, it was owned and operated by the Roman Catholic "Order of St Camillus" until 2001. At that time it was near bankruptcy, and a local volunteer board of directors, led by the administrator and director of nursing, agreed to take control in an effort to prevent its closure. Shortly after the transition, St Camillus began its culture change journey.

Before the change in ownership, St Camillus was considered to be at Stage 1: a traditional long-term care facility (Table 4). Nurses delegated tasks to CNAs and documented care plans for reimbursement. CNAs did not manage their own schedule. Nursing staff would float from unit to unit, dependent on task need. There was no consistent assignment on any one unit. There was a central dining area; residents waited for their individual pre-made trays. The residents had no choice in the meal plan. If the residents did not like the food they were given, the staff called down to the kitchen and requested another tray—usually a sandwich or other simple meal. Often this call resulted in conflict between the nursing and dietary staff. The dietary staff would be working on another unit's trays and would not have time to stop their assembly line.

The leadership team at St Camillus wanted to implement the concept of consistent assignment early in their work; however, faced with strong opposition, including threats of quitting, they initiated a 9-month process of educating staff members on the benefits of consistent assignments. It was at this point that St Camillus entered Stage 2, in that staff became knowledgeable about culture change. Leadership implemented about one education session per month for 9 months, across all shifts. These sessions needed to be repeated several times a month over all shifts, to make the educational times convenient for staff. Some topics included "encouraging residents to dictate their morning routine," "home versus homelessness," and "we create people's behaviors." Crucial to these sessions were case examples of residents in the home, so that the staff could put a familiar

face to the issue. The facility also fully informed the medical staff of the changes that were occurring.

Throughout this time, leadership advocated for allowing people to sleep through the night. This would mean not doing bed checks and not turning residents unless absolutely necessary. The facility also implemented high-absorbency briefs, so that patients who were incontinent would not necessarily need to be changed in the middle of the night. Furthermore, residents would be gently awakened in the morning, as opposed to having strictly set hours on when to wake up. The leadership decided to trial these innovative changes on the one unit with the most vocal and opinionated staff, in hopes that they would speak up with their concerns. This staff did speak up and voice their concerns about these changes, including how to improve them. It was at this time that the direct care staff came to the conclusion that it would be better if they had consistent assignments. This process of education and allowing the staff to guide the timing of interventions helped lead to success. Education and empowerment of the direct care staff to speak their minds has become St Camillus' cornerstone on which other changes were based.

Consistent assignment led to a natural transition to the neighborhood model. Thus, St Camillus transitioned to Stage 3: neighborhood identity. Now St Camillus has 3 neighborhoods, each with about 41 residents. Although structurally the traditional long-term care unit and neighborhood are the same, the difference is that staff stays only in that neighborhood. They decide what goes on in that neighborhood, in conjunction with the residents.

The leadership was pleasantly surprised by the fact that all staff—housekeeping, nurses, CNAs, and so forth—found it easier to participate in decision making. Soon self-directed teams emerged within the neighborhoods. This is where St Camillus began Stage 4: the household model. For instance, CNAs established what bathing assignment they were going to have in conjunction with the residents. The CNA would ask the resident "Do you want a bath/shower? How many times do you want this per week? What time of day do you want your bath/shower?" The resident and CNA worked out daily routines, and would communicate the plan to other staff in care plan meetings. As opposed to being asked by nurses or other staff to do the task, the CNAs owned the task and contributed to the care planning. If there were scheduling conflicts, the CNAs and residents worked it out among themselves. If a resident had dementia, the CNA would talk to family members. If there was no family support for these elders, then the CNA would schedule the bath/shower for when the patient was awake. This bathing example is one of many in which the CNAs are able to choose their own assignment.

Nurses' roles also changed. Encouraging the CNAs to take ownership of their tasks relieved the registered nurses from scheduling bowel care, baths, meals, and so forth. Instead, nurses focused on medical assessment and oversight of care. They also provided continuity, as they were consistently assigned to the same neighborhood. This consistency allowed for the nurses to develop enhanced relationships with residents and families.

St Camillus' concerns over dining serves as an example of staff cross-training. The facility de-centralized the dining into 3 separate rooms. Residents were invited to eat in the main dining room or in their room. If residents needed assistance, they were encouraged to eat in a smaller dining room. The leadership at St Camillus wrote a grant to the Massachusetts Department of Health for "heat-and-serve" carts. These carts allow for a variety of hot and cold foods to be served on a plate on the neighborhood. Akin to a waiter/waitress service, CNAs would ask the residents what they wanted for that meal, and write it down on a menu (Figure 1). Initially the CNAs were upset about this change; they felt the process created more work for them. CNAs would have to set the tables, take orders, go back for the food, and then clean up afterward. The leadership acknowledged this concern, and a dining committee, composed of dietary assistants, CNAs, housekeeping, and activities staff addressed the issue. It quickly became apparent that the new model created less work for the dietary assistants, as they no longer had to deliver trays to a floor or wash trays. Therefore, they offered to set up the dining room, and housekeeping offered to clean up. This reduced the friction between nursing and the dietary staff.

Most St Camillus residents use Evercare as their health plan provider,[55] which provides a nurse practitioner (NP) on site much of the time. That NP learned to schedule medications so that patients were not awakened to take a medication unless absolutely necessary. Thus, by making slight changes in her practice, she was able to support resident centeredness. The leadership made a point to keep her fully informed of facility changes, so that she could be supportive of this process without misunderstandings.

St Camillus' transformation demonstrates that it is possible to provide high-quality health care without making residents and family members feel like they are in an institution. This home has an outstanding record on Department of Public Health (DPH) Surveys, as well as high scores on the DPH-administered family satisfaction survey in 2007. Furthermore, St Camillus has noticed less food waste, improved healthy weights, less agitated behavior, and more wakeful residents during the day.

CONCLUSION

The culture change movement provides a tremendous opportunity for us to provide the best possible quality of care and quality of life for everyone who lives in an LTCF. At the 2008 Pioneer Network Conference, there were more than 1000 participants but only approximately 15 physicians. Thus, strategies to involve physicians more in culture change could both help the movement advance and enhance the image of medical providers as advocates for quality-of-life and patient-centered care.

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