Improving Nursing Home Culture

Final Report
October 2005
Improving Nursing Home Culture Pilot Study
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for Nursing Home Quality Improvement

Final Project Report – October 2005

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I. Executive Summary

A. Background and Objectives

The Center for Medicare & Medicaid Services agreed to provide Quality Partners of Rhode Island (the Rhode Island Quality Improvement Organization and National Support Center to the Quality Improvement Program) the opportunity and resources to create and pilot test a model and a methodology for achieving transformational change. The primary objective is to provide strategies to nursing homes that will teach a process of change moving from an institutionalized culture to an individualized culture of care positively affecting the quality of life and satisfaction for residents, families and staff as well as increasing retention within the workforce. This dynamic pilot study known as Improving Nursing Home Culture (INHC) would run from August 2004 to October 2005.

The INHC Pilot Study worked with two distinct groups. The first, the Person-Directed Care (PDC) group included teams from twenty-one QIOs who, in turn, worked with 168 nursing homes. The second, the Workforce Retention (WFR) group engaged eight corporations (known as multi facility partners for quality or MPQs) who worked with 86 of their nursing homes. Each home individualized its path to change, guided by a common curriculum and a collaborative approach that facilitated sharing and spread.

Through the INHC Pilot Study, QPRI along with its partner B & F Consulting accomplished several tasks:

- Designed the model of individualized care,
- Developed a curriculum to support the change process,
- Pilot tested the educational materials used with nursing homes,
- Provided formal expert information on individualized care and workforce retention,
- Demonstrated the effectiveness of a train the trainer program using adult education principles,
- Created tools to assist homes in transferring new knowledge into concrete action, and
• Used quality improvement strategies to operationalize, measure, and spread effective change.

The design team with assistance from the Colorado Foundation for Medical Care (CFMC), the Quality Improvement Organization in Colorado, evaluated the results of this special study by:

• Measuring retention and turnover,
• Gathering, analyzing, studying, and interpreting data from satisfaction surveys,
• Collecting reports of change from individual nursing homes,
• Studying nursing homes PDSA cycles used to implement change, and
• Studying the results of homework assignments that gathered baseline data.

B. Major findings
The INHC Special Study resulted in many significant gains. From the PDC group, comparing the First Quarter 2004 Quality Measure rates to the First Quarter 2005 Quality Measure rates, 168 nursing homes with both sets of data saw a 5.4% relative decline in their pain Quality Measure rates (chronic care population) from 6.41 to 6.06. More impressive, these same 168 nursing homes experienced a 14.5% relative decline in their physical restraint Quality Measure rates from 6.69 to 5.72.

Nationwide, nursing homes suffer from a 70% annual turnover rate of their nursing department personnel. Most long-term care experts agree that staff instability is the greatest barrier to significant breakthroughs in quality outcomes. Therefore, the accomplishments from the nursing homes in the WFR group were remarkable. Four MPQ’s representing 51 nursing homes consistently submitted the turnover data of their nursing departments (RNs, LPNs, and CNAs). Comparing the baseline quarter (Aug/Sept/Oct 2004) to the re-measurement quarter (Mar/Apr/May 2005) in seven months of participating in the pilot study, these nursing homes experienced a 5.6%
decline in their annualized turnover rates (55.2% to 49.6%). This represents a relative change of 10%. The most significant decline occurred amongst the LPNs who typically serve in the capacity of the charge nurse of a unit (30 – 40 elders) in a nursing home. LPNs experienced a 7.6% decline in their turnover rates that represents a relative change of 15.9%. The CNAs, who deliver 85% of the hands-on care elderly nursing home residents receive, had 136 fewer terminations (annualized) that represented a relative turnover decline of 9%. Overall, as a result of participating in the INHC pilot study, these nursing homes experienced 196 fewer terminations (annualized) of nursing department personnel thereby saving these nursing homes approximately $490,000.

The WFR pilot group of nursing homes also experienced some impressive declines on their Quality Measure rates. Comparing the First Quarter 2004 Quality Measure rates to the First Quarter 2005 Quality Measure rates, 86 nursing homes with both sets of data saw a 14% relative decline in their pain Quality Measure (chronic care population) from 6.32 to 5.44. In addition, these same nursing homes experienced a 9% relative decline in their use of physical restraints from 6.51 to 5.94. Among the post-acute care elders, a significant decline was noted in the delirium Quality Measure (25% relative decline).

Translating Quality Measures to people – as a result of the INHC Pilot Study, approximately 143 elders were relieved of moderate to severe pain and 245 elders were released from physical restraints. Clearly, SNF leaders who embrace the principles of person-directed care and focus on retaining their staff are those who make significant gains on those Quality Measures that impact elder’s quality of life.

C. Other Measures

Additionally, homes reported greater satisfaction among families and employees. Anecdotal stories tell of the extraordinary record of transformational change. In their own words, people working in nursing homes share what they did, what it meant to them, and why they will never go back to an institutionalized model of care. Their work this past year has changed life and work in their nursing homes. People now wake up, spend their
days, and go to bed according to their own routines, and as they are restored to their own rhythms, they are thriving. So are those who care for them. As work is reorganized to follow the pace of each resident, instead of a rigid institutional routine, workers are able to fulfill their intrinsic motivation to care for others, and to experience respect and care from their organizations.

These changes reached far beyond the nursing homes and even went on to affect the QIO community. QIO participants time and again volunteered publicly and on evaluations how this work finally helped them to feel that they were making a difference in serving the nursing home community. Many who felt their days at the QIO were numbered stated an enthusiastic delight in promoting a new model of care and a renewed sense of vigor.

Using PDSA cycles, individual facility’s creatively measured many areas with an eye on quality of life. Some of their results are listed below:

- Room tray requests – reduced from 15 per day to 6,
- Plate waste – reduced by 75%,
- Resident socialization – increased,
- Staff stress levels – decreased,
- Resident behaviors – declined,
- Focus group responses – from negative to positive,
- Staff time with residents – increased, and
- Peanut butter sandwiches – declined from 6 to 0.

Individual facilities also experienced these results:

- Falls – dropped 8.9%,
- Antipsychotic medications – decreased by 50%,
- Resident satisfaction – 100% said staff listen to me,
- Staff satisfaction – from 60% to 80%,
- Worker’s Compensation claims – dropped from 44 to 7,
- Weight loss – reduced to 0,
- Survey results – from 13 deficiencies to 3,
- Pressure ulcers – from 4.9% to .7%, and
- Suppositories – reduced from 9 to 0.

D. Implications

The INHC has proven that transformational changes within nursing homes that will positively affect the lives of residents and staff can take place in a very short span of time. Equally, INHC created momentum for the 8th SoW that can potentially, significantly affect clinical measures and turnover. The lessons from the study have been spread to all QIOs by the design team based on a request from CMS to provide this training to all QIOs who did not participate in the pilot. Seeing the effects that workplace practice can have on the improvement of quality measures in nursing homes as evidenced by the WFR pilot group, we respectfully encourage homes to adopt these change practices to initiate their journey into individualized care. Thanks to the staff, residents, and families of the 254 homes participating in this pilot, we now have a body of evidence to support the clinical efficacy and business sense of individualized care for residents and staff in nursing homes.
II. Final Report

A. Background

Research reveals that many older adults state that they would choose death over life in a nursing home (Mattimore, et al, 1997). This is due in part to the loss of control, sense of isolation, boredom, despair, and loneliness associated with nursing home life. The absence of a sense of home, both physically and psychologically, the inflexibility associated with rigid scheduling based on staff organizational needs, processes imbedded in an institutionalized model which set disease and illness as a priority over individualized care, and quality of life detract from the nursing home climate. Through tacit historical acceptance of these ills, nursing homes (NH), despite the diligent effort of those who work within these settings, are often perceived by media, and consumers as a “last resort” or “end of the road”. The climate within many NHs in turn, reflects this dreary perception. Equally, the method of care employed within many NHs - restrictive and authoritative, is indicative of an ageist society and would be incomprehensible were it to be foist upon any other group within our society. Low satisfaction ratings among family members, outdated hierarchical leadership strategies, financial instability, difficulty in supplying and maintaining adequate staffing, materials and equipment are but a few of the more common problems facing nursing homes. These struggles have a great impact on the quality of care and the culture that is created within the nursing home community. The persistent nurturing and supporting of the current culture and its systems perpetuates the continuous poor outcome.

Through the years, many attempts have been made to bring about a new age of quality to nursing homes. Organizations such as Eden, the Pioneer Network, ActionPact, PEAK, and Wellspring have all provided input into creating a new future for nursing homes. Though unique and visionary in their strategies, none have been effective in transforming large numbers of nursing homes using a prescribed method for change. In fact, costs of such programs, the lack of clear steps to initiate change, the lack of consistent
terminology, philosophical differences surrounding the practical and tangible changes necessary to change culture and the limited number of leaders who could offer such education limited the ability to create change from institutional to individualized care on a large scale.

During the 7th Scope of Work, Quality Improvement Organizations were given the opportunity to assist nursing homes throughout the country in offering support, education and tools focusing on specific clinical topics to improve quality. Many valuable insights were gained as a result of this work. Conversations began to arise within the QIO community which debated the practicality of focusing exclusively on clinical areas when many of the barriers facing clinical care related to other critical issues including an absence of high quality leadership and management skills, high turnover, lack of effective training that turned knowledge into practice, financial instability, and a regulatory climate that held hostage change practices. To move nursing homes from institutional care to an individual-centered approach would require a complete organizational change. Many believed that deep systems change could significantly impact the nursing home industry if, along with clinical topics, other domains including workplace practices, environmental issues, leadership, the inclusion of families, community and regulators were included in the change model. The success that QIOs had in utilizing the Model for Improvement in making system changes in nursing homes coupled with the currency of relationships developed in the 7th SoW and the added strength and resources of the QIO community based on sheer numbers of individuals positioned in every state made the possibility for an effective and dramatic QIO-lead change in nursing homes to individualized care. QIOs were anxious to assist in the movement that would usher in a renewed vision of the nursing homes purpose as a vibrant and stimulating community for living, focusing on the individuals needs and spirit, representing excellent quality, compassionate care, filled with opportunities for personal growth for all individuals who venture within-residents, staff and family alike.
B. Overview

The INHC Special Pilot Study was organized in a framework of training sessions, conference calls, and learning assignments (homework) delivered to two distinct groups (See Appendix 1a, b, c –Training Chart and Training Calendars). The first group was represented by 21 QIOs who attended four training sessions using a train the trainer format focusing on all domains of the HATCh model. Those QIOs included Arizona, California, Colorado, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Massachusetts, Michigan, Minnesota, Missouri, North Carolina, New York, Ohio, Oklahoma, Pennsylvania, South Carolina, Texas, Washington, and Wisconsin. In the INHC Pilot Study, they became known as the PDC (Person-Directed Care) group.

The second group brought together a team of individuals from 7 corporations (later known as Multi-facility Partners for Quality - MPQs). Those groups included Beverly Healthcare, Catholic Health Initiatives, the Florida Triad, Genesis Health Care Corporation, the Kansas Triad, UHS-Pruitt Corporation and Sava Senior Care. Though this group was exposed to sessions that embraced the HATCh model they were charged with focusing on one single domain of the model-that of workplace practice in order to enhance workforce retention. In the INHC pilot study, they became known as the WFR (Workforce Retention) group.

Each group was responsible for gathering a small number of volunteer nursing homes who would be trained and follow certain prescribed actions to begin their journey of change. Each group was given an array of challenging action-learning assignments (homework) that helped participants gather their own evidence about the impact of their practices on care and workplace outcomes. A list-serve (email list) that allowed them to communicate regularly supported each group. Both groups met for monthly conference calls that were used as a vehicle for teaching, sharing, and spreading of ideas. A separate list serve allowed all 254 pilot nursing homes to talk and share with one another.
C. Methodology
To facilitate success, a model was created that identifies the philosophical structure and the essential domains for individualized care. The model became known as the HATCh Model (Holistic Approach to Transformational Change) (See Appendix 2 - HATCh).

HATCh 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. The decision to adopt each of these domains, along with the interconnectedness of the domains, was carefully considered and key to facilitating change. It was our hypothesis that specific changes within these domains could affect the movement from institutional to individualized care.

Changes are necessary within each domain to achieve this level of transformational change. We created change packages for person-directed care and workforce retention, which essentially provided participants with detailed examples of the change possibilities in each area. The improvements in each domain contribute to positive results for residents, staff, and families. The handout material from the Outcomes Congress on October 5 & 6, 2005 provides abundant examples of changes in each domain, and the way the changes in one domain touch on all the others.

Transformational change requires first a change in the Domain of Workplace Practice. We based our curriculum in this domain on the research of the late Susan Eaton, who identified five key management practices that made the difference between high and low turnover for nursing homes in the same labor market. In the Domain of Care Practice, we drew on the work of Joanne Rader who has transformed practice in our field, first with her work on individualized dementia care, then in rethinking the use of restraints, and most recently in the area of bathing practices. In each of her change initiatives, staff
involvement was the key to individualizing care. We also incorporated, for both domains, on the work of Anna Ortigara, whose LEAP curriculum teaches nurses to be leaders.

Judith Carboni’s 1987 work on home and homelessness among nursing home residents provided the framework for the Domain of the Environment. She described a continuum from homelessness to home, based on how connected a person was to his/her environment. Her finding that home is where a “fluid, intimate, dynamic relationship exists between person and place” provided nursing homes a yardstick for their efforts in this domain.

These domains all operate within the Domain of Leadership. In addition to Eaton, we relied on the work of Kouzes and Posner and Jim Collins. Their field guides to leadership facilitated our transfer of knowledge into practice. They brought their evidence-based practices to life through a self-assessment process in which leaders were able to mark their progress over time. Their focus was on “creating a climate where the truth could be heard,” and leadership practices that challenge the process, encourage the heart, and enable others to act – leadership concepts necessary for the process of transformational change. Connie McDonald, the administrator who led the change process at Maine General Rehabilitation and Nursing Care at Glenridge, exemplified this type of leadership and shared her story at the first learning session.

A dynamic shift in relationships with family members, close friends, community organizations and volunteers is captured in the Domain of Family and Community. Lori Todd and her staff from Loomis House, and Carolyn Blanks from the Mass Extended Care Federation provided powerful examples to support efforts in this domain.

The Domain of Regulation and Government grounds HATCh in the requirements of OBRA ’87, that each facility “must provide care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.” Karen Schoeneman from CMS taught the group to “think like a surveyor” and engaged the collaboration of several State Survey Agencies in this pilot.
Supporting the HATCh model is a change package that identifies ideas, concepts, and action items that lead to transformational change (See Appendix 3 – Change Package). Below is a brief overview of potential changes shared during the pilot related to each domain.

Within each of the six domains: Environment, Care Practices, Workplace Practices, Leadership, Family and Community, and Regulation is an array of opportunity to create change. These changes move nursing homes from a perspective of institutional care to one of individualized care.

Examples of changes within the domain of Care Practices include:
residents-inclusive choices in the areas of waking and sleeping, meal-service (delivery, variety, and food preference), daily routine (bathing-frequency, time, and method), changes in ADL’s (activities, acknowledging rituals and celebrations), high quality clinical care with resident, family, staff input, innovative, creative care solutions, “I” format care plans, and community mourning.

In the domain of Environment we gave examples that encouraged participants to consider changes such as: the creation of sanctuary, shelter and peace that provides a sense of community, safety and free of unwanted intrusions; the creation of beauty and comfort; de-institutionalize the common rooms (bathrooms, living areas); designing for accessibility; diminishing barriers; attention to adequate lighting; the provision for nature; the demonstration of appropriate displays of affection, validation and support; encourage personal items that reflect individuality; personal items such as refrigerators, calendars, pictures, comforters, personal space, shrines; a shift towards neighborhoods and communities.

The domain of Workplace Practice offered these possible changes: establishing relationships as the number one organizational priority, supporting necessary changes and adjustments that will allow relationships to flourish personally, organizationally, and
environmentally; the inclusion of elders, caregivers, and families in developing avenues for relationship building; the use and promotion of learning circles; welcome and hospitality committees; Red carpet orientation programs; ways of welcoming new families, staff, and residents.

Other Workplace Practices encouraged and adopted during the Pilot included consistent assignment, peer mentoring, self governed work teams, cross training, communities / neighborhoods; the elimination of unjustifiable work, care processes, and mandates; opportunities for leadership development for all; becoming a learning organization by sharing the wealth and value of education by sending staff to conferences, workshops; outside the box in-service training.

Also adopted were practices such as community mourning, social support for staff’s needs, the creation of an openness within the organization for the personal needs, personal accomplishments, personal tragedies of all; programs that elevated on-going & consistent recognition the highest status.

Other change practices in the workplace domain includes: scheduling that reflects resident and staff needs, the redesign of space and schedule, assuring the accessibility and provision of all necessary equipment, a shared sense of mission.

Examples of changes that were encouraged in the domain of **Leadership Practices** include:

Leadership and management that mirror a sense of vision, optimism, trust, openness, and generosity; leadership that invites opinions, feedback and ideas from staff: empowering staff to make decisions; supporting the full empowerment of workers - allowing them to grow, direct, and affect the care of elders; creating a climate in which compassion and common sense can flourish; managing by walking around; imbuing an attitude that places elders and caregivers at the heart of all decisions and at the heart of the home; the demonstration of a deep sense of meaning and mission both personally and
organizationally; offering and receiving regular, positive and constructive feedback; recognizing the value of all staff; inclusive, non-hierarch decision making.

The domain of Family and Community invited these ideas for change. Invite families to make a commitment to become part of the community through care conference, committees, councils, volunteering, and recognition; create nursing home emersion into the community through the creation of porous nursing homes, offer services to the community, provide space that benefits all; provide support by sharing talents, gifts and skills.

In the final domain, that of Regulatory and Government, changes we encouraged include: bringing regulators into your culture change story, creating a repository for changes made by nursing homes embraced by regulators, developing collaboratives that create inclusive opportunities for SSA, Ombudsman, Trade, families, other key state groups into the culture change process.

Because the homes represented in the pilot varied in size, number of residents, architecture, experience, longevity of staff, staff ratios, finances, support, leadership, and geography it was necessary to create a design that allowed for tremendous flexibility in initiating change and while working from a common curriculum. In order to accomplish this, we developed a change process known as the “Way of Inquiry” (See Appendix 4 – Way of Inquiry). The “Way of Inquiry” allowed organizations to discover and work through change by way of a process of self-guided exploration. The “way of inquiry” describes a process whereby people begin to notice situations, beliefs and commonly held misconceptions within their current system (irritants) and awaken to the possibility of change. This gives them the impetus to explore and envision new possibilities, and the openness to choose to do something different. The “way of inquiry” maps the initial steps that lead to change. By establishing a change process, coupled with activities and discovery exercises that sent participants out to discover some of the irritants within their organization (catalyst), we were able to harness the energy and desire to change. Once
participants had the “aha” moment (awakening), they were anxious to initiate change. The change process then, became a simple matter of sharing a strategy common to the QIO community, the Model for Improvement using PDSA cycles. Supporting this were Change Idea worksheets, which offered practical tips identifying common barriers and steps to change the process (See Appendix 5 - Change Ideas). As a result, organizations were awakened to the needs of their residents in the areas of waking and sleeping, the desire to bathe in settings that were conducive to safety and comfort, more natural diets, dining times that allowed for a freer choice of when and where to dine, having the option to create their own daily schedules, clinical care that was personal and specific to peoples needs including the termination of suppository use, psychotropic drugs use and sizeable decreases in agitated and aggressive behaviors. The remarkable stories found within the book also provide insights into the creative changes and attempts homes made to create individualized care. In the same way, changes within the domain of workplace practice affected positively the lives of CNAs. Finding new ways to value and appreciate staff, supporting and acknowledging their grief after the death of residents, reinventing staffing schedules and creating a climate where staff could have significant input into the care of residents along with the opportunity to develop close relationships through consistent assignment allowed for significant satisfaction and a reduction in turnover for many of our participating homes.

After an exhaustive review, we determined that no existing measurement tool could adequately capture the new model of change we created. Our strategy, then, was to identify, through the pilot process, the wide array of areas that would be measurable in the future, by encouraging participants to evaluate and measure their interventions and results. We used a wide-angled lens approach, so as to capture any and all results of significance. We taught the homes how to evaluate and measure throughout their change process, as part of the quality improvement process. We created measurement tools to assist participants in assessing their own personal and organizational practices (See Appendix 6 – VoteM; Appendix 7a and 7b - Susan Eaton Grid; and Appendix 8 - Drill Down). The results of the VoteM satisfaction survey along with other pertinent data
related to the WFR pilot group can be view in Appendix 9. Through homework assignments and tools to drill down into root causes, we gave homes qualitative and quantitative ways to measure their current practice as a baseline for evaluating improvements. Participants documented direct links between improvements in retention and in clinical outcomes and their work in the pilot. The wide array of measurement tools and outcomes generated by the pilot provide the basis for development of a measurement strategy and instruments for the transformational change work going forward.

To initiate change, our first objective was to create a curriculum that would effectively educate our two groups. Our education design made a commitment to using sound adult learning principles with six specific objectives.

- Helping learners gain new knowledge
- Creating training sessions that reflect openness, innovation and respect for learners knowledge
- Creating opportunities for exploration and self discovery through active learning assignments (homework)
- Making training replicable by allowing participants to practice during sessions and providing all the necessary tools to be successful on site
- Enhancing methods for the seamless transfer of knowledge into practice that will positively affect the life of a nursing home resident
- Sustaining that knowledge through shared discussions on conference calls and by way of the list serve

The following provides the content and nature of the PDC pilot group and WFR pilot group training by way of a training overview and summary completed after each session. Following that are the homework assignments that provided the “catalyst” for our participants.
Person-Directed Care Training Sessions:

PDC Training Session #1: September 22-23, 2004

Training Overview

As part of the "Improving Nursing Home Culture Special Study," Quality Partners of Rhode Island provided the first person-directed care (PDC) training session at the Quality Net Conference on September 22 and 23, 2004. The session brought together the 23 pilot states for some highly interactive training. Project staff from each QIO had the opportunity to learn together and to continue building relationships with other QIO project staff to encourage networking and sharing of good ideas. Using adult learning principles, QIOs participated in exercises to promote relationship building and communication among the nursing home community. The PDC training series was approved for nursing continuing education credits (CEUs) through the Colorado Foundation of Medical Care (CFMC). CEUs were awarded to 66 participants. The overall goal for the two-day training was to provide information, resource material and education to QIOs that will assist them in training nursing homes in the basic concepts and issues that related to the person-directed care model based on culture change theory.

On the first day of training, the agenda included the following items:

- Project overview and framework
- Getting started in your culture change journey
- Relationship building
- Leadership
- Finding clues to person-directed care
For the first day of training, the session goals were the following:

<table>
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<tr>
<th>Goal</th>
<th>Detail</th>
</tr>
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<tbody>
<tr>
<td>Provide opportunities for participants to begin the process of developing relationships and interacting with others</td>
<td>Relationships are the key to culture change and should be in the forefront of everyone’s mind, both QIO and nursing home staff.</td>
</tr>
<tr>
<td>Bring clarity and vision to the study</td>
<td>QIOs need to have a full understanding of the foundations of person-directed care, including the change package and way of inquiry to assist nursing homes with the “getting started” phase of culture change.</td>
</tr>
<tr>
<td>Provide opportunities for QIOs to formulate their own vision for the culture change journey on which they are about to embark</td>
<td>The training includes an incredible amount of material and concepts; therefore, the training includes time for the QIOs to process the information as well as to talk as a group about how they will use the information in their individual state.</td>
</tr>
<tr>
<td>Provide a concrete application of the change concepts and to provide participants with a team experience that can be replicated in the nursing home</td>
<td>Participants need to have knowledge of the direct application of materials to allow for the easy transfer of knowledge.</td>
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</table>

As a result of participating in Training Day One, QIOs should have an understanding of the PDC framework, the change package and change concepts, along with an understanding of how a nursing home could go through the “way of inquiry” to have their “ah-ha” moment prior to embarking on a culture change journey. The goals allowed for the application of adult learning principles by using exercises and interactive discussion.

On Training Day Two, the agenda included the following items:

- Building a case for culture change
- How regulations support culture change
- Journey of a Maine nursing home
Goals for the second day included the following:

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<tr>
<th>Goal</th>
<th>Detail</th>
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<tbody>
<tr>
<td>Provide sound, critical background information in support of culture change related to financial, clinical and regulatory issues</td>
<td>Nursing home leadership will ask for documentation to support culture change. They will ask, “why should I do this?”</td>
</tr>
<tr>
<td>Provide participants with a realistic sense of the person-directed care journey through the eyes of the administrator and a nurse</td>
<td>Examples from professionals who have actually done culture change in a nursing home has valuable input to share with QIOs, including the specific how-to.</td>
</tr>
<tr>
<td>Provide participants with hands-on experience in beginning their work with nursing homes</td>
<td>Participants need guidance (what to do after this training) and clarity about QIO role.</td>
</tr>
<tr>
<td>Provide a framework for the learning process ahead</td>
<td>Participants need time during the training to process the mass of presented material and to start planning their own nursing home training.</td>
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As a result of participating in Training Day Two, QIOs should be able to build a case for culture change and use the laws, regulations and survey guidelines in support of culture change.

**Training Summary**

Much of the training on day one was lead by Barbara Frank and Cathie Brady, both formerly of the Paraprofessional Healthcare Institute, who have many years of experience working with nursing homes on individual culture change journeys. Discussion centered on a vision of culture change through photos showing the physical appearance of culture change before and during a culture change journey. Instead of merely reading the nursing home (NH) training materials, QIOs had the opportunity to experience the exercises first-hand. QIOs experienced “paired” conversations and people bingo (to encourage relationship building) and the “mystery game” (to provide a concrete application of PDC). These are tools QIOs can use with their individual NHS. On hand during the session were staff from Maine General Rehabilitation & Nursing Center (Glenridge, ME), a nursing home that is on a culture change journey. The QIO audience had the
opportunity to learn about the "how to" directly from NH professionals who have actually done culture change.

The second day provided input from key presenters such as David Farrell, CEO at the Wellspring Institute, Connie McDonald and Ellen Fuller from Glenridge and Karen Schoeneman from CMSO. The presenters demonstrated true facts and real life examples that QIOs could use in their statewide culture change trainings. By the end of the two-day training, QIOs had the foundation needed to start planning for training sessions they would provide in their individual states.

It was a long two-day training, but QIOs enjoyed having the time to spend together as a group to learn and talk about culture change. Adult learning principles take into account the three different ways in which adults learn: visual, auditory and kinesthetic. The training session included a PowerPoint presentation containing photos that demonstrated the appearance of culture change in a nursing home (visual). Participants had the opportunity to discuss the material in small group exercises with the mystery game (auditory); and they were also able to actually experience many of the exercises by doing them (kinesthetic). As a result, they are now more comfortable with working with nursing homes using the provided materials.

QIOs were provided with an elaborate series of homework assignments both for them and the nursing homes with whom they will be working over the course of the project. These assignments are designed to provide real-time learning both for the QIO and the “change team” within the nursing home. Each assignment is designed to:

- Delve more deeply into the culture within that they are immersed
- Investigate, in a non-threatening manner, the issues, systems and barriers that perpetuate institutionalized culture and
- Begin to bring about an awareness of change that could benefit the nursing home
The assignments focus on developing, improving and working diligently on relationships. There are eight to ten weeks of assignments within the homework package carrying participants through until our next training session.

Evaluations from both sessions were positive and provided good comments and feedback for future culture change training sessions.

**QIO Communications**

At the start of the special study, pilot QIOs received a 2004-05 training calendar that included the in-person training dates and conference calls. An email list (list serve) was created to support ongoing communications among the pilot QIOs by encouraging sharing materials developed by QIOs, asking questions and sharing stories as well as to providing a communications channel between the QIOSC and QIOs. Quality Partners will facilitate this list.

**Evaluation Summary**

Participants provided feedback on the training by completing session evaluations. On the first page of the evaluations, participants were asked how well each session objective was met and how well the overall goal related to the information presented. For both training days, the majority of participants responded to those questions as either excellent or good. The presenters received high ratings for teaching effectiveness. David Farrell (89% rated as excellent) and Barbara Frank (90% rated as excellent) received the highest ratings. When asked what they found most useful about the session, participants responded by saying they especially liked the following:

- The small groups
- Having the opportunity to experience the interactive exercises that they will use with their nursing homes staff
- The specific “how to” of culture change
Building the business case for culture change
Having the perspective of the surveyors

When asked what they found least useful about the sessions, participants were at a loss for suggestions. Finally, when asked for recommendations for future sessions, participants responded by requesting information about facilitation skills and leadership development. Quality Partners will use these suggestions when planning future training sessions.

**CMS Communications**

Following every training session, Quality Partners and CMS will participate in a training debriefing session via conference call to discuss any issues that arose during the training. This interactive format will assist the team in solving problems and identify future areas of improvement.

**PDC Training Session #2: November 30-December 1, 2004**

**Training Overview**

As part of the "Improving Nursing Home Culture Special Study," Quality Partners of Rhode Island provided the second person directed care (PDC) (previously person centered care) training session at the Providence Biltmore Hotel in Providence, RI on November 30 and December 1, 2004. The session brought together 22 Quality Improvement Organizations (QIOs) with the shared goals of learning together, learning from one another, and networking with other QIO project staff. We aimed to encourage participants to share good ideas.

Whereas Training Session One focused on communication and relationship building among nursing home staff, Training Session Two focused on leadership. In order to make the transformational change that occurs with culture change, nursing homes need
leadership skills. By “leadership,” we mean not only the appointed leaders—such as the administrator and director of nursing (DON)—but also staff including (but not limited to) nurses (charge nurses, staff nurses, unit managers), certified nursing assistants (CNAs), housekeeping, dietary and maintenance. Everyone has the potential to become a leader in his/her organization; the only thing necessary is nurturing leadership skills and “freeing the leader within.”

The PDC training series was approved for nursing continuing education credits (CEUs) through the Colorado Foundation of Medical Care (CFMC). CEUs were awarded to 68 participants. The overall goal for the two-day training was to teach the QIO project staff the skills of exceptional leaders and techniques to facilitate development of these skills in nursing home staff.

**Training Day One**

On Training Day One, the agenda included the following items:

- Tips and tales from the trails
- The five principles: Kouzes and Posner homework
- The practical application of leadership principles in nursing homes
- Barriers along the rainbow trail

For Training Day One, the session goals were the following:

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>The five principles: Kouzes &amp; Posner homework</td>
<td>To learn the fundamental practices of exemplary leaders and brainstorm practical applications for nursing home staff</td>
</tr>
<tr>
<td>The practical application of leadership principles in nursing homes</td>
<td>To understand the link between leadership concepts and organizational practices and how these practices affect nursing home employees and their ability to deliver care</td>
</tr>
<tr>
<td>Barriers along the rainbow trail</td>
<td>To examine barriers that often impede the growth of leaders, ideas and creativity in long term care</td>
</tr>
</tbody>
</table>
As a result of participating in Training Day One, QIOs should have a clear understanding of the five leadership principles of exemplary leaders identified by Kouzes and Posner (2003):

- Encourage the heart
- Challenge the process
- Model the way
- Enable other to act
- Inspire a shared vision

One leadership myth is that leaders are born, not made; but leaders can indeed be created. Through a discussion of the homework reading, The Leadership Challenge by Kouzes and Posner, QIOs learned how to create leaders by building upon skills that staff already possess. This reading, which is research based, includes multiple real-life examples of incredible leaders. As the authors spoke to hundreds of individuals, they identified five leadership principles (listed above) that have remained constant over time. These leadership principles apply not only to administrators and DONs, but also to CNAs, dietary staff, housekeeping staff, and maintenance staff. In other words, anyone can be a leader.

**Training Day Two**

On Training Day Two, the agenda included the following items:

- Good to great—the flywheel effect
- Color workshop
- Creating rainbows: A “hope builders” guide
- Kouzes and Posner synthesis
Goals for Training Day Two included the following:

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good to great—the flywheel effect</td>
<td>When you let the flywheel do the talking, you do not need to communicate big goals</td>
</tr>
<tr>
<td>Color workshop</td>
<td>To establish an understanding of personality traits and to further discover ways that we can honor and respect the many traits that affect the workplace environment in long term care</td>
</tr>
<tr>
<td>Creating rainbows: a “hope builders” guide</td>
<td>To learn from an administrator and staff the growth that facilitated change in their nursing home</td>
</tr>
<tr>
<td>Kouzes &amp; Posner synthesis</td>
<td>To allow for synthesis of practical ideas with the principles of Kouzes and Posner</td>
</tr>
</tbody>
</table>

As a result of participating in Training Day Two, QIOs should have an understanding of the leadership principles and how to assist nursing home staff—from Administrators to CNAs—develop their leadership potential.

**Training Summary**

The training was facilitated by Marguerite McLaughlin, Project Coordinator at Quality Partners of Rhode Island, along with Barbara Frank and Cathie Brady, both from B & F Consulting. A great deal of Training Day One was used to teach the five leadership principles of Kouzes and Posner, how the principles could be applied to the nursing home setting and potential barriers to “freeing the leader within.”

This leadership discussion framed the training session for the two days. The participants needed to have a general understanding of leadership and applications to the nursing home setting. During Training Day One participants discussed *The Leadership Challenge* (Kouzes and Posner, 2003), part of the QIOs’ homework assignment between QIO training sessions one and two. To strengthen the homework assignment, QIOs were put into one of five groups based on the principles (i.e., encourage the heart, challenge the
process model the way, enable others to act and inspire a shared vision), and each group
presented to the audience about that particular principle, comparable to a book discussion
group. QIOs participated in exercises (e.g., Exploring Power and Power Island) to
demonstrate the use of power and the relationship of power and leadership. Afterwards,
Christine Bishop, PhD and Jodie Gittell, PhD from Brandeis University presented an
update from their research project entitled, “The Practical Application of Leadership
Principles in Nursing Homes,” which demonstrated the relationship between leadership
and long term care and put framework around the overall leadership discussion.
Training Day Two provided participants with more opportunities to discuss the Kouzes
and Posner leadership principles. Participants built on their experiences in the two-day
training by forming five groups, again based on the five leadership principles, and
developed and presented a storyboard based on one of the principles. Through the
storyboard presentations, participants had the opportunity to “match” interventions with
the five principles. Many of the ideas had no cost to implement. David Farrell, Project
Manager at Quality Partners and former Wellspring CEO, gave a presentation entitled
“Good to Great—The Flywheel Effect.” He talked about level 5 leaders and practices of
organizations that went from good to great, and how those practices could be applied to
nursing homes. During the Color Workshop, QIOs used a self-assessment tool to fit
themselves into one of four colors (green, blue, gold and orange) and had the opportunity
to talk to others who were the same “color.” The purpose of the exercise was to make
participants aware of the different traits people have and how those traits determine how
people approach their work. Used in the nursing home setting, staff can discover ways
they can honor and respect the many traits that affect the workplace environment in
nursing homes.
Training coordinators presented the QIOs with change idea templates to capture change
ideas from the nursing homes visited. The ideas can range from simple solutions to very
creative and complex organizational strategies. These ideas are those that have helped to
move the change process and equally offer valuable lessons to those who journey after us
to try to make these changes.
Evaluations from both sessions were positive and provided good comments and feedback for future culture change training sessions.

**QIO Communications**

At the start of the special study, QIOs received a 2004-05 training calendar that included the in-person training dates and conference calls. An email list (list serve) [inhc-pcc@cfmc0010.vwh.net] was created by CFMC to support ongoing communications among the QIOs by encouraging asking questions and sharing training agendas and materials. Quality Partners facilitates this listserv.

**Evaluation Summary**

Participants provided feedback on the training by completing session evaluations. On the first page of the evaluations, participants were asked how well each session objective was met and how well the overall goal related to the information presented. The majority of participants responded to those questions as either excellent or good. When asked to provide comments for improving the session, participants responded by saying:

- They want to hear about best practices (lessons learned) and stories from other QIOs
- They want to have more tools (similar to Training Session #1) to assist bringing the information to the nursing home. One example was to provide exercises to go with the Kouzes and Posner principles.
- They want information on measurement
Training Overview

As part of the "Improving Nursing Home Culture Special Study," Quality Partners of Rhode Island provided the third Person-Directed Care (PDC) training session at the Providence Biltmore Hotel in Providence, RI on March 9 – 10, 2005. Twenty-one Quality Improvement Organizations (QIOs) attended this session, and shared goals of learning together as well as from one another, and networking with other QIOs. QIOs participated in learning circles and were encouraged to share their ideas and put together change idea sheets. The Colorado Foundation of Medical Care (CFMC) approved all of the PDC trainings for nursing continuing education credits (CEUs), and participants who sign in are awarded CEUs.

Training Session #3 focused on developing a process for problem solving which leads to Person-Directed Care. Providing Person-Directed Care by learning how to implement significant practices and change ideas was the overall goal for participants during this two-day training Person-Directed Care.

Training Day One

Agenda items included:

- Flywheel I: Sharing Exercise
- Wanting to Dance When Your Expected to March
- Modifying the Environment
- Bathing without a Battle
The session goals were:

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flywheel: Sharing Exercise</td>
<td>Gather essential learning from Training Session II that will further spread significant practices.</td>
</tr>
<tr>
<td>Wanting to Dance When Your Expected to March</td>
<td>Provide an understanding and framework for the roles, language and needs related to PDC.</td>
</tr>
<tr>
<td>Modifying the Environment</td>
<td>Understand what key elements within nursing home environments can be changed to support residents and further support Person-Directed Care.</td>
</tr>
<tr>
<td>Bathing without a Battle</td>
<td>An opportunity to hear Joanne Rader’s now, infamous “Bathing without a Battle” lecture and learn how it relates to person-directed care (PDC). Using this creative philosophy, participants can apply it to other areas of PDC.</td>
</tr>
</tbody>
</table>

**Training Summary**

Training was facilitated by Marguerite McLaughlin, Project Coordinator at Quality Partners of Rhode Island, along with Barbara Frank and Cathie Brady, both from B & F Consulting; and a guest speaker, Joanne Rader, RN, MSN, Oregon Health & Science University, School of Nursing.

As a result of participating in the training, the QIOs learned the four roles to problem solving and creating Person-Directed Care (being a Magician, Detective, Carpenter, and Jester). The “4-role process” is very similar to other problem solving processes except that the first step is to step into the person’s world. Becoming the magician directly relates to becoming the other person in order to recognize how strange and difficult making even small changes is and why resistance is part of the change process. The detective role is similar to the “planning” and “study” parts of the PDSA process. The carpenter’s role is to choose appropriate interventions. Finally, the role of the jester encompasses the other roles while continually energizing and enhancing creativity of the group.
Through a role-play exercise participants were able to dramatize the ways in which conversation, attitudes and real-life situations can play into the understanding and implementation of any process. They learned what it is like when people are asked to change systems and the complexity of the changes. The exercise demonstrated how to effectively gain trust and buy-in.

Participants learned different strategies to alter the external environment to improve behaviors and quality of life for residents. The three areas of change were organizational, psychosocial, and physical. Examples included structuring the day, providing support and education, communication, staff attitude, nurturing healthy relationships, activities, family support and education, noise, lighting, flooring, and furniture. These examples segued into the last agenda item for the day, “Bathing Without a Battle”. With outcome measures from a clinical trial of two bathing interventions in dementia, participants were taken through residents’ bathing experiences and learned how to individualize care rather than substitute one specific method or task for another.

The last segment of training divided the participants into groups to develop detailed implementation plans for creating person-directed bathing in a facility. They began to discuss potential barriers, how to measure success, and how to implement the changes.

Training Day Two

Agenda items included:
- Sweet Slumber: Care at Night
- Employee Centered Workplace practices
- Flywheel II: QIOs Facilitating Change
Goals for the second day included the following:

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sweet Slumber: Care at Night</td>
<td>Consider the impact that one system has on the many nursing home departments and consider how to begin a change process that is inclusive and supportive of all.</td>
</tr>
<tr>
<td>Employee Centered Workplace practices</td>
<td>Integrate an understanding of workplace practice into the PDC model.</td>
</tr>
<tr>
<td>Flywheel II: QIOs Facilitating Change</td>
<td>Take a variety of different change concepts and begin to consider all that will be required to implement change.</td>
</tr>
</tbody>
</table>

**Training Summary**

Training was facilitated by Marguerite McLaughlin, Project Coordinator at Quality Partners of Rhode Island; Barbara Frank and Cathie Brady, both from B&F Consulting; David Farrell, Project Manager at Quality Partners of Rhode Island; and guest speaker Joanne Rader, RN, MSN, Oregon Health & Science University, School of Nursing.

With day one’s training as a reference, participants developed implementation strategies specific to their pilot homes. Using the example of routine night care, participants compared the nursing home process to what a resident would experience at home. They discussed residents’ responses to the current approach by putting themselves in the residents’ shoes. Participants learned the many alternatives to provide Person-Directed Care at night. Through learning circles, the QIOs discussed what their first step would be in individualizing nighttime assistance.

Training coordinators presented the QIOs with national turnover and vacancy rates as an introduction to Employee-Centered Workplace Practices. Participants received information about what types of people are entering the CNA field, emphasizing that most have intentionally chosen long-term care because they have a desire to help others. Discussed why employees leave one facility to work at another healthcare organization.
The discussion of workplace practice led to an overview of the benefits of culture change in nursing homes which included intrinsic motivation, satisfaction, stability, quality of life, quality of care, and financial.

Participants learned about what distinguished low vs. high turnover facilities from the results of a research study by Professor Susan Eaton from Harvard. The results were leadership visibility, caring for caregivers, orientation, career ladders, flexible scheduling, primary assignments, and rarely working short staffed. Discussed the core components of a strategic framework designed to create a high-retention culture; this strategic plan will create the culture, which will allow nursing homes to retain their top performers. The eight pillars in the plan reflected broad categories of leadership practices identified by researchers to have the most positive impact on the culture in nursing homes. They are the eight areas of action in which nursing home leadership will get the greatest mileage for their efforts. This segment provided the participants with many different strategies to become an employee-centered workplace.

Finally, each table became a workgroup assigned to think through a change area (i.e. dining and diets, care planning) and complete a change idea sheet. Each group used their change idea to design a creative learning experience showing the change from the old, institutional culture to a new, individually directed way of approaching their topic area. Each group presented their changes through role-play exercises and songs, making the exercise a great way to end the training. The goal was to synthesize the session’s learning with the participants’ knowledge of quality improvement and nursing home care to learn how they can assist nursing homes through the change process.

**QIO Communications**

The QIOs continue to attend monthly conference calls and are utilizing the email list (list serve) [inch-pcc@cfmc0010.vwh.net], which was created by CFMC to support ongoing communications, and Quality Partners continues to facilitate the listserv.
nursing homes use the NHCC email list (list serve) [nhcc@cfmc0010.vwh.net], which was also created by CFMC to support sharing ideas, practice, and advice among all of the nursing homes in the pilot study.

**Evaluation Summary**

Participants provided feedback on the training by completing an evaluation for each day. Participants were asked how well the session objectives were met and how well the overall goal was presented. The majority of participants responded to those questions as either excellent or good. Although Quality Partners of Rhode Island worked closely with the guest speaker to ensure training encompassed adult learning principles, the session was very didactic. Participants commented on the didactic nature as well. As in previous training sessions, the QIOs value the opportunity to share with one another during learning circles. Participants would like to receive more education on workforce retention at the next learning session and possibly spend time discussing ‘MyInnerview’ since many trade associations are engaged in this. CEUs continued to be offered to participants for each PDC Training Session.

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**PDC Training Session #4: June 21 - 22, 2005**

**Training Overview**

As part of the "Improving Nursing Home Culture Special Study," Quality Partners of Rhode Island provided the fourth (and final) Person-Directed Care (PDC) training session at the Providence Biltmore Hotel in Providence, RI on June 21 – 22, 2005. The two-day session brought together 51 individuals representing 21 Quality Improvement Organizations. Through the Colorado Foundation of Medical Care (CFMC) continuing education credits (CEUs) were awarded to all 51 participants.

The overall goal of the session was to assist participants in learning significant practices and change ideas necessary for person-directed care. Many of the materials and exercises
previously presented to the participants of the Work Force Retention portion of the study were accumulated and presented to the QIOs during this session.

**Training Day One**

The session goals for the first day of training were as follows:

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Susan Eaton: High Turnover / Low Turnover Homes</td>
<td>• To gain a better understanding of frontline caregivers and the existing research, practice, and policy gaps</td>
</tr>
<tr>
<td>Format: PowerPoint Presentation and Group Exercises</td>
<td>• To overview the five key management practices associated with low turnover</td>
</tr>
<tr>
<td></td>
<td>• To provide a tool for facilities to self assess their high and low turnover factors</td>
</tr>
<tr>
<td>Leadership</td>
<td>• To brainstorm better approaches to address issues</td>
</tr>
<tr>
<td>Format: Group Exercises</td>
<td>• To develop an understanding of the leadership practices that supports an effective change process by analyzing the experiences of homes in the pilot in relation to the principles in Kouzes and Posner.</td>
</tr>
<tr>
<td>Voices Of The Staff: Looking At Satisfaction Data</td>
<td>• To better understand quality of work life measures</td>
</tr>
<tr>
<td>Format: PowerPoint Presentation and Worksheets</td>
<td>• To understand the value of collecting staff satisfaction data through the use of interactive exercises</td>
</tr>
<tr>
<td>WFR Homework Summary / Way of Inquiry</td>
<td>• To summarize findings from the homework assignments of the previous six months</td>
</tr>
<tr>
<td>Format: PowerPoint Presentation and Handout Material</td>
<td>• To learn about the tools and skills that support a way of inquiry customized to each nursing home</td>
</tr>
</tbody>
</table>
**Training Day Two**

The session goals for the second day of training were as follows:

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coaching &amp; Supporting A Change Process</td>
<td>• To build skills related to coaching and supporting a nursing home through a change process</td>
</tr>
<tr>
<td>Format: PowerPoint Presentation and Group Exercise</td>
<td></td>
</tr>
<tr>
<td>Valuing The Work Of All Staff</td>
<td>• To learn specific change ideas that support the retention of staff</td>
</tr>
<tr>
<td>Format: Group Exercise</td>
<td></td>
</tr>
</tbody>
</table>
| Change Ideas: Creating A Climate Of Collaboration | • To identify strategies for recruiting the right kinds of people and a screening process that identifies the best candidates  
  Format: PowerPoint Presentation, Group Exercise, and Handout Material  
  • To identify strategies for creating a welcoming environment for new staff  
  • To create an awareness of quality customer service |
| My InnerView                                     | • To gain a better appreciation of how essential is satisfaction data in the operational story of a facility using the example of My InnerView. |
| Format: PowerPoint Presentation                  |                                                                     |
| Show Me The Money: Case Study                    | • To revive dollars spent on turnover into retention strategies through an exercise. |
| Format: PowerPoint Presentation and Group Exercise |                                                                     |

**Training Summary**

Marguerite McLaughlin, Project Coordinator at Quality Partners of Rhode Island, and Barbara Frank and Cathie Brady, both from B & F Consulting, facilitated training. Additional speakers included David Farrell, Project Manager at Quality Partners of Rhode Island; Jan Gulsvig, RN, BSN, My InnerView; along with Maria Elena Del Valle and Kate Waldo, both from the Paraprofessional Healthcare Institute.

Covering the main components of workforce retention, during the first half of the day, participants were given the opportunity to learn methods and practices that identify the specific management strategies that support workforce retention. The second half of the
day was spent exploring methodologies for workforce retention giving participants an opportunity to work with several tools. Results of homework assignments from the previous six months were reviewed and discussed. The summary of the homework assignments received focused on cycle of turnover, cycle of understaffing, expenses related to turnover, financial incentives, what employees want, and management practices that support retention.

During the second day of training, the focus continued to be on change practices that retain staff. Additionally, participants discussed their role as a “Culture Change Consultant” and learned how best to Coach and Support A Change Process. This part of the training session provided participants with an opportunity to consider different approaches to site visits and conference calls that supports their clients.

**QIO Communications**

On July 19, 2005, the QIOs participated in the last of the seven scheduled monthly conference calls. They will continue using the email list (list serve) [inhc-pcc@cfmc0010.vwh.net], which was created by CFMC and facilitated by Quality Partners to support ongoing communication. One-on-one telephone calls with participants will be scheduled if necessary. Communication about the Outcomes Congress will be via the email list. Participant nursing homes continue to use the NHCC email list (list serve) [nhcc@cfmc0010.vwh.net], which was also created by CFMC to support sharing ideas, practice, and advice among all of the nursing homes in the pilot study.
Evaluation Summary

Evaluation are always created to obtain ideas for improvement and to fill one of the requirements for obtaining CEUs. Session evaluations were received from 71% of the participants.

1. Rate how well each objective has been met for you:  
   a. Management Practices That Make a Difference: Participants had the opportunity to learn and identify specific management practices that support retention. 
      
   b. Methodologies for Workforce Retention. Participants had the opportunity to learn about several quantitative and qualitative tools and explore their usefulness, as well as learn from data gathered over the past six months in the Workforce Retention Pilot. 
      
2. Overall, rate how well this program assisted QIO participants in learning about specific leadership retention practices and a methodology designed to assess turnover data more comprehensively.

Workforce Retention Training Sessions:

<table>
<thead>
<tr>
<th>WFR Training #1: October 14 – 15, 2004</th>
</tr>
</thead>
</table>

Training Overview

As part of the "Improving Nursing Home Culture Special Study," Quality Partners of Rhode Island provided the first workforce retention (WFR) training session at the Providence Biltmore Hotel in Providence, RI on October 14-15, 2004. The session brought together for two days of interactive training the seven nursing home corporations or multi-facility partners for quality (MPQ) and two state triads. The state triads include the state QIO, the state chapters of the American Association of Homes and Services for the Aging and the American Health Care Association. Participants had the opportunity to
learn from and network with other project staff to encourage sharing of good ideas. MPQs participated in exercises based on adult learning principles that focused on relationship building and communication among nursing home leadership and staff. The WFR training series was approved for nursing continuing education credits (CEUs) through the Colorado Foundation of Medical Care (CFMC). CEUs were awarded to sixty-one participants. The overall goal for the two-day training was to provide participants with innovative methods, strategies and exercises that they can use with their nursing home teams to improve behaviors proven to increase staff retention in the nursing home setting.

On Training Day One, the agenda included the following items:

- Project overview and framework
- Creating a high retention culture
- Management principles to promote workforce retention
- Leadership
- Building on intrinsic motivation

For Training Day One, the session goals were the following:

<table>
<thead>
<tr>
<th>Goal</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide a strong defense in support of the financial, social, clinical and practical concerns related to workforce retention</td>
<td>Culture change is the right thing to do, but it has a cost of both time and money. The presentation to support this goal sites research studies to support the financial commitment to workforce retention through culture change.</td>
</tr>
<tr>
<td>Bring clarity and vision to the study</td>
<td>Participants need to have a full understanding of the foundations of culture change and how the 2 pieces – person-directed care and workforce retention—fit together, in addition to an understanding of the change package and way of inquiry to assist nursing homes with the “getting started” phase.</td>
</tr>
<tr>
<td>Goal</td>
<td>Detail</td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Provide a group sharing activity that allows participants to examine characteristics of high-and low-turnover nursing homes</td>
<td>Participants need to have an understanding of the factors that contribute to high-and low-turnover homes along with a concrete application of these factors. Participants need to identify what factors their own nursing homes possess before management practices can be applied.</td>
</tr>
<tr>
<td>Provide participants specific management practices and interventions that will help to increase workforce retention</td>
<td>Participants need to have an understanding of how care practice affects workforce retention and management practices that can be used.</td>
</tr>
<tr>
<td>Provide the opportunity for participants to consider management practices built within their own systems that can enhance or detract from retention.</td>
<td></td>
</tr>
</tbody>
</table>

As a result of participating in training day one, participants gained an understanding of the person-directed care framework, the change package and change concepts, along with an understanding of how a nursing home could work through the “way of inquiry” to have their “ah-ha” moment prior to embarking on a workforce retention (culture change) journey. The goals allowed for the application of adult learning principles by using exercises and interactive discussion. With this knowledge, participants can embark on their projects at their own organizations—concentrating on workforce retention through relationships and person-directed care.

On Training Day Two, the agenda included the following items:

- Creating a learning climate through culture change (adult learning principles)
- Collection and calculation of data
Goals for day two included the following:

<table>
<thead>
<tr>
<th>Goal</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>To provide participants with the basics of adult education in a way that will also demonstrate the techniques as applied to culture change</td>
<td>Adult education techniques include providing education in the three ways in which adults learn—auditory, visual, and kinesthetic, to provide for the ultimate learning experience.</td>
</tr>
<tr>
<td>Participants will be part of a discussion regarding data collection, tracking and outcome measurement</td>
<td>Overview of measurement package outlined with input from the participants</td>
</tr>
</tbody>
</table>

As a result of Training Day Two, participants learned the skills to apply adult learning principles when involved with teaching and educating nursing home staff as it applied to the workforce retention focus through culture change.

**Training Summary**

The training was facilitated by Marguerite McLaughlin, Project Coordinator at Quality Partners of Rhode Island, along with Barbara Frank and Cathie Brady, culture change consultants for Quality Partners. Training day one was used to lay the groundwork for the workforce retention (WFR) special study. The facilitators spent time presenting the project overview and framework that included the following:

- Relationship-centered workplace
- Change package, and
- Way of inquiry.

This discussion framed the training session for the two days and provided the participants with an understanding of how workforce retention and person-directed care complement one another, as well as how relationships in the workplace affect workforce retention. Time was spent on defining the problem (lack of a consistent workforce) that included the cycle of turnover and staff longevity. David Farrell, CEO of Wellspring Institute,
provided a presentation that included evidence in support of creating a high retention culture (workforce retention). Barbara Frank facilitated a session called “The SNF Test for High and Low Turnover,” which gave participants more of an understanding about the factors that contribute to high and low turnover. This session included exercises (e.g. pair conversations) that participants can use at their own nursing homes to help develop relationships between MPQ and nursing home staff and among individual nursing home staff. The latter part of day one included a session presented by Cathie Brady that illustrated the impact of care practice on retention by using Joanne Rader’s “Bathing Without a Battle” compact disc that provided real-life examples of the connection.

Day Two provided participants with information about how to teach adult learners. When working with and teaching adults (i.e. nursing home staff), MPQs need to apply adult education principles. LaVrene Norton and Megan Hannon from ActionPact, Inc. provided a morning of adult education principles as applied to culture change that included group exercises and information that is easily transferable to the individual nursing homes. Adult learning principles take into account the three different ways in which adults learn: visual, auditory and kinesthetic. In the afternoon, Kris Mattivi, from CFMC, provided a guided talk about the project measurement strategy and data collection based on the work of the measurement workgroup comprised of Quality Partners of Rhode Island; CFMC; Brown University; Jill Scott-Cawiezell, PhD and Texas Long Term Care Institute. Participant feedback will be incorporated into the final measurement package. MPQs were provided with eight homework assignments that will require each MPQ team member to pair up with a pilot nursing home to complete assignments. These assignments are designed to provide real-time learning both for the MPQ and the pilot nursing home. Each assignment will:

- Assist the MPQ staff to learn about the cycle of turnover by talking to current employees and those who have voluntarily resigned,
- Strengthen relationships within the MPQ team,
- Determine the cost of recruitment at an individual nursing home,
- Assist staff in looking at recruitment and retention financial incentives given to employees,
- Assist MPQ staff to determine what employees want, and
- Look at an individual nursing home’s culture by completing a facility assessment to review turnover.
- Assist MPQ staff to track employee longevity, examine employee areas such as the break room, and review facility sponsored training opportunities
- Assist MPQ staff to appreciate the resident experience by observing waking and dining practices within one of their facilities

The assignments focus on developing, improving, and working diligently on relationships. There are assignments within the homework package for the participants to work on prior to the next training session that is scheduled for January 2005.

Evaluations from both sessions were positive and provided good comments and feedback for future training sessions.

**MPQ Communications**

At the start of the special study, pilot MPQ received a 2004-05 training calendar that included the training and conference call dates. An email list (list serve) was created to support ongoing communication among the MPQs by encouraging questions and sharing training agendas and materials that the MPQs will use at their individual organizations. Quality Partners’ staff facilitates this list by responding to questions, providing information and stimulating dialogue among MPQ staff.

**Evaluation Summary**

Session evaluations were created to obtain ideas for improvement for upcoming sessions as well as fulfill one of the requirements for obtaining CEUs. Participants were asked
how well each session objective was met and how well the overall goal related to the information presented.

For both training days, the majority of participants responded to those questions as either good or fair.

<table>
<thead>
<tr>
<th>Rate how well each objective has been met for you:</th>
<th>No Response</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have an understanding of what it takes to retain staff, how it benefits my organization financially and clinically, and will be able to teach these concepts to others.</td>
<td>0%</td>
<td>5%</td>
<td>62%</td>
<td>28%</td>
<td>5%</td>
</tr>
<tr>
<td>I can identify characteristics that perpetuate high turnover at my nursing home and can apply “change ideas” to my setting.</td>
<td>0%</td>
<td>3%</td>
<td>64%</td>
<td>28%</td>
<td>5%</td>
</tr>
<tr>
<td>I have a basic understanding of management practices that detract from retention and can apply specific management practices and interventions, which will help increase workforce retention.</td>
<td>3%</td>
<td>3%</td>
<td>46%</td>
<td>41%</td>
<td>8%</td>
</tr>
<tr>
<td>I understand that changing the manner in which some care is delivered can aid in workforce retention.</td>
<td>0%</td>
<td>0%</td>
<td>49%</td>
<td>49%</td>
<td>3%</td>
</tr>
<tr>
<td>I can use adult education techniques and apply them to teaching strategies within my setting.</td>
<td>3%</td>
<td>8%</td>
<td>44%</td>
<td>41%</td>
<td>5%</td>
</tr>
<tr>
<td>I will be able to track employee turnover using the stated method.</td>
<td>0%</td>
<td>3%</td>
<td>41%</td>
<td>33%</td>
<td>23%</td>
</tr>
<tr>
<td>Rate how well this program provided a perspective on workplace practices using innovative methods, strategies and practices that will serve as a catalyst to improve staff retention in MPQ settings.</td>
<td>0%</td>
<td>5%</td>
<td>51%</td>
<td>38%</td>
<td>5%</td>
</tr>
</tbody>
</table>

According to these results, the majority of participants has an understanding of the principles presented and has the ability to apply them in practice. The following items were rated “most useful” on the evaluations:

- Resident-focus to improve quality of life
- The homelessness video
- Barrier/driver activity
- The organization/identification of key or irritant areas related to retention
- Creating a culture of retention and learning
- Data collection information
- Information regarding employee satisfaction as related to job responsibilities
The following items were rated “least useful” on the evaluations or identified as areas for improvement:

- Management practices that support retention
- Need additional information on the steps of culture change and the associated management practices
- Insufficient time allotted for individual team discussion and planning
- Lengthy lectures
- Directions prior to the end of the sessions need to be clearer and provide more time for questions

Recommendations for future sessions included the following:

- More suggestions on how to create a positive work environment and rehabilitate the negative attitude of employees
- More discussion about planning and implementation; time for teams to map out steps to achieve goal
- Spend a little more time on examples for data collection processes and structure of the actual facility teams

**CMS Communications**

Following every training session, Quality Partners and CMS will participate in a training debriefing session via conference call to discuss any issues that arose during the training. This interactive format will assist the team in solving problems and identify future areas of improvement.
Training Overview

As part of the "Improving Nursing Home Culture Special Study," Quality Partners of Rhode Island provided the second workforce retention (WFR) training session at the Providence Biltmore Hotel in Providence, RI on January 11-12, 2005. The session brought together 8 Multi-facility Partners for Quality (MPQs) (nursing home corporations) with the shared goals of learning together, learning from one another, and networking with other WFR staff. We aimed to encourage participants to share good ideas.

Whereas Training Session #1 focused on communication and relationship building among nursing home staff, Training Session #2 focused on leadership. In order to make the transformational change that occurs with culture change, nursing homes need leadership skills. By “leadership,” we mean not only the appointed leaders—such as the administrator and director of nursing (DON)—but also staff including (but not limited to) nurses (charge nurses, staff nurses, unit managers), certified nursing assistants (CNAs), housekeeping, dietary and maintenance. Everyone has the potential to become a leader in his/her organization; the only thing necessary is nurturing leadership skills and “freeing the leader within.”

The WFR training series was approved for nursing continuing education credits (CEUs) through the Colorado Foundation of Medical Care (CFMC). CEUs were awarded to 39 participants. The overall goal for the two-day training was to teach the WFR staff the skills of exceptional leaders and techniques to facilitate development of these skills in nursing home staff.
Training Day One

For Training Day One, the session goals were the following:

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tips and tales from the trails</td>
<td>To gather learning from homework assignments initiated during training session one</td>
</tr>
<tr>
<td>The five principles: Kouzes &amp; Posner homework</td>
<td>To learn the fundamental practices of exemplary leaders and brainstorm practical applications for nursing home staff</td>
</tr>
<tr>
<td>Good to great—the flywheel effect</td>
<td>When you let the flywheel do the talking, you do not need to communicate big goals</td>
</tr>
<tr>
<td>The practical application of leadership principles in nursing homes</td>
<td>To understand the link between leadership concepts and organizational practices and how these practices affect nursing home employees and their ability to deliver care</td>
</tr>
<tr>
<td>Leadership exercises</td>
<td>To examine the barriers that often impede the growth of leaders, ideas and creativity in long-term care</td>
</tr>
</tbody>
</table>

As a result of participating in training day one, MPQs should have a clear understanding of the five leadership principles of exemplary leaders identified by Kouzes and Posner (2003):

- Encourage the heart
- Challenge the process
- Model the way
- Enable other to act
- Inspire a shared vision

One leadership myth is that leaders are born, not made; but leaders can indeed be created. Through a discussion of the homework reading, *The Leadership Challenge* by Kouzes and Posner, QIOs learned how to create leaders by building upon skills that staff already possess. This reading, which is research based, includes multiple real-life examples of incredible leaders. As the authors spoke to hundreds of individuals, they identified five
leadership principles (listed above) that have remained constant over time. These leadership principles apply not only to administrators and DONs, but also to CNAs, dietary staff, housekeeping staff, and maintenance staff. In other words, anyone can be a leader.

Training Day Two

Goals for Day Two included the following:

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measurement and data</td>
<td>To further understand the measurement strategies and tools used in the project</td>
</tr>
<tr>
<td>From recruitment to retention</td>
<td>To see the value in investing in staff retention vs. staff recruitment</td>
</tr>
<tr>
<td>Your systems are causing your outcomes</td>
<td>To learn how to change systems to create new outcomes</td>
</tr>
<tr>
<td>Kouzes &amp; Posner synthesis</td>
<td>To allow for synthesis of practical ideas with the principles of Kouzes and Posner</td>
</tr>
</tbody>
</table>

As a result of participating in training Day Two, MPQs should have an understanding of the leadership principles and how to assist nursing home staff—from Administrators to CNAs—develop their leadership potential.

Training Summary

The training was facilitated by Marguerite McLaughlin, Project Coordinator at Quality Partners of Rhode Island, along with Barbara Frank and Cathie Brady, both from B & F Consulting. A great deal of Training Day One was used to teach the five leadership principles of Kouzes and Posner, how the principles could be applied to the nursing home setting and potential barriers to “freeing the leader within.”

This leadership discussion framed the training session for the two days. The participants needed to have a general understanding of leadership and applications to the nursing
home setting. During Training Day One participants discussed The Leadership Challenge (Kouzes and Posner, 2003), part of the MPQ’s homework assignment between MPQ training sessions one and two. To strengthen the homework assignment, MPQs were put into one of five groups based on the principles (i.e., encourage the heart, challenge the process model the way, enable others to act and inspire a shared vision), and each group presented to the audience about that particular principle, comparable to a book discussion group. MPQs participated in exercises (e.g., Power Island) to demonstrate the use of power and the relationship of power and leadership. David Farrell, Project Manager at Quality Partners and former Wellspring CEO, gave a presentation entitled “Good to Great—The Flywheel Effect.” He talked about level 5 leaders and practices of organizations that went from good to great, and how those practices could be applied to nursing homes. Afterwards, Christine Bishop, PhD and Jodie Gittell, PhD from Brandeis University presented an update from their research project entitled, “The Practical Application of Leadership Principles in Nursing Homes” demonstrated the relationship between leadership and long-term care and put a framework around the overall leadership discussion.

Training Day Two provided participants with more opportunities to discuss the Kouzes and Posner leadership principles. Participants built on their experiences in the two-day training by forming five groups, again based on the five leadership principles, and developed and presented a storyboard based on one of the principles. Through the storyboard presentations, participants had the opportunity to “match” interventions with the five principles. Many of the ideas had no cost to implement.

Evaluations from both sessions were positive and provided good comments and feedback for future culture change training sessions.
**MPQ Communications**

At the start of the special study, MPQs received a 2004-05 training calendar that included the in-person training dates and conference calls. An email list (list serve) [inch-pcc@cfmc0010.vwh.net] was created by CFMC to support ongoing communications among the QIOs by encouraging questions and sharing training agendas and materials. Quality Partners facilitates this list serve.

**Evaluation Summary**

Participants provided feedback on the training by completing session evaluations. On the first page of the evaluations, participants were asked how well each session objective was met and how well the overall goal related to the information presented. The majority of participants responded to those questions as either excellent or good.

When asked to provide comments for improving the session, participants responded by saying:

- More examples of practical applications in developing practices of exemplary leaders
- Continue with the mixed groups
- Would be helpful to have CMS to attend
- Content should be customized to MPQ roles, not geared to Admin/DNS
Training Overview

As part of the "Improving Nursing Home Culture Special Study," Quality Partners of Rhode Island provided the third Work Force retention (WFR) training session at the Hotel in Providence, RI on April 12-13, 2005. The session brought together for two days of interactive training seven multi-facility partners for quality (MPQs) that included two state triads. One MPQ attended as an “observer” due to a recent acquisition that resulted in leadership change and transition throughout the company. They are not conducting facility training at this time but are collecting and submitting data and hope to use the training with their facilities in the future. Participants had the opportunity to learn and network with other project staff to encourage sharing of good ideas.

Whereas, Training Session #1 focused on communication and relationship building and Training Session #2 focused on leadership, the title for Training Session #3 was Creating Change: The Actions of Change Agents. The focus was on implementation or the “how to” of culture change with a specific segment on the role of nursing. Anna Ortigara, RN, VP from Life Services Network, provided exciting and dynamic presentations throughout the training, continually challenging the audience with her thoughts and ideas.

The WFR training series was approved for nursing continuing education credits (CEUs) through the Colorado Foundation of Medical Care (CFMC). CEUs were awarded to 26 participants with 30 staff attending. The overall goal for the two-day training was to demonstrate to participants how to be change agents, providing tools for their nursing home teams as they continue their culture change journey.
**Training Day One**

The session goals for the first day of training were as follows:

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Goal</th>
</tr>
</thead>
</table>
| Open Sharing: Flywheel (from Good to Great by Jim Collins). Method used was the Learning Circle. | • To learn from each other about experiences/learning from participating facilities  
  • To build our capacity for collaboration  
  • To learn that it is the little changes that get the flywheel moving |
| The Hao of Change. Method used was a presentation and discussion – David Farrell. | • To model the kind of teamwork, open sharing, collective examination and building relationships that we want nursing homes to experience. This is the Hao of Change; it is not what you do but how you do it. |
| Root Cause Analysis. Method used was presentation, fishbone exercise and sharing of homework assignments – David Farrell. | • To learn how to conduct a root cause analysis that identifies why staff leave their facility or organization.  
  • To identify how to create a staff satisfaction survey and interpret results. |
| Valuing the Work of All Staff – The How To: Consistent Staff Assignments. Anna Ortigara. Method used was presentation, discussion and exercise- “I’m only brushing my teeth.” | • To learn the importance of valuing all staff and demonstrate the implementation practices to support it. |
| Recognizing each Person’s Talents – The How To: LEAP – Changing the Model of Nursing - Anna Ortigara. Method used was presentation and discussion | • To learn the specific practices to recognize each person’s talents.  
  • To understand the essential role of nurses in a Culture Change Organization. |
| Creating Person-Directed Care Teams: The Power of Language in the New Work force – Anna Ortigara. Method was presentation and interactive exercise, “Who knows Mrs. Valdez?” | • To implement practices that support the power of language and being heard in the work force. |
Kicking off Training Day One, Mary Tess Crotty, VP of Quality Management for Genesis, NE Region shared a video of the storyboards that the participating centers developed around the culture change practice or idea they were implementing. She shared that the center teams have been enthusiastic and energized and many of them had totally re-vamped dining room practices by adding meal choices and having food served from steam carts right in the dining room.

**Training Day Two**

Goals for day two included the following:

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mystery Shopper – The Recruitment, Interviewing and Hiring Process. The Post-Hire Interview -David Farrell</strong>&lt;br&gt;Method used was discussion and use of worksheets</td>
<td>▪ To use the technique of mystery shopping to understand the processes of recruitment, interviewing and hiring.&lt;br&gt;▪ To identify opportunities for improvement in these processes.</td>
</tr>
<tr>
<td><strong>Creating a Welcome Environment for New Staff – Paraprofessional Healthcare Institute</strong>&lt;br&gt;Methods used were: presentation, change idea worksheets and discussion.</td>
<td>▪ To implement change ideas that promote a welcoming environment for new staff.</td>
</tr>
<tr>
<td><strong>Supporting Individual Growth – LEAP Career Mobility Ladder and Peer Mentor Programs – Anna Ortigara</strong>&lt;br&gt;Methods used were presentation, video and discussion.</td>
<td>▪ To understand the value of supporting individual growth.&lt;br&gt;▪ To learn to implement strategies such as career mobility ladders to support it.</td>
</tr>
<tr>
<td><strong>Flywheel – Part Two: Moving from Old to New Culture – Quality Partners team</strong>&lt;br&gt;Method used was each table became a workgroup to think through a specific change area.</td>
<td>▪ To brainstorm change ideas that promote the move from old to new culture.&lt;br&gt;▪ To identify strategies for use with participating nursing home teams.</td>
</tr>
<tr>
<td><strong>Drilling Down – Homework – David Farrell</strong>&lt;br&gt;Method used was an introduction to data</td>
<td>▪ To have a clear understanding of the homework assignment related to turnover, attendance rates and...</td>
</tr>
</tbody>
</table>
collection tools being piloted in the study. incentives.

| Encouragement as Feedback – Cathie Brady | To develop a greater awareness of the power of praise and the importance of being heard. |
| Method used was presentation and exercise. | |

Training Summary

The training was facilitated by Marguerite McLaughlin, Project Coordinator at Quality Partners of Rhode Island and David Farrell, Project Manager at Quality Partners of Rhode Island, along with Barbara Frank and Cathie Brady, culture change consultants for Quality Partners. As a result of participating in Training Day One, participants gained knowledge regarding how to conduct a root cause analysis to determine why staff are leaving their facilities or companies; how to implement practices that support the valuing of staff as well as practices that support the power of language and being heard in the workforce. There were interactive exercises and discussions where participants were able to share what their nursing home teams were experiencing and the learning from homework assignments. With this knowledge, participants will develop additional strategies and practices (the how to) to work with their teams as they continue their culture change journey.

As a result of training day two, participants learned the skills to use the mystery shopper technique to obtain information that looks at the recruitment, hiring and interviewing processes and identifies the opportunities for improvement within those processes. Additional skills learned were the identification of strategies to move from the old to the new culture and to develop practices that promote the power of praise. It was an extremely interactive day of learning.

David Farrell presented a number of Work Force Retention data collection tools that are being piloted during this study. He asked MPQ staff to use them to “drill down” in order
to identify information and root causes that will be helpful in identifying areas where change is needed. Also, since the tools are being piloted, he asked that staff provide him with feedback regarding design and formatting.

Evaluations from both sessions were extremely positive, yielding the highest scores to date. Participants clearly valued the practical “how to” focus of this training.

**MPQ Communications**

At the start of the special study, pilot MPQ received a 2004-05 training calendar that included the training and conference call dates. An email list (list serve) was created to support ongoing communication among the MPQs by encouraging questions and sharing training agendas and materials that the MPQs will use at their individual organizations. Quality Partners’ staff facilitates this list by responding to questions, providing information and stimulating dialogue among MPQ staff. Linda Drummond, consultant to Quality Partners, acts as a liaison with the MPQs. She has monthly conference calls with each of them individually and also is the point person for data collection. A status report is created after these monthly calls are conducted that identifies what MPQs are focusing on, where they are seeing change, what barriers they encounter and lastly what, if any, additional assistance they need from the WFR team.

**Evaluation Summaries**

Session evaluations were created to obtain ideas for improvement for the next session as well as fulfill one of the requirements for obtaining CEUs. Individual evaluations were provided for each day of training and the summary from the first day follows:
Participants were asked how well each session objective was met and how well the overall goal related to the information presented. For both training days, the majority of participants responded to those questions as agree (with very high percentages noted).

<table>
<thead>
<tr>
<th>Please evaluate the session’s goals by circling the one number that describes your rating.</th>
<th>Agree</th>
<th>Disagree</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing my colleague’s experiences provided strategies that will help me going forward.</td>
<td>84%</td>
<td>4%</td>
<td>12%</td>
</tr>
<tr>
<td>I can conduct a root cause analysis to identify why staff leave</td>
<td>92%</td>
<td>0%</td>
<td>8%</td>
</tr>
<tr>
<td>I learned the importance of valuing all staff and could implement practice to support it.</td>
<td>88%</td>
<td>0%</td>
<td>12%</td>
</tr>
<tr>
<td>I learned specific practices to recognize each person’s talents.</td>
<td>80%</td>
<td>8%</td>
<td>12%</td>
</tr>
<tr>
<td>I am able to implement practices that support the power of language and being heard in the workforce.</td>
<td>88%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Overall, this session provided me with useful information</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

According to these results, the majority of participants developed skills that will assist them in moving their teams forward. The following items were rated “most useful” on the evaluations:

- The interaction and information. This session provided more opportunities than the previous sessions have.
- Primary assignment information and discussion.
- Exercises to take back and use with the nursing home teams.
- Valuing the work of staff.
- Root cause analysis.
- Change in the perception of the Nurse’s role.
- Anna was fabulous- her energy, passion and message are inspiring.
- The entire session was useful. Every aspect was useful.
The following items were rated “least useful” on the evaluations or identified as areas for improvement:

- Brushing the teeth exercise – However, it was worth the try.
- Nothing – a great day.
- Hao of change.
- I loved it all, even the part about nurses.
- Memo conversation.
- Too long – ended too late in the day.

Recommendations for future sessions included the following:

- Quality mentoring styles
- Primary assignment implementation and data
- LEAP training
- Language
- Rewarding the right behavior
- More presentations from corporations who have been in the culture change process for some time

**Evaluation Summary for Training Day Two**

<table>
<thead>
<tr>
<th>Please evaluate the session’s goals by circling the one number that describes your rating.</th>
<th>Agree</th>
<th>Disagree</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am able to implement change ideas that promote a welcoming environment for new staff.</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>I understand the value of supporting individual growth and can implement strategies such as career mobility ladders to support it.</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>The group exercise related to brainstorming change ideas to promote the move from old to new culture provided strategies to use with my participating nursing homes.</td>
<td>91%</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>
I have a clear understanding of the homework assignment related to rate and staff increases, attendance data and turnover rates.

| Percentage Distribution | 91% | 0% | 9% |

I have greater awareness of the power of praise and importance of being heard; and, I am equipped to implement practice to support it.

| Percentage Distribution | 91% | 0% | 9% |

Overall, this session provided me with useful information.

| Percentage Distribution | 91% | 0% | 9% |

According to these results, the majority of participants developed skills that will assist them in moving their teams forward. The following items were rated “most useful” on the evaluations:

- Anna and David were great. Anna’s presentation.
- Brainstorming change.
- Career mobility ladders. Anna was very helpful with good and new information.
- Caregivers assessment guide.
- Creating a “welcoming” environment. I loved Maria Elena and Kate’s session.
- Letting groups work together in their own teams.
- The role of supervisors. The impact on retention and good orientation.
- These two days have been the best of the learning sessions so far.

The following items were rated “least useful” on the evaluations or identified as areas for improvement:

- Did not feel PHI had much to offer. Wrong focus given the audience.
- Interview/ideal candidate traits – I already know this – old information. Should have gotten into more detail on mentoring options.
- Mystery Shopping – mainly because I haven’t done this.
Given us time within the session to strategize how we communicate and teach this information to our centers/employees. Speakers need to present their information so that it meets the needs of MPQ leaders who have over achieving responsibilities.

- I had trouble staying focused on welcoming and interviewing – not the point of reference I am looking for.
- Not enough material to fill the day.
- Request approval from NAB for CEUs for NHA’s.

Recommendations for future sessions included the following:

- Challenge the corporate leaders/participants on practicing what they are ‘preaching’ at the top-level structure.
- Homework assignment improvements and outcomes.
- Pulling it all together and how to apply.
- This is such a terrific learning opportunity.
- Have each MPQ share best practices.

**CMS Communications**

Following every training session, Quality Partners and CMS will participate in a training debriefing session via conference call to discuss any issues that arose during the training. This interactive format will assist the team in solving problems and identifying future areas of improvement.
Training Overview

As part of the "Improving Nursing Home Culture Special Study," Quality Partners of Rhode Island provided the fourth Workforce Retention (WFR) training session at the Biltmore Hotel in Providence, RI on July 12-13, 2005. The two-day session brought together 24 individuals representing 7 Multi-facility Partners for Quality (5 nursing home corporations and 2 state triads). Through the Colorado Foundation of Medical Care (CFMC) continuing education credits (CEUs) were awarded to all 24 participants.

The session was entitled, “Connecting the Pieces: Integrating Workforce Practice, Environment, and Care Practices”. Essentially, it was the culmination of tools, strategies, and homework assignments from the previous three sessions, which, together, provide a complete understanding of important workforce issues. The theme of Training Session #4 was how to organize systems around the people who live and work in nursing homes in order to improve quality of life. This was the first session that brought together the components of the Person-Directed Care Model, which include the domains of environment, care practice, and workplace practice. Until now, the majority of the training had been mostly in the domain of workplace practice.
**Training Day One**

The session goals for the first day of training were as follows:

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Blueprint for Change</strong>&lt;br&gt;Format: PowerPoint Presentation</td>
<td>• To assimilate the three domains more and more deeply into the lives of residents&lt;br&gt;• To provide broader and greater opportunity for the people who live and work in nursing homes to have power over their lives and lifestyles&lt;br&gt;• To understand how this work puts into the hands of each individual the opportunities needed to live their best life</td>
</tr>
<tr>
<td><strong>Dynamic, Intimate, Fluid, Environments</strong>&lt;br&gt;Format: PowerPoint Presentation</td>
<td>• To provide concrete examples of transformative practice in the nursing home environment, including a powerful comparison between home and homelessness</td>
</tr>
<tr>
<td><strong>McNally—Where the Rubber Meets the Road</strong>&lt;br&gt;Format: PowerPoint Presentation, Worksheet</td>
<td>• Through this person-centered care composite case study participants would follow a case study to determine in teams:&lt;br&gt;  ○ Circumstances that contributed to the resident’s decline&lt;br&gt;  ○ Strategies that could have helped him improve and thrive</td>
</tr>
<tr>
<td><strong>Moving Day</strong>&lt;br&gt;Format: PowerPoint Presentation, Worksheet</td>
<td>• To gain an appreciation for what many nursing home residents experienced when they prepared to “move” into a nursing home&lt;br&gt;• Participants were asked to think about their personal belongings (photos, clothes, souvenirs, art, keepsakes, pots and pans). They had to decide which of their belongings they would take with them to the nursing home and which items would be left behind.</td>
</tr>
<tr>
<td><strong>The Intimacies of a Quality Life</strong>&lt;br&gt;Format: Worksheet</td>
<td>• To understand how to implement change related to person-directed care practices&lt;br&gt;• A continuation of the previous case study. In teams, participants will be assigned to one change idea to describe how best to implement it.</td>
</tr>
<tr>
<td><strong>The Change to “I-Format” Care Plans</strong>&lt;br&gt;Format: PowerPoint, Worksheet</td>
<td>• To gain an understanding of the importance of changing the culture of care planning</td>
</tr>
<tr>
<td><strong>Valuing Life Through a Dignified Death</strong>&lt;br&gt;Format: Discussion, Worksheet</td>
<td>• To provide participants with a tool to capture change ideas related to death and dying</td>
</tr>
</tbody>
</table>
Training Day Two

Goals for day two included the following:

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Goal</th>
</tr>
</thead>
</table>
| Leadership Practices that Support an Effective Change Process Format: Discussion, Worksheet | • To develop an understanding of leadership practice that support an effective change process by analyzing the experiences of homes in the pilot in relation to the principles in Kouzes and Posner.  
• Participants identified one home in their pilot that was particularly successful in moving forward and one home that was not very successful. Using the worksheet, they noted traits, skills, and actions taken by leadership in the five areas of leadership practices. |
| Connecting the Pieces Format: Discussion, Worksheet | • To learn about and use tools and skills that support a way of inquiry customized to each nursing home.  
• This exercise had three parts: analyze data, plan interventions, and practice discussion. Each part included table work and group discussion |
| Coaching & Supporting a Change Process Format: Discussion, Worksheet | • To build skills related to coaching and supporting a nursing home through a change process.  
• In teams, participants were given a scenario describing circumstances at a home. They discussed:  
  • The home’s strengths and weaknesses,  
  • How they would help the home’s leadership better understand how its current systems are creating its current outcomes,  
  • Change ideas,  
  • How to help them build their skills and abilities to take on change. |
| Synthesizing the Mornings Work Format: Discussion, Worksheet | • To provide a way of analyzing the accumulation of data before taking action. For each of the data tools used in the morning’s work, participants discussed key ideas, learning, and ‘aha’ moments. |
| Creating a Plan for Action Format: Worksheet | • To provide a template organizational tool that can frame a timely plan of action. It can be an effective method to track tasks and reach goals |

Training Summary

The training was facilitated by Marguerite McLaughlin, Project Coordinator at Quality Partners of Rhode Island and David Farrell, Project Manager at Quality Partners of Rhode Island, along with Barbara Frank and Cathie Brady, culture change consultants for
Quality Partners. As a result of participating in Training Session #4, participants should have a better understanding of the Person-Directed Care Model in its entirety.

The process of examining turnover data to gather conclusions that can lead to positive changes was a concept that was new to the participants. It wasn’t until they were doing the exercise on Training Day Two (Connecting the Pieces) that “lights bulbs” could be seen going off in the room. Coupled with other data information, this effective exercise forced people to draw conclusions based on satisfaction data and responses to homework assignments before considering the actions they would toward improvement. This provided lively conversation and a clear awareness that people “got it”. Prior to this, it was not evident that the participants fully understood the value involved of the data collection.

Evaluations from the session were extremely positive. The practical “how to” focus of this training was valued. Participants indicated that they fully understand the complexities and importance of staff retention and its direct effects on the care of residents. The session provided participants with several new ideas that they would like to implement within their own organizations.

**MPQ Communications**

At the start of the special study, pilot MPQ received a 2004-05 training calendar that included the training and conference call dates. An email list (list serve) was created to support ongoing communication among the MPQs by encouraging questions and sharing training agendas and materials that the MPQs will use at their individual organizations. Quality Partners’ staff facilitates this list by responding to questions, providing information and stimulating dialogue among MPQ staff. Linda Drummond, consultant to Quality Partners, acts as a liaison with the MPQs. She has monthly conference calls with each of them individually and also is the point person for data collection. A status report is created after these monthly calls are conducted that identifies what MPQs are focusing
on, where they are seeing change, what barriers they encounter and lastly what, if any, additional assistance they need from the WFR team.

**Evaluation Summaries**

Evaluations are always created to obtain ideas for improvement and to fill one of the requirements for obtaining CEUs. Session evaluations were received by 75% of the participants. Below is the evaluation summary:

Please evaluate the session’s goals by circling the *one* number that describes your rating:

<table>
<thead>
<tr>
<th>Goal</th>
<th>Agree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beyond the domain of workforce, I learned about change concepts within the domains of environment and care practice.</td>
<td>93%</td>
<td>7%</td>
</tr>
<tr>
<td>I have a greater understanding of the importance of creating change within the environment that enhances a sense of home.</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>I have a better understanding of how to support people thru a change process.</td>
<td>87%</td>
<td>13%</td>
</tr>
<tr>
<td>The session provided me with several new ideas that I would like to implement within my own organization.</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Looking at data and surveys gave me a greater understanding of ways to use data to make informed decisions and changes.</td>
<td>93%</td>
<td>7%</td>
</tr>
<tr>
<td>Overall, this session provided me with useful information.</td>
<td>100%</td>
<td>0%</td>
</tr>
</tbody>
</table>
When asked what was most useful about the session, participants indicated the following:

- The “drill down” data analysis exercise (Many participants listed this as the most useful information from the session.)
- The discussion about data, financial incentives, and the satisfaction survey provided good ideas.
- Activities (penny for your thoughts and pick up sticks)
- The “card exercise” was excellent and usable
- Talking about what worked and what didn't
- Examples of transformational practices vs. current practices
- "I" centered care plans
- The “Moving Day” and Mr. McNally exercise.
- Remembrance Circle, moving day, and Mr. McNally case.
- Shared our individual stories with each other. The discussion with the other corporations on what is working for them with staff satisfaction. Looking back and evaluating the hard work everyone has done.

The following items were rated “least useful” on the evaluations or identified as areas for improvement:

- All parts useful. NA. Nothing. NA. All useful, preference suggestion that drill down and similar exercises be moved to earlier in the program.
- Yesterday’s circle of ceremonies. Death & dying exercise too personal people may feel uncomfortable in sharing personal feelings with strangers.
- Didn't have enough time on homework discussion in our group.
- Drill down on human resource data.
- I thought going over the home vs. homelessness was a little repetitive.
- Team action plan-with team members unavailable. Yesterday’s planning part.
Suggestions for improvement included the following:

- Awesome-you did a great job! NA. Thank you!
- Drilling down into AR data should come first.
- I enjoyed it! I know some was repeat but maybe we need to hear it over and over again.
- I think we all did a good job giving suggestions.
- Moving session gets a little long before first break.
- Tense out "connecting the price" presenting more, more examples of real life facilities that have gone through and successfully implemented R&R activities.
- The "death and dieing" experience might have been better data permission to some to not be an active participant.

**CMS Communications**

Quality Partners and CMS participate in a conference call on a weekly basis to discuss various project work including the Improving Nursing Home Culture study. On one of these conference calls, the group had an opportunity to debrief about the session and to discuss any issues that arose during the training.
D. Homework Assignments

<table>
<thead>
<tr>
<th>Homework for:</th>
<th>QIOs</th>
<th>Nursing Home Leadership Teams</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals:</td>
<td>1. To strengthen relationships between QIOs and participating nursing homes</td>
<td>1. To strengthen relationships among the leadership and within each unit/department</td>
</tr>
<tr>
<td></td>
<td>2. To strengthen teamwork within QIO PDC team and with participating nursing homes</td>
<td>2. To strengthen teamwork within and across departments</td>
</tr>
<tr>
<td></td>
<td>3. To open up a different level of conversation within QIO team and between QIO and nursing home</td>
<td>3. To open up a different level of conversation within the leadership team and within each department/unit</td>
</tr>
<tr>
<td></td>
<td>4. To begin to explore person-directed care and to begin to see nursing homes with new eyes</td>
<td>4. To begin to explore person-directed care and to begin to see your nursing home with new eyes</td>
</tr>
<tr>
<td>Team Meetings:</td>
<td>The QIO PDC team should meet weekly for at least 30 min. to discuss the homework and worksheet, determine the next homework assignment. This can be as part of another meeting or be freestanding.</td>
<td>Your nursing home leadership team should devote at least 30 minutes weekly to a discussion of the homework and worksheet, and decide which homework to do next.</td>
</tr>
<tr>
<td>By the end:</td>
<td>Establish relationships with each nursing home</td>
<td>Identify a starting point for work in this project</td>
</tr>
</tbody>
</table>

**Homework for QIO PDC Team**

<table>
<thead>
<tr>
<th>Learning from each other: Strengthening relationships, team building, and seeing with new eyes</th>
<th>October</th>
<th>November</th>
<th>December</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Debrief from Qual-net as a group and map out course of action for the fall. (#1)</td>
<td>✓ Visit homes in the special study to meet with the leadership team and talk over the project. Find out what they have learned in their work to date and what they see as possible next steps. (#4)</td>
<td>✓ Complete visits to homes in special study. (#4)</td>
<td></td>
</tr>
<tr>
<td>✓ Prior to your learning session, talk by phone or in person with each Administrator to describe what the first session will be like and to learn about their work to date, lessons learned, hopes and fears going forward. (#2)</td>
<td>✓ With each nursing home, either</td>
<td>✓ Complete sessions on home/homelessness, Look At Me, and the review of slides (either by doing this program for the leadership team or by coaching the PDC team through it so</td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>Details</td>
<td></td>
<td></td>
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<tr>
<td>---------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓ Convene learning session and debrief it. (#3)</td>
<td>Conduct session for leadership team or coach PDC team in leading session himself or herself on home/homelessness, Look At Me, and review of slides. (#5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>they can do it themselves. (#5)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning from others:</td>
<td>Watch CMS video on culture change</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discuss each reading, video, visit as a group, using worksheets (#6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Watch CMS video on culture change</td>
<td>Read articles in packet by:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explore these websites:</td>
<td>Carter Williams</td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="http://www.Pioneernetwork.org">www.Pioneernetwork.org</a>,</td>
<td>Helen Gossett</td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="http://www.actionpact.org">www.actionpact.org</a>,</td>
<td>Wendy Lustbader</td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="http://www.edenalt.org">www.edenalt.org</a>, QIOSC.</td>
<td>Charlene Boyd</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If your participating homes are at the beginning of their journey, visit one or more homes further along in their culture change journey.</td>
<td>Read: The Leadership Challenge by Kouzes and Posner Beyond Unloving Care by Susan Eaton</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Homework 1. What is your cycle of turnover?**

1. Conduct Post-Exit interviews with all staff that have left voluntarily within the last three months. Use a TH-2 Worksheet for each interview.
2. Analyze the responses and put them into a chronological sequence. Draw your own cycle of turnover.
3. Share your findings with others on your team. Draw a composite cycle that incorporates information each of you have gathered.
Homework 2. What is your cycle of understaffing?

1. Collect information for the next three months on the number of shifts not fully staffed because of late call-outs that could not be filled or were staffed through agency or by someone staying for another shift.
2. Ask a staff person from every shift, unit and department how often they feel understaffed and what the work feels like when that’s the case. Ask what it feels like when they have enough staff. How often is that the case? Ask them what teamwork is like and what happens related to teamwork when they are understaffed.
3. Ask that staff person what are the things that happen for people that lead to them having to call-out at the last minute.
4. Map your own cycle of understaffing. Include the reasons why people call-out and the culture on the floor when they do.
5. Share your findings with your MPQ team members and draw a composite map incorporating all your information.

Homework 3. Where is your money going?

1. Compile all spending related to recruitment and all spending related to retention in the last fiscal year. Determine as a group which costs will be counted.
2. Compare spending in recruitment and retention and discuss your findings.

Homework 4. What are your financial incentives?

1. Find out what financial incentives you give your staff. What do you pay bonuses for? Examples could include a bonus for accepting a last minute assignment, a shift differential, having people work two 12 hour shifts and be paid for 36 hours work, extra per hour take-home pay for working per diem, attendance, holiday work, sign-on bonuses, recruitment bonuses, longevity bonuses, completing a class, mentoring a new co-worker, etc. What do you offer new hires to start and how does that compare with what longer term employees are paid?
2. Compile information on types of financial incentives available within your assigned nursing home and determine how frequently they are given.

3. What incentives do these bonuses create? How do they affect staff retention?

4. Discuss with team.

Homework 5.
High-Turnover/Low-Turnover – Looking at your facility’s landscape

At your nursing home, complete the HT/LT Facility Assessment. You will be asked to do this quarterly.

Homework 6.
What Do Employees Want in Their Job?

Ask five staff people what brought them into care giving, what keeps them there, and what their frustrations are. Ask them what matters most to them, what they most want in the job.

Homework 7.
Management Practices That Support Retention

1. Chart longevity in your workplace -- how many staff have been there by number of years of service.

2. Ask three staff who have been there less than a year what it was like to come in new and what they think would be helpful to do to welcome in new staff. What would have helped them?

3. Sit in the employee break room. Make a list of what you see that’s comfortable and inviting, what you see that isn’t, and what you could see that could be done to make it better. What would you like to eat in here? Is this a comfortable place to relax and replenish? Ask at least three staff who come in these same questions.
4. Review in-service training and opportunities for on-the-job classes. For classes given in the last year, what was the content and what teaching mode was used (video, lecture, tape, discussion, role-play, case study, etc.)? Ask at least one staff person from each shift about in-service and opportunities for on-the-job classes. Were there any in the last year that they liked? What suggestions do they would have for areas they’d like to have a class on? What suggestions do they have for scheduling of classes? What could make classes better?

Homework 8.

Building on Intrinsic Motivation

1. On two occasions visit the home early in the morning from 5:00 a.m. to 8:00 a.m. 
   Observe the morning routine.

2. On two occasions visit the home during mealtime, once for lunch and once for dinner. 
   Watch for the following:

3. Talk to five CNA’s, two of whom are fairly new, and three who have been working in 
   the home for at least three years. Ask them about the work—how scheduling is done 
   on weekdays, weekends and holidays, what are their frustrations about scheduling? 
   Ask them about their relationships with residents, co-workers, and supervisors. Do 
   they feel a sense of team?
IV. Outcomes Congress

A. Evaluation Summary

On October 5th and 6th, Quality Partners hosted the Improving Nursing Home Culture Pilot Study’s Outcomes Congress in Providence, RI. It was an amazing two days of implementation strategies and sharing success stories. Attendees included 167 individuals from 33 states (AK, AR, AZ, CA, CO, CT, DC, DE, FL, GA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, NH, NM, NY, OK, PA, RI, TX, VA, VT, WA, and WI), who represented nursing homes, corporations, national organizations, Quality Improvement Organizations, and the Centers for Medicare & Medicaid Services. 19 nursing homes and 1 trade association gave presentations.

An evaluation was distributed to attendees (partners) in order to capture: what was learned from the two-days of presentations, what attendees plan to do as a result of what they learned, what was useful or not, and whether their needs and expectations were met. Evaluations were completed by 72 attendees (43%). Results were as follows:

What was learned

The evaluations received were extremely positive. Partners were eager to provide feedback about what they learned from the two-day Outcomes Congress and from the pilot in general. Partners gained an in-depth understanding of the Holistic Approach to Transformational Change (HATCh) Model, how each individual contributes, and how an organization fits into the national initiative. Some partners felt that HATCh is directly in line with how they’ve always felt care in nursing homes should be given. These partners are breathing a sign of relief that what they’ve always known to be right is finally forth coming. Other partners felt supported to learn that there are many people concerned about the culture of our nation’s nursing homes. They agree with the importance of this
work to all seniors and support changing the culture to be individualized rather than institutional. One partner shared that in all her 30 years of in-services, conferences, or seminars, she learned more in these two days than all of them combined!

Through the exciting stories that were shared, partners learned ideas, tips, and strategies to help carry out activities in their facilities and in the 8SoW (from a QIO perspective). The nursing homes shared comprehensible, useful information because they told their stories using “real” examples of the activities taking place in nursing homes today. This openness validated to many that their nursing home is not all that different from the many nursing homes on the same journey no matter what state it is in. Additionally partners realized that although they’ve come so far in the culture change journey, they still have a ways to go to completely individualized care.

Partners that completed the evaluation from the session learned key attributes necessary to changing culture and to maintain the momentum throughout. Suggestions include avoiding focusing on the initiative right from the start, but rather on the “people” who will be part of it and contribute to the development of an initiative. Provide education to the team about the amount of time and effort on everyone’s part (everyone in the facility) that it will take to have an individualized culture. Once the people are on board and supported, begin the initiative with small, incremental steps to avoid overwhelming them. It was suggested that teams continually ask why something is done a certain way and think about whether or not it could be done some other way. It is important to collect and track data to stay abreast of all changes. It is strongly suggested by the partners that regardless of where you start this valuable work, the important thing is to start.

Partners learned about the many resources available to them when embarking on changing their culture. They can learn from facilities on the same journey and get support from the Quality Improvement Organization (QIO) in their own state. Another important resource is the data collected during the initiative and what it will reveal.
One comment seemed to be the ‘theme’ from the partners in attendance at the Congress: “There is no stopping us now!”

**What feelings were experienced**

When asked about how their experience at the Outcomes Congress or in the pilot in general, partners used many adjectives to describe express their feelings: excited, motivated, energized, overwhelmed, encouraged, honored, positive, renewed, humbled, scared, relieved, committed, ready, armed, empowered, rejuvenated, impatient, inspired, urgency, skepticism, hopeful, proud, challenged, comforted, validated, joy, eager, charged, connected, and focused.

Partners were encouraged by each other through the shared stories and experiences. Many indicated how excited they are to go back to their facilities and share what they’ve learned. There was a sense of sadness reflecting on how seniors have been treated for too many years in nursing homes, hope that their care will change, and empowerment to be part of that change. Feelings of ‘home’ surfaced and partners are committed to making nursing homes a true ‘home’ for seniors. The partners feel challenged to overcome barriers (financial and regulatory) and change their culture. They’ve gained knowledge of what could be for seniors living in nursing homes, feel connected with culture change agents, and are proud to be part of this national initiative.

One comment stood out from the rest when asked to describe her feelings, “I feel like I am moving from homelessness to home in my career. Thank you!”

**What actions will be taken**

When asked what they will do after attending this training, it was clear that the partners were eagerly planning their next steps, be it small, they are steps to transformational
change. Many partners will immediately focus on educating staff, residents, family, and the community. Some will involve front-line staff in planning and implementing consistent assignments. Another will look to the staff when making decisions about offering choices to residents. A couple of partners plan to support the staff by sharing their passion and energy. Several partners will begin to spread the information what they’ve learned by contacting local and national stakeholders (i.e. SSA, NAAP, Hospice, Ombudsman, trade associations, professional organizations), working with their local QIO, and talking to any and all providers about the need to initiate this work in their facilities.

Several partners (QIOs) indicated that they have the tools to teach and facilitate their 8SoW efforts in their state (QIO). When training, several will focus on the workforce first. Other partners (nursing homes) were specific in their plans to: create a ‘spa’ environment for bathing, assign spa attendants, purchase terry-cloth robes and luxurious towels, create a comfort quilt for use when a resident passes, put skirts on carts, place mailboxes at doors, and use the assessments being done on residents’ lives that are usually thrown in the back of the chart.

One comment adds a perspective to this work that is essential to understand at the very beginning, “This work is a journey not a race!”

**What was most useful**

When asked what was most useful about the Outcomes Congress or the pilot in general, partners were gracious in their compliments. Positive responses were received about the segments of the two-day event including the: workforce retention ideas, stories that touched the heart of our residents and family members, concrete examples of change in each domain, ideas on spread, statistical information, the struggles other facilities are going through, concepts of making prudent business decisions based on analyses of data, and demonstration of quantitative results in satisfaction, turnover, and clinical quality.
Partners felt immense support from CMS. They indicated how connected they felt by having William Rollow, Yael Harris, and Karen Schoeneman from CMS’ Central Office in attendance. Quality Partners of Rhode Island and the INHC Outcomes Congress Faculty did a great job of encouraging partners and reinforcing the importance of the work in this initiative. There was a sense of ‘teamwork’ between nursing homes, corporations, QIOs, CMS, and other national organizations at this event. One partners particularly appreciated the ideas of how to bring legislators into nursing homes in an effort to gain support of this valuable work.

Getting information about what other nursing homes did, what worked, what didn’t, and how they made it over hurdles without giving up was useful. Although some partners felt they received thorough step-by-step plans and methods of implementation, others would like to have received more in-depth information from each of the presenting nursing homes.

The success stories, networking, nursing home staff attendance, and the facilitation by Barbara Frank added to the celebratory atmosphere of this event. One comment that dispels a misconception about this work was…

“Staff and resident relationships are most important – more important than the physical changes in a building.”

What was least useful

When asked what was least useful about the Outcomes Congress or the pilot in general, partners were gracious in their criticism. Many partners enjoyed the stories from the participant nursing homes, but thought there were too many similar stories, particularly about renovating bathrooms, and would have enjoyed fewer presentations with more Q & A time with the presenting nursing home. The open discussion (Q & A) that was allotted would have been more meaningful if it followed each presentation. The segment entitled, “PDC: Involving Your Medical Director” did not truly address how to engage a medical
director in this important work. Several partners felt the morning exercise on the second
day (paired conversations) was not useful with such a large group in a small area. One
partner indicated that the reading material provided to participants prior to the first
training session was not particularly helpful.

Other comments pertained to meeting logistics including the: bright window light was
blinding, hotel location was difficult to find, presenters did not have handouts for note
taking, and contact information for all presenters was not available.

The one comment that complimented the ‘momentum’ of the event was…

“Sleep was least useful – this was such an exciting time that I wanted to keep going!”

**How attendees’ needs could have been better met**

Partners commented on how their needs could have been better met. Their feedback will
be considered when planning future training in these areas. Specifically, partners would
have liked to have more specific detail from the facilities already engaged in the
transformational process particularly on improving workplace practices and
environmental changes (non-bathroom) without spending a lot of money. Contact
information was a common theme for improvement. Partners enjoyed the few
networking opportunities that they had, but would have appreciated more time to network
(i.e. reception, longer breaks). It was suggested that Quality Partners create a directory of
transformational change leaders recommended as speakers including their names, contact
information, photos, and short biographies.

The open discussions became to long and repetitive almost forced conversations. This
time would have been better used if it followed each presentation. An interesting
suggestion was to have paired up those nursing homes with success stories with those
organizations just getting started for more personal Q & A time. Additionally, it was
suggested that Quality Partners capture more information from the non-presenting nursing homes that did not attend the event.

One partner would have preferred to end the event discussing Family and Community rather than Regulatory issues, which seemed to leave everyone feeling less positive. Several partners would like to have all materials available to them for use in spread. Yet another partner would have liked their nurses, administrators, and corporate leaders, as well as advocates and other nursing home representatives to be in attendance to learn and spread the information.

A comment shared by several partners,

“This was a wonderful opportunity; and, I am honored to be a part of it.”

Topics for future presentations by Quality Partners of Rhode Island

Partners were eager to provide their suggestions for future education and presentations. Topics include:

- Workforce issues (more in-depth)
- Building relationships with residents and staff
- Interdisciplinary team interactions to better the lives of the residents
- Educating your community
- Educating your surveyors
- Getting publicity
- Sustainability (revisit those on the journey)
- Environmental changes
- Changing negative attitudes
- Supporting overwhelmed leaders
- Relating individualized care to the quality measures and the MDS
What hasn’t worked and realistic solutions
Tools successful facilities used to analyze, plan, and evaluate
Breakout sessions for front-line/interdisciplinary staff to explore ideas for change
Restraint usage
LTC facilities and surveyors working as a team
Data: What can QIOs collect to assess impact of culture change efforts?
Leadership development from a front-line staff perspective
Depression improvement goals/tasks to improve
Expand on what has already been presented (i.e. implementing consistent assignment, collecting data – technology necessary, etc.)
Improvement plans based on pilot participants’ experiences – facilities can use the plans and/or modify them for their own journey
Partnerships – working together in your state
Restraint reduction
Quality and regulation: Breaking down barriers
Cost breakdown from each presenting nursing home
B. Ideas Into Action

Faculty

Quality Partners Project Team
Gail Patry, RN, C, Project Director
Marguerite McLaughlin, MA, Project Manager
Linda Drummond, MSM, Project Coordinator
Paula Mottshaw, Project Coordinator
Melissa Miranda, Project Specialist
Shannon Massaroco, Administrative Assistant
Ann Gray, Brown University MPH Assistant

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Introduction

On these pages are extraordinary stories of transformational change. In their own words, people working in nursing homes share what they did, what it meant to them, and why they will never go back. Their work this past year has changed life and work in their nursing homes. People now wake up, spend their days, and go to bed according to their own routines, and as they are restored to their own rhythms, they are thriving. So are those who care for them. As work is reorganized to follow the pace of each resident, instead of a rigid institutional routine, workers are able to fulfill their intrinsic motivation to care for others, and to experience respect and care from their organizations.

The pilot and the model

Through a special pilot study from August of 2004 to October of 2005, the Center for Medicare & Medicaid Services provided Quality Partners of Rhode Island (the Rhode Island Quality Improvement Organization and National Support Center to the Quality Improvement Program) the opportunity to create and pilot test a model and a methodology for achieving transformational change. We worked with volunteer Quality Improvement Organizations and Corporations to teach, explore, engage in, and measure the results of transformational change in 254 nursing homes.

Our model for person-directed care focuses on the interconnection of work, care, and environment - essential areas for quality improvement work. Our model recognizes the critical role of leadership in every nursing home’s culture. We piloted a model of leadership that utilizes the high performance management practices found by Susan Eaton (2002) to make a difference in retaining staff, by supporting them. Our educational programming focused on leadership development and on the “how” of change.

Our process for change utilized the “way of inquiry” in which each home identified its own needs for change and its own path to accomplishing it. We developed a curriculum to support the change process; pilot tested the educational materials used with nursing homes; created tools to assist homes in transferring new knowledge into concrete action; and used quality improvement
strategies to operationalize, measure, and spread effective change. We addressed the impact of regulation on nursing home care by bringing a regulatory lens to the process of change. We taught pilot participants to “think like a surveyor.” What we found, over and over again, was that the regulations of OBRA ’87 supported and encouraged everything the homes were doing to individualize care.

Twenty-one QIOs, 7 national corporations, and 254 nursing homes embraced the journey of change. Each home individualized its path to change, guided by a common curriculum and a collaborative approach that facilitated sharing and spread. Recognizing that we were exploring uncharted territory that no existing instrument could measure, we encouraged each of the homes to think “outside the box” in order to measure its own journey. We will incorporate use their experiences in the development of future measurement tools. The homes’ outcomes are a quantum leap forward in implementing the call in OBRA ’87 for individualized care as the basis for improved quality. Many of their successes are captured in this scrapbook, which was in preparation for this Outcomes Congress to celebrate their work.

What we did and why

The Pilot Study, known as Improving Nursing Home Culture (INHC), integrated quality improvement practices with work on person-directed care and workforce retention. To achieve this integration, we drew on both the science and the psychology of change in a way and on a scale never before done in long-term care.

Through the science of quality improvement, we gave homes tools to support a systemic analysis and transformation of their current practices. Homes learned the evidence supporting the efficacy of changes in practice. We created tools through which they could gather their own evidence about the impact of their own practices on their care and workplace outcomes. Using basic quality improvement methods, homes determined root causes of problems, piloted solutions, evaluated their effectiveness, made mid-course adjustments, and made the operational changes necessary to adapt these as new day-to-day practices. Through a modified collaborative model, homes shared their experiences and spread their successes. This is the science of change on which we grounded our work.
Our holistic model for transformational change required more than the science of change. It also
required participants to undertake skill development required to engage in open, honest dialogue.
The experience of the 7th Scope of Work taught the QIOs that a purely clinical scientific approach
to quality improvement resulted in slow incremental change, but it did not improve the old,
institutionally centered culture. A new culture requires a new set of human relations skills and a
new way of working together. To achieve change on that level, we needed to utilize what we have
come to call the "psychology of change."

We applied the concept of person-directed care to both workplace and care giving practices so
that staff became as much a focus of our work as residents. We taught management practices
proven to lower turnover and care practices proven to lead to clinical improvement. We grounded
our work in the intrinsic motivation of employees to care for others by encouraging homes to put
in place structural systems such as consistent assignment that are the bedrock of person directed
care. Thus, the focus of our work is to move away from an institutional model that revolves
around the tasks, schedules and systems of delivery related to medical care and illness. We strive
to move to an individualized care model that addresses the human spirit, needs, strengths and
necessity of connectedness, relationships and growth at the heart of every person. This would
include all people - residents, staff, and families alike.

A core principle of quality improvement is that “your systems are creating your outcomes.” In
this pilot we encouraged participants to analyze and reorient their systems so that they became
person directed. The results are captured in the phenomenal stories, innovations and changes,
accomplished in only one year, which are set forth in this book. Their success in such a short time
and on such a broad scale demonstrates the strength of this holistic approach to transformational
change. What distinguishes the INHC’s model is that it integrates the science and psychology of
change using quality improvement principles supported by relationship building skills using an
interactive, experiential teaching design.
HATCH – The Holistic Approach to Transformational Change

Through this work, the INHC design created by Quality Partners of Rhode Island along with partner, B&F Consulting, has provided a unique and unprecedented contribution both to the world of Culture Change and to the world of Quality Improvement. The design, now known as HATCH: the Holistic Approach to Transformational Change is the result of one year of work that involved 21 Quality Improvement Organizations working with a total of 168 volunteer nursing homes and 7 Multi-facility Partners for Quality (MPQs) working with 86 nursing homes.

HATCH 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. The decision to adopt each of these domains, along with the interconnectedness of the domains, was carefully considered and key to facilitating change. It was our hypothesis that specific changes within these domains could affect the movement from institutional to individualized care.

Changes are necessary within each domain to achieve this level of transformational change. We created change packages for person-directed care and workforce retention, which essentially provided participants with detailed examples of the change possibilities in each area. The improvements in each domain contribute to positive results for residents, staff, and families. This book provides abundant examples of changes in each domain, and the way the changes in one domain touch on all the others.

Transformational change requires first a change in the Domain of Workplace Practice. We based our curriculum in this domain on the research of the late Susan Eaton, who identified five key management practices that made the difference between high and low turnover for nursing homes in the same labor market. In the Domain of Care Practice, we drew on the work of Joanne Rader who has transformed practice in our field, first with her work on individualized dementia care, then in rethinking the use of restraints, and most recently in the area of bathing practices. In each of her change initiatives, staff involvement was the key to individualizing care. We also
incorporated, for both domains, on the work of Anna Ortigara, whose LEAP curriculum teaches nurses to be leaders.

Judith Carboni’s 1987 work on home and homelessness among nursing home residents provided the framework for the **Domain of the Environment**. She described a continuum from homelessness to home, based on how connected a person was to his/her environment. Her finding that home is where a “fluid, intimate, dynamic relationship exists between person and place” provided nursing homes a yardstick for their efforts in this domain.

These domains all operate within the **Domain of Leadership**. In addition to Eaton, we relied on the work of Kouzes and Posner and Jim Collins. Their field guides to leadership facilitated our transfer of knowledge into practice. They brought their evidence-based practices to life through a self-assessment process in which leaders were able to mark their progress over time. Their focus was on “creating a climate where the truth could be heard,” and leadership practices that challenge the process, encourage the heart, and enable others to act – leadership concepts necessary for the process of transformational change. Connie McDonald, the administrator who led the change process at Maine General Rehabilitation and Nursing Care at Glenridge, exemplified this type of leadership and shared her story at the first learning session.

A dynamic shift in relationships with family members, close friends, community organizations and volunteers is captured in the **Domain of Family and Community**. Lori Todd and her staff from Loomis House, and Carolyn Blanks from the Mass Extended Care Federation provided powerful examples to support efforts in this domain. The **Domain of Regulation and Government** grounds HATCh in the requirements of OBRA ’87, that each facility “must provide care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.” Karen Schoeneman from CMS taught the group to “think like a surveyor” and engaged the collaboration of several State Survey Agencies in this pilot.

**The “way of inquiry”**

Because the needs for and ability to change are uniquely different for each organization, HATCh uses, a process for personal and organizational transformation that we call the “**way of inquiry**.” Variations in size, number of residents, architecture, longevity of staff, staff ratios, finances,
support, leadership, and geography mean that a manual or recipe book would never do. Nor would a top-down directive within a facility allow for the subtle, yet necessary foundational and systems changes to take place.

The “way of inquiry” allowed organizations to discover and work through change by way of a process of self-guided exploration. The “way of inquiry” describes a process whereby people begin to notice what isn’t working in their current system (irritants) and awaken to the possibility of change. This gives them the impetus to explore and envision new possibilities, and the openness to choose to do something different. The “way of inquiry” maps the initial steps that lead to change.

Our first learning session and the subsequent homework gave participants the new eyes with which to see the impact of their current practices and begin to explore what they could do about it. Our second learning session focused on leadership skills, using a field guide to leadership with practical applications related directly to their experiences and circumstances. This gave nursing home leaders the skills to take on change.

The “how of change”

Next, we helped homes learn the “how of change.” Once they learned how to change, they would be able to go forward independently and make improvements. Our change process starts with thinking about how we individually, as people, need our lives to be, and then looking at what happens instead in a nursing home. What we need is what our residents’ need, because they are people too. Then we need to step back and dissect the current process. What are we doing now? What would we want for ourselves? We keep what’s good, what’s working. Then list out what doesn’t work from the point of view of how you would need it to be for you.

For each area we figure out how it can be done in a person-directed way. We take on the easy things to change that don’t bump up against other areas and that will be building blocks that, by making them, open up other opportunities. We ask what else will be affected by this change, and who else. Who needs to be involved? The easier changes build each home’s capacity to change. By clearing out the old practices, homes continually grow, with each change having a ripple
effect. We encourage homes to bring others in, create a passionate dialogue and open debate, rather than force change by top-down unilateral decision making. We emphasize the importance and necessity of mid-course adjustments as each new experience creates knowledge, energy, and the ability to envision the possibilities for the next move forward.

Adult learning design

Our teaching methodology was an integral part of our basic strategy for supporting change. We broke through educational barriers to change the paradigm for teaching adults. We used experiential methods that drew on participants’ previous experience, created new experiences in the classroom, provided opportunities to reflect on these experiences and homework assignments through which they could apply their insights to their day-to-day nursing home practice. We taught the “way of inquiry”, and gave participants experience with the analytical and human relations tools and skills to support that inquiry. Our premise was that each home would find its own questions and its own answers by engaging in a systematic, collaborative process of change.

Our training provided ways for participants to see their current practices with new eyes and make changes accordingly, involving all those affected throughout the change process. It was this total participation that made the changes successful. QIO and MPQ groups successfully adopted this educational process, as did the nursing homes. This change in teaching methodology is directly responsible for the high degree to which we were able to transfer knowledge into practice.

Measurement Strategy

After exhaustive review, we determined that no existing measurement tool could adequately capture the new model of change we created. Our strategy, then, was to identify, through the pilot process, the wide array of areas that would be measurable in the future, by encouraging participants to evaluate and measure their interventions and results. We used a wide-angled lens approach, so as to capture any and all results of significance. We taught the homes how to evaluate and measure throughout their change process, as part of the quality improvement process. We created measurement tools to assist participants in assessing their own personal and organizational practices. Through homework assignments and tools to drill down into root causes, we gave homes qualitative and quantitative ways to measure their current practice as a baseline.
for evaluating improvements. Participants documented direct links between improvements in retention and in clinical outcomes and their work in the pilot. The wide array of measurement tools and outcomes generated by the pilot provide the basis for development of a measurement strategy and instruments for the transformational change work going forward.

**Our Lessons for Spread**

We have compelling stories to share that show evidence of improvement in the lives of residents. Through the activities of the nursing homes involved in the INHC we have begun to see very positive results and a great sense that we are on the right road to transforming the current day culture of nursing homes from an institutional to an individual focus. Residents and staff give testimony to the difference this work has made in their lives. Their collective experiences, insights, and lessons provide a field guide to holistic, transformational change. The many stories and measures contained in this scrapbook are merely the tip of the iceberg. Because HATCH achieved an unprecedented level of results within such a short timeframe, we’ve asked the homes who tell their stories in these pages to share their “how of change”, their lessons learned. How they changed can provide valuable lessons for the 2,500 nursing homes that volunteer to be the second wave of change in the 8th Scope of Work.

Nursing homes participating in this pilot are well on their way in their change process and are now able to sustain change on their own. They are increasingly living out the promise and the vision of OBRA ’87. Thanks to the staff, residents, and families of the 254 homes participating in this pilot, we now have a body of evidence to support the clinical efficacy and business sense of individualized care for residents and staff in nursing homes. We are thrilled to be able to offer the lessons from this pilot to 2,500 nursing homes across the country participating with QIOs in this Holistic Approach to Transformational Change. We invite stakeholders across the country to join together to support the spread of this good practice to the entire long-term care community.

Our thanks to all who participated, shared, supported and contributed to the learning in this pilot. We offer a heartfelt salute to the nursing home staff, QIOs, and corporations who braved a new world, and by so doing, have helped to make the long-term care world a better place for all of us.
Care Practices

Elevating the needs of the human spirit, the strengths of each individual despite infirmity and focusing on ways to help individuals to thrive is at the heart of the care practices domain. Within this domain we explore ways that we can place into the hands of each person as much control and choice as possible. We seek out ways to restore personhood, individuality and normalcy to all.

To do this, relationships between staff and residents become the heart of care. Often this is enhanced by the practice of consistent assignment. We seek out ways to build and strengthen those relationships so that individual preference, as much as possible, can be honored. This means exploring with residents families, other staff members on all shifts, those daily comforts, long held routines and lifestyle preferences that are important to individuals.

The changes in Care Practices that are supported in the INHC focus on moving away from long held notions about tasks that cause the dehumanization of those involved in the care, both staff and residents alike or the iatrogenic problems associated with taking all decision making opportunity away from an individual. In the INHC we shift to those practices that restore life, wholeness, trust and wellness. This includes allowing people to wake within the frame of their natural body rhythms; allowing a full night sleep to ensure rest that leads to health and wellness; the power to choose, to the extent possible one’s own daily routine; changes in the loneliness, isolation and sadness often associated with those who die in nursing homes by creating a community of compassion that recognizes and acknowledges death and provides opportunity for community members to celebrate the lives of others; changes in the means by which we serve food including the times, variety and the honoring of individual preference based on lifestyle, culture and ethnicity; moving to a more natural pattern of meaningful, purposeful activities that draws in a sense of spontaneity; and any other practice which wholesales a care practice such as the use of suppositories to groups of individuals without the careful consideration of other alternatives.

This is, in no way an exhaustive list of care practices. Within the context of our pilot, we saw creative, innovative practices adapted to ease, support, and bring joy to residents.
**Benedictine Health Center, Minnesota**

Benedictine Health Center now has an increased emphasis on mind, body, and spirit while offering total care to their residents. The health center provides memorial services at the facility for residents who are unable to attend the funerals of their loved ones. Staff members noticed the difficulty residents were having with closure after a loved one died and they were unable to attend the funeral. The Benedictine Health Center service is held in their chapel, and family members, the chaplains, and any staff members join the residents during the memorial service. This service helps the resident into the grieving process and aids residents with both past and present losses. Benedictine Health Center has also started making ‘Look at Me’ scrapbooks for all residents on the dementia care units. These scrapbooks include pictures given by the families and information about the resident’s hobbies and interests. Everyone on the unit works together to help make the residents’ scrapbooks. This has been an excellent way for staff to see the residents as whole people and for the residents to share their scrapbooks with others around them.

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**Manor of Farmington Hills, Michigan**

Improving relationships between residents and staff has been the Manor of Farmington Hills’ focus for their person-directed care changes. The facility has pooled their residents’ biographies, implemented person-directed care plans, started fine dining and bathing programs; and, now has a welcome booklet for new admissions to the home. In order to ease into these changes, the Manor of Farmington Hills held fun and educational staff activities. The noticeable results from these changes have been more staff satisfaction and the residents seem happier at the facility.

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**Arrant Nursing Facility, California**

PIQI stands for Performance Improvement Quality Improvement, and is the program created by Arrant Nursing Facility to drive quality improvement changes. PIQI involves professional growth, employee recognition and empowerment, human resource excellence, and resident-directed care delivered with compassion and respect. PIQI has led to three major successes at Arrant Nursing Facility: implementation of the CNA primary care program; use of the CNA career Ladder; and implementation of the CNA recognition program. Since implementing such changes, staff members feel empowered and acknowledged, creating professional and accountable behaviors from all staff levels. The result is high family and resident satisfaction, a decreased turnover rate, and a reduction in falls, weight loss, and pressure ulcers.

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Commitment to improving care practices led Gold Empire Convalescent Hospital to form a committee designed to incorporate resident preferences into daily routines. The hospital realized they were not always considering what the resident would prefer in their daily routine or recognizing individual resident needs. The committee used the Plan Do Study Act (PDSA) worksheet and each committee member chose a resident they felt could have special attention during their daily routines. Staff’s awareness of the change concept grew and all staff started to move away from old patterns. Additionally, Golden Empire Convalescent Hospital looked at the institutional approach they were using to deal with bathing in the facility. The old institutional schedule had each resident on a hall receiving a bath at a specific time on a specific day. Golden Empire Convalescent Hospital knew this schedule was not flexible enough for their residents and staff. The facility used ‘Bathing Without a Battle’ as a model and taught the information to all caregiver staff. The forms for scheduling bathing were changed to enable charting for alternative bathing methods. The Assistant Director of Staff Development was the leader for the newly formed bathing committee and was able to teach, on the floor, different approaches to bathing. The facility also utilized a communication board, a monthly newsletter and voluntary staff meetings to reach staff members not present when the information was originally presented. Currently, both residents and staff are happier with the alternative bathing times and methods.

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After staff discussions around person-directed care, talks at morning meetings about resident issues and current problems, and family forum meetings, Laurie Health Care Center decided to make some changes. The center now offers buffet style dining with many choices and substitutions, and a daily salad bar. Before the change, residents were refusing certain foods. Now that they have more choices, the staff has noticed better food consumption and no weight loss. Additionally, Laurie Health Care Center now asks residents what time they prefer their baths, and if they want a bath or a shower. Currently, showers are given on all three shifts, which leaves more time for CNAs to tend to residents’ care of nails and facial hair and has reduced dry skin problems in the home.

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No one likes to have their sleep disturbed or to be awakened very early in the morning, including residents at Mercy Retirement and Care Center. The early morning routine for a number of residents at Mercy Retirement and Care Center involved being woken up to receive a laxative suppository. During the day, these residents were sleepy, did not participate in activities, had reduced oral intake, and some exhibited problematic behaviors. In order to address these problems, Mercy Retirement and Care Center decided to discontinue the use of suppositories and to implement an intensive bowel management program tailored to each resident's needs. Staff on an interdisciplinary team - including dietary, physical therapy, nursing, and administration - worked together to create individualized bowel management programs for each resident and tested the personalized plans one resident at a time. The plans included steps such as increased activity, increased length of toileting time, high-fiber dietary supplements, and regular coffee. The resulting resident behavior changes demonstrate the positive effect of the personalized bowel programs. The residents are able to sleep through the night; and, as a result, they participate in activities during the day, their oral intake improved, and symptoms of adverse behaviors reduced. Mercy Retirement and Care Center focused on resident-directed care by eliminating medical treatments that interfere with normal life cycles, replacing suppositories with individualized bowel programs, and improving resident quality of life.

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The change from care plans to ‘Plans of Care’ has been excellent for Lenawee Medical Care Facility. The Plans of Care are person-directed ‘I’ care plans that include input from the elder, family members, and all levels of staff. The Plans of Care are used to tell the elder’s life story and to increase relationships between staff and the elder. Lenawee Medical Care Facility has found the new care plan format easier to read and to see the elder as a person; the plans are no longer problem or diagnosis focused. This change has opened more possibilities of getting to know the elder and caring for what the elder sees as a personal need. Lenawee Medical Care Facility is monitoring the impact of the change to Plans of Care through satisfaction surveys and quality indicators and measures, looking closely at depression and activity levels. The facility’s main goal is to further address the plagues of loneliness, helplessness and boredom, and to improve the quality of life for the elders.

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Morristown Manor, Indiana

Morristown Manor has improved the quality of the dining experience for their residents in many ways. The facility now offers five meals a day: three smaller meals on the units and two buffets served in the dining room. The new meal plan was designed to eliminate residents’ complaints of a lack of variety of food options. The elders no longer have assigned seating and can enjoy a social meal with personal control over their food choices. Many staff and residents were involved in the planning of the new dining experience, including resident input for the menus. Morristown Manor also encourages socializing during the afternoon meal they call ‘Snack and Yak.’ The facility had to be flexible with activity schedules and adjusting to the costs associated with making a large change. Initially the food costs rose, but the costs have since stabilized due to less food waste. The main outcomes have been increased resident satisfaction, fewer food complaints, weight loss decrease, and positive family members’ response.

Dining changes were not the only improvements made to Morristown Manor; the facility has also decided to make each unit and room feel more home-like. They have removed all laundry carts from the hallways and have installed laundry cubbies in each room. The residents can bring in furniture if they wish, or they can special request furniture for their room. Each new resident is given a welcome gift basket and all residents are encouraged to decorate their space to make themselves feel comfortable and at home.

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The Scripps Home, California

A resident had a life-long dream of learning how to play the clarinet, and the Scripps Home helped him make it happen. The resident had been exhibiting signs of depression as his wife’s health was continuing to decline. In order to enrich this resident’s life with meaning and to take his mind off not being able to care for his wife anymore, the Scripps Home tried to find a way for him to take clarinet lessons. The home rented a clarinet and found a high school volunteer to teach the resident in weekly lessons. The resident and the teacher developed a strong bond and enriched each other’s lives through their intergenerational experience. Additionally, the resident has found a sense of renewed purpose and now plays the clarinet for other residents, sharing with them his excitement and achievement. As one resident commented: “If he can learn something new at this stage in life, maybe I can, too.”

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Residents at The Venturan dine on white tablecloths and use china and stemware at all meals. Each resident can choose his/her desired portions from the several entrées and side dishes offered, and all food is brought to each table by a cart. Finalizing this dining program has been a long effort for The Venturan. The facility tried many different dining formats and options for one meal, one day a week until settling on the current format. The Venturan was financially prepared for the initial changes and variations that would occur in the dietary budget. Now that the change period has ended, the food costs have actually reduced due to residents eating more of what is offered and needing fewer dietary supplements. Since implementing new dining options for the residents, The Venturan has noticed changes in many areas of satisfaction: the residents eat more food; there are fewer residents with weight loss; and complaints about the dining program have reduced. The residents enjoy a social meal, commenting on each other’s choices and enjoy the home-like setting they now have.

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Mornings have now become fun at SEM Haven Health & Residential Care Center. The residents have the option of eating a hot breakfast served in the dining room, having their breakfast delivered to their rooms, or sleeping late and eating a continental breakfast later in the morning. Personal food preferences are accommodated and staff, from all departments including leadership, helps to serve the meal. The residents and staff members at SEM Haven Health & Residential Care Center have formed stronger relationships through interacting over breakfast and there has been a marked decrease in weight loss at the facility. The residents are happier because their mornings now begin with a pleasant breakfast and they have more control over their morning routine. The relaxed breakfast idea was formulated by a dining committee of staff from all departments and continues to work through ongoing communication and the facility’s willingness to make changes for improvement.

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Residents at The Veterans’ Home used to participate in a single group recreational activity offered to many elders at once. The problem emerged when residents with dementia were unable to participate in these large activities in a meaningful way, due to the size of the group and the lack of choices for the programs. The solution was to create a large living room designed to accommodate smaller groups of residents. The Veterans’ Home found some furniture in storage and redecorated the large room formerly used for the single group activity. The residents now choose the activity in which they would like to participate, thus improving activity participation, stimulation, and meaning. Caregivers also participate and help facilitate the activities; their participation strengthens the relationship between staff and residents. The programs are flexible and include a variety of activities: cards; table games; trivia; arts and crafts; movies; special meals; laughter club; drum circles; and even a gossip club. Residents and caregivers enjoy the activity time so much that caregivers have started to view participation as part of their care-giving duties.

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Improving end-of-life care was an important step for the residents and their families at Westminster Village. Compassionate staff nurses were dissatisfied and frustrated with the amount of time they were able to spend with actively dying residents. Westminster Village collaborated with staff, hospice workers, and the resident council health services committee to create a volunteer program for end-of-life care. The staff and volunteers spend time with actively dying residents while the family members are not at the facility. The program has been so successful that Westminster Village developed a copyrighted training manual. Initially, the facility surveyed family members of deceased residents and nursing staff, and then repeated the survey after the end of life care program was implemented. There was improved satisfaction with end-of-life care in both the family member and staff groups for the post-change survey.

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Improving Nursing Home Culture Final Report
The Jewish Home of San Francisco, California

The Jewish Home of San Francisco held their sixth annual Summer Arts Festival this summer. The residents and community members enjoyed a variety of activities and shows during the three-month long festival. The multicultural entertainment ranged from educational lectures to dance performances. The Jewish Home of San Francisco also had four residents, who ranged in age from 90 to 75, recently become bar or bat mitzvah. This accomplishment was made possible by the support from the local community and the teachings of the home’s Rabbi. The Rabbi has also implemented a new end-of-life program for the residents and families of the Jewish Home. The end-of-life program is a collaborative effort with a local healing center and a Zen hospice program.

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Not available

Bel-Aire Center, Vermont

A buffet dining service with expanded meal times is now offered at Bel-Aire Center, offering customers more choices and control over their daily meals while living at the center. The residents now decide what foods they eat, when they have their meals, and who their dining companions are. Within the first month of implementation, the facility saw many improvements: 16 elders experienced a weight gain; 25 elders maintained their weight; there was a decrease in supplement usage; a reduction in the number of people choosing to eat in their rooms; and a decrease in plate waste. Due to the success of the new dining program, Bel-Aire Center also decided to implement primary assignments for the nursing staff. Now, with primary assignments, residents can choose when to wake up and when to have their meals on their own personal schedule. Residents linger in the dining room enjoying each other’s company and conversation. Bel-Aire staff currently use learning circles to solve problems on the unit and to share positive experiences as well. Since the implementation of the new dining plan and the transition to primary assignment, Bel-Aire Center feels more like a home; there are fresh cookies baking in the oven for dessert and lively conversations and socialization at every meal.

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Heritage Manor, Massachusetts

Each resident chooses his or her own meals from Heritage Manor Lowell’s selective menu system. It is amazing the impact such choice has on the satisfaction of residents at the facility. The selective menu plan was created because residents had mentioned on surveys and at Resident Council meetings that they were dissatisfied with their meals. Now elders can choose their menus within their specific dietary needs, and each resident feels empowered by being included in decisions about their nutrition program. There has been a decrease in calls to the dietary department and overall, the projected savings from implementing this program are an average of $10,200.00 per year. Resident satisfaction surveys show an increased approval rating, and each response included positive comments about the new selective menu program. Giving the choice back to the residents has had a powerful impact on the facility, as one resident said, “Finally, I feel like I am at home.”

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Grandview Christian Ministries, Minnesota

Grandview Christian Ministries implemented a program entitled, “Rise At Will”, which allows residents to wake up whenever they choose in the morning. The facility was trying to move away from a structured, institutional environment and to create a setting that feels more like home. Both the staff and the residents are enjoying the ‘Rise at Will’ program; staff are more relaxed and happier to spend more time with the residents in the morning, and residents are more alert later in the day. Other results have included: increased resident, family, and staff satisfaction; increased appetites; staff spending more time with the residents; and decreased problem behaviors from residents during the day.

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Residents at Pinewood Terrace had been complaining about waking up during the night due to noise and nighttime activity of staff. Pinewood Terrace decided to stop all nighttime laundry delivery, and stop incontinence checking and changing skin treatment during the night. The facility purchased 8-hour incontinence products that allow the residents to sleep through the night. The result is less soiled laundry on the night shift and early mornings, a decrease in offensive odors throughout the facility, a decrease in falls during the night, and an immediate decrease in resident problem behaviors. The residents now sleep better, completely undisturbed, and therefore are happier during the day.

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The resident council at Pleasant View Center requested that the facility’s interdisciplinary staff make some changes to the dining experience. The council’s requests included: greater entree variety; extended dining time; more consistent food temperatures; and the ability for the communities and individuals to make meal selections. The resident council clearly stated their requests and Pleasant View Center ensured each request was met with resident approval. The staff at the facility was dedicated to making the changes and to improving resident satisfaction and quality of life. Pleasant View Center has seen a dramatic reduction in plate waste and improved satisfaction reports from residents and the community council. Individual choice and preference is embraced during the dining experience and many residents are now more satisfied during meals.

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Workplace Practices

Since CMS implemented the NHQI in November 2002, the state QIOs have brought together key stakeholders and we began to work together to promote wider adoption of proven, evidence-based quality improvement approaches in nursing homes. Nearly three years later, the NHQI is widely recognized as a turning point for nursing home quality, particularly for the more than 2,500 nursing homes that have volunteered for intensive assistance from their local QIO. Nursing homes and their QIO partners have shown significant nationwide improvement as measured by several indicators. However, while providers working with QIOs have made significant progress on the quality problems in long-term care, it is clear that nursing home staff turnover and high staff vacancy rates are significant barriers preventing breakthrough and sustained improvement. The American Health Care Association estimates that there are over 100,000 vacant full-time nursing positions (RNs, LPNs, CNAs) and that there is an average turnover rate of more than 70% in our nation’s nursing homes.

Turnover causes a significant financial drain for nursing homes. Experts estimate the total national cost of nurse aide turnover exceeds $2.5 billion dollars ($2,500 per nurse aide departure). However, beyond the direct costs of turnover is the significant human and operational toll turnover imposes. Turnover leads to staff instability and vacant positions which result in rushed, de-personalized care for nursing home residents. Providers with severe staffing issues are unable to focus on quality improvement. Thus, the key to radically improve care involves a more holistic approach to quality improvement that embraces a commitment to improve quality of work life of nursing home staff.

In 2004, CMS granted a special study to Quality Partners of Rhode Island and the Colorado Foundation for Medical Care to work with seven nursing home corporations (10 – 18 facilities each) in a collaborative to test evidence-based practices designed to enhance the quality of work life of their staff and thereby lower turnover rates. We used as a basis the work of Susan Eaton who, in her landmark study, “What a Difference Management Makes,” identified human resource management practices that were the determining factor in nursing homes ability to retain staff. Using these practices as the base, we started the learning for the corporate participants with a set of homework assignments that provided them with a new in-depth
knowledge of the impact of their current practices on workforce stability. As a result, the network of nursing home corporations working collaboratively in the special study led to several significant lessons learned:

- Most turnover occurs in the first six months of employment. Facilities that employ best practices supporting new staff, such as individualized orientation and peer-mentoring programs during orientation, lead to higher rates of retention.
- Frontline caregivers’ greatest frustration is working “short-staffed.” Facility leaders need to implement strategies to address absenteeism, such as: employee assistance programs, flexible scheduling, affordable health insurance programs, on-site day care and wellness programs.
- Front line staff and residents flourish when facility policies support a consistent caring relationship. The common practice of rotating staff assignment among groups of residents severs relationships and is detrimental to resident quality of care and quality of life.
- There are strong links between the quality of nursing home employee’s work life, resident’s quality of life and clinical outcomes of care.

Quality measurement alone is not enough to close the long-term care quality gap. Nursing homes are fragile ecosystems. Thus, according to Dr. Barbara Bowers from the University of Wisconsin, while many initiatives designed to lower nursing workforce turnover have flourished, replicating successful programs is difficult. There are many reasons for this. First, individual facilities need individualized approaches, and typically “one size does not fit all.” In addition, organizations need ongoing assistance and support to “stay the course.” She found no “quick fix” to turnover and little documentation regarding the “how to” or the process of change necessary to enhance retention rates. Through the CMS funded special study, we have begun to address these concerns. We have found and documented the impact of implementing consistent assignment of staff to the same residents. Not as a quick fix, but as the basic foundation for workplace stability and quality care. The work of the corporations documents the efficacy of the “how” of change through a holistic approach to transformational change.
Simply focusing on the workforce domain will not address the root cause of staff instability. Transformational changes must also occur within the domains of the environment and care practices within long-term care facilities. Fortunately, over the next three years, QIOs will fulfill a critical need of long-term care leaders by providing the education and support necessary to implement the holistic approach to transformational change.
Workplace Practices Into Action

**Landis Homes, Pennsylvania**

The monthly ‘House Meetings’ that Landis Homes has implemented impact many aspects of working and living at Landis Homes. The meetings occur on a monthly basis, both during the day and in the late evening, ensuring afternoon and night shifts attendance. All staff is invited in order to problem solve in the House and to include everyone's thoughts and suggestions. Each House has primary staff assignments; therefore, all problems relating to the House can be discussed and resolved at the House Meetings. The House Meetings also feature one resident’s life story, hobbies, and interests. This segment of the meeting, in particular, has had a tremendous impact on building strong relationships between residents and staff. As one staff member commented: "We are all learning more about the residents, who they are and what matters to them."

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**Medilodge of Rochester Hills, Michigan**

In order to create a positive environment for living and working at Medilodge of Rochester Hills, the facility started a recognition program for its residents and staff. The facility now honors ‘Resident of the Month,’ ‘Employee of the Month,’ and ‘Medilodge’s Monthly Staff Stars.’ The new staff orientation currently includes information about Medilodge’s goal of making the facility welcoming and helping all staff to feel ownership for their work. The turnover rate used to be high at Medilodge of Rochester Hills, but now that the facility is working on retaining their staff and recognizing everyone’s accomplishments, there has been a definite shift in attitudes towards a positive work environment.

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In order to address the apparent disconnect between decision makers and decision implementers, Botsford Continuing Health Center implemented "neighborhood meetings." These meetings are a time for discussion and resolution of issues or concerns on the unit. All staff members attend these meetings, bringing together decision makers and unit staff working directly with the residents. Solutions to the problems and frustrations addressed at the meetings are created and modified as necessary. These neighborhood meetings have empowered all staff and allowed for many change possibilities at Botsford Continuing Health Center.

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Without permanent assignments in a hospital as large as The Veteran’s Home, staff and residents never get to know each other and never form close relationships. The Veteran’s Home transitioned to permanent assignment for several reasons: to empower staff; allow close bonds to form between staff and residents; and to improve staff’s ability to recognize changes in the residents for which they care. The transition was rolled out over several months and used the ‘small test of change’ approach; the change started with one assignment on one floor and slowly moved throughout the home. The results have been wonderful for both the residents and staff at The Veteran’s Home, the staff is much more aware of their residents’ needs. One CNA put a resident on an hourly turning schedule due to their high risk for developing a pressure ulcer. Additionally, staff and residents have closer relationships than before, as seen when one staff member visited a resident who was in the hospital. This staff member also brought her children to visit the resident in the hospital, explaining that he is almost part of her family because she takes care of him everyday.

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The monthly Employee Recognition Program at San Joaquin Gardens is to honor and recognize a staff member’s dedication and accomplishments at the home. The program chooses a staff member who excels in five areas: customer service; innovation; teamwork; mentoring/learning; and encouragement. A resident, family member, or fellow staff member presents a certificate to the employee. San Joaquin Gardens also has an employee of the month who is featured in the home’s monthly newsletter. Additionally, San Joaquin Gardens holds a yearly Star Awards ceremony to recognize employees who exemplify excellence in the five areas important to the home. These employees are encouraged to bring their families to the ceremony and to dress formally if they’d like. The results of honoring their staff are seen in San Joaquin Gardens’ decrease in staff turnover and increase in job satisfaction, employee self-esteem, and employee pride in their work.

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Residents at Heritage Hall East Center enjoy a cocktail hour before their lunch is served. The residents congregate and talk over punch or other drinks before enjoying their now-social and lively meals. Previously, staff would monitor the residents during their lunch hour; this felt stifling to many residents and therefore they did not participate in conversations or feel very comfortable during their lunch. After forming a committee and using learning circles to generate ideas, Heritage Hall East Center decided to have staff join residents during the lunch hour. Now everyone enjoys lunch together and the conversation flows freely. Staff members were happy to act as bartenders for the pre-lunch cocktail hour, and the residents look forward to sharing their meals with staff. One resident, who used to keep to herself, has taken to checking on all her friends and neighbors to ensure everyone is going to the cocktail hour and lunch.

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**Ridgewood Center, New Hampshire**

An entire floor at Ridgewood Center has shifted to consistent assignment and currently the residents are able to direct their care and personal schedules. The old mentality at Ridgewood Center was that a well-trained staff member could work with any resident on any floor; therefore, floating staff to other floors was a way to maintain an excellent staff skill level. Unfortunately, this mentality prevented staff and residents from forming strong relationships with each other. Ridgewood Center made it a goal to build staff relations with residents, their families, and other staff members on a floor. Through these relationships, the residents developed a high comfort level with staff and began to truly trust their primary caretakers. The residents now have the opportunity to direct their daily schedules and care. The staff chosen for consistent assignments were dedicated and prepared for the challenge. Initially, there were scheduling conflicts, so the facility reminded all floors that staff would no longer be floating off the consistent assignment floor. With all implementation problems resolved, the impact of the change is most noticeable for staff in the following areas: reduction of staff overtime due to fewer call outs; increase in staff retention; and a reduction in costs for recruitment, hiring, and new employee orientation due to the current high level of staff satisfaction. The impact to residents includes: a reduction in medical costs due to fewer skin issues; a reduction of costs for incontinence supplies due to better toileting procedures; a drop in pressure ulcer rates; a decrease in falls; no unplanned weight loss as of June 2005; and a significant increase in resident participation at recreational activities.

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**Golden Empire Convalescent Hospital, California**

Posting letters of appreciation and compliment was an important recognition of the staff’s work at Golden Empire Convalescent Hospital. The letters were gathered and posted in a central location allowing all visitors, staff, and residents to read the comments on the care provided at the hospital and recognize the difference caregivers make in people’s lives. Golden Empire Convalescent Hospital believes it is important to give staff the credit they deserve based on the quality of the care they provide.

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The Villas At Sunny Acres, Colorado

The nursing home team of The Villas at Sunny Acres worked with their Catholic Health Initiatives (CHI) sponsors to do homework assignments throughout the year. The assignments led to the implementation of a variety of actions designed to change the nursing home culture and improve workforce retention. Changes included (1) re-furbishing the shower rooms to make them non-institutional, (2) re-furbishing the employee break room to be more inspirational to staff, (3) instituting progressive HR policies such as the Mastery Development Program, (4) changing the names of our resident halls to reflect an actual address, (5) adding wood floors in a dining room and a day area, replacing very institutional looking tile that had been there before, (6) re-designing the whirlpool room to be relaxing and peaceful, (7) instituting a Culture Change policy. The purpose is to transform the culture of the healthcare center by affirming the dignity and value of each individual who lives and works there, and enhancing “rampant normalcy” in the nursing home setting, and (8) open-dining. The nursing home is much less institutional and has a better atmosphere than before.

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A smile makes all the difference!
Another way of saying the Domain of the Environment is to say “home.” In the holistic approach to transformative change, we used the research of Judith Carboni to help us define and gain a deeper understanding of the deep human need we all have for the sense of belonging we feel when we are at “home.” In her research, Carboni defines home as a strong, intimate relationship between the individual and the environment and explains that the experience of home acts as a center to an individual’s existence: it provides meaning in a chaotic world and lies at the core of human existence. She found seven separate and distinct aspects to feeling “home.” The seven aspects are:

- Identity ~ A bonding of person and place, a sense of belonging
- Connectedness ~ The connectedness to people, with the place, with the past and with the future
- Journey ~ A sense of reach, a point of departure
- Privacy ~ Being able to decide when to be in and out of contact with others
- Power/Autonomy ~ Personal freedom to make choices and decisions
- Safety/Predictability ~ Having a sense of certainty and familiarity
- Lived space ~ A meaningful experience of space

Carboni describes home and homelessness as on a continuum. At the homeless end of the continuum, individuals who experience homelessness find deep pain in the lack of connection and an overwhelming feeling of the loss of meaning in life. Aspects of homelessness include a lack of identity, with a downward spiral into non-person-hood; a lack of privacy with no place one can retreat to or withdraw from, save a withdrawal into oneself. Another aspect is an absence of meaningful space, and this all engenders a sense of powerlessness and dependency. The nursing home residents she interviewed were aware that the institution and not they made the rules. Individuals who are at this end of the spectrum experience such deep pain that they either shut down or develop coping mechanisms such as “pretending” that allow them to cope with the pain of the deep loss they feel. Her research suggested that these coping mechanisms are often
misinterpreted by nursing home professionals as acceptance or adjusting to the nursing home setting.

She found that due to the multiplicity of losses nursing home residents have experienced even before coming into the nursing home, combined with the institutional nature of the nursing home itself, contribute to the reality that individuals coming into a nursing home tend to fall more towards the homeless end of the continuum.

Using this research as a way to understand the deep human need for home we have a better understanding that home is not just about making our nursing homes pretty spaces. To truly be Home, there must be an honoring of the human need for connection, for privacy, to be able to make decisions, to have the space we live in reflect our own individuality, and to create ways for individuals to bond with their own space. This then is the requirement if we are serious about helping to create home in our nursing homes.
Golden Empire Convalescent Hospital, California

Golden Empire Convalescent Hospital wanted to make environmental changes to their shower room because staff felt it was uninviting and cold. They used the room to store items as well, which made it look and feel very institutional. The facility formed a committee to change the design and atmosphere of the shower room. Fortunately the committee leader had previous experience in interior design and was able to motivate the team to come up with ideas for the room. Once they decided upon the color schemes and ideas, the committee presented the information to the Administrator for approval. The total estimated cost was $300.00 for redesigning the entire shower room. The room is now much more inviting with a less institutional feeling. This team approach to change has spread throughout the hospital and currently resident rooms are being renovated with new wallpaper and a more pleasing color scheme.

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Passavant Retirement Community, Pennsylvania

Over the past two years, Passavant Retirement Community has made many changes to their facility. Some of the most powerful changes include: resident dining on the units; nursing staff grocery shopping for elders; gardens added to the neighborhoods; and elders performing jobs at the facility such as setting the table or welcoming new elders. Passavant Retirement Community has adopted a number of pets and currently allows staff to bring their children and pets to work. The facility also has the Second Wind Dreams program; in which some of the elders have been able to ride a motorcycle or learn about Mars at the Science Center. Another important change has been the facility’s shift to permanent nursing assignments. Passavant will be agency-free by October 31, 2005. Staff and residents are happier working and living at the facility, and people feel free to bring up a complaint and understand how to work as a team to find a solution. The main objective for the changes at Passavant Retirement Community is to have staff and residents work and live together in a kind, loving, and peaceful environment.

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### Horizon Health and Subacute Center, California

Horizon Health and Subacute Center was looking to relieve some feelings of loneliness and boredom that elders can experience while living in a nursing home. The facility decided to adopt a yellow Labrador Retriever puppy named Veda, who provides the elders with companionship and joy. The staff, family members, and residents all took part in the decision to adopt Veda, and everyone shares in the responsibilities of taking care of the puppy. Having a puppy at Horizon Health and Subacute Center has helped staff and residents build stronger relationships as they work together to care for Veda.

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### Liberty Country Place, Washington

The bathing procedure has been completely revamped at Liberty Country Place. Previously, residents were bathed on a predetermined schedule and were taken to their bath or shower in a shower chair, with only a blanket wrapped around them for privacy. Liberty Country Place trained all staff on the importance of changing their bathing system. Many improvements were made to the environment including: purchasing robes for all residents; purchasing new shower curtains (picked by the residents) for the private baths; redecorating the common shower rooms with a home-like theme; and placing a lock on the door of common shower rooms to ensure privacy. Residents can choose if they want a bath or a shower, and a bed bath is now offered to residents who cannot tolerate a tub or shower. Residents who bathe in the common shower rooms get undressed/dressed in the privacy of the shower room. Additionally, after a few minor schedule changes, bathing now is offered on the evening shift also. Currently the residents are much happier and have more privacy and dignity during their bathing experience.

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Heritage Park, Indiana

Heritage Park completed multiple environmental changes to their facility including: creating a spa room from a tub room; creating a welcoming entrance for the Memory Care Center; redecorating resident rooms; and updating the neighborhood kitchens. These improvements were designed to make the facility feel more home-like for the residents and to make staff feel comfortable at work. The staff was dedicated to helping make the improvements and motivated by the environmental change projects. Heritage Park held numerous fundraisers to help with the costs of redecorating, and donations were given to the facility from staff and resident families. The staff now takes pride in their organization and its changes, and they are happier coming to work. Heritage Park is continuously looking for areas of improvement; their next focus will be on staff relationships with residents, family members, and other staff at the facility.

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Hickory Creek Healthcare Foundation, Inc., Indiana

Hickory Creek Healthcare Foundation implemented ‘Bathing Without a Battle’ as a corporate-based program for all their facilities. The goal was to provide a resident centered bathing experience in a comfortable environment that maintains the resident’s dignity and privacy. Each facility within Hickory Creek Healthcare Foundation has shown the ‘Bathing Without a Battle’ video to all staff and new hires. The facilities have the freedom to choose how to implement the changes necessary for a pleasant and comfortable bathing experience. Several homes have redecorated their bathrooms and made them more home-like with the use of color, tiles, and different themes for each bathroom. Partnering with community members has been financially helpful for the facilities, and some community members have donated materials for the facilities’ use. The nursing homes that have completed the changes with their bathing process and bathroom environment have a positive reputation in the community and now enjoy a higher census.

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In January 2004, Peabody Retirement Community opened a state-of-the-art healthcare facility, memory enhancement center, and assisted living facility. These buildings were newly built, with design help from an environmental design specialist. All transportation, linens, trash, and food programs come from outside the buildings; there are no longer large carts being pushed through the hallways disturbing residents’ peaceful and quiet environment. The healthcare facility is divided into neighborhoods of 24 residents, with eight residents to a cluster. There is a fireplace, coffee nook, lounge, kitchen, and dining room for each neighborhood. Additionally, choice dining is offered in each neighborhood dining room. The rooms are larger (private rooms are now 364 square feet) and every room has four large windows adding plenty of natural light. Every private room has a bathroom with a shower. The memory enhancement center has 12 residents to a neighborhood and offers a Montessori-based program for the residents. There are many different ‘life stations’ in the neighborhoods dealing with life aspects such as gardening, home making, a rummaging station, and games. The staff in the “memory enhancement neighborhoods” follow the residents’ lead during the day.

The Assisted Living facility focuses on social aspects as well as medical care, offering special dining programs and recreational activities. Peabody Retirement Center started diversified worker training four months before opening the new facility to prepare their workers for the shift in delivery of care. Overall, the new facility offers residents more space, privacy, and dignity, and is a much quieter, more home-like living environment.

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At The Cedars, the unit staff cooks a homemade hot breakfast for each resident as they wake up in the morning. The breakfast includes bacon and eggs cooked to taste, and the residents wake to the smell of breakfast filling the air each morning. The residents, when they are ready, enjoy eating a nutritious warm meal, and since implementation, the facility has noticed a decrease in food waste. Breakfast used to be cold when some residents would wake up, and the eggs were always hard. As one resident said “I’m 93 years old and I’ve been eating soft eggs all my life and I’m still alive. Please don’t tell me I can’t have an egg I can dunk my toast in.” The Cedars will now cook the eggs to taste and there is always a piece of hot toast ready also. The residents and staff enjoy their new morning routine of preparing and enjoying a warm and satisfying breakfast.

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The Wellstar Paulding Nursing Center decided to focus on the bathing procedure and shower room environment to improve the quality of life for their residents. The three areas for improvement were the physical environment, bathing schedules, and the customer service of bathing. The physical environment was altered by adding heat lamps, aromatherapy, music, special shower fixtures, and cushioned shower chairs for added comfort. Each resident also has his/her own personal bathing kit that is kept in the resident’s room. The bathing schedules are now logged in the ‘Bathing Appointment Book’ and are created around resident preferences. Customer service improvements were made by educating staff with the ‘Bathing Without a Battle’ video, and by demonstrating techniques to reduce combative behavior during bathing. The changes to the bathing experience are just the beginning for Wellstar Paulding Nursing Center. Thinking “out of the box” has lead the facility to explore more ways for quality improvement.

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Family and Community

A dynamic change consistent with the openness reflected in the rest of the INHC Pilot Study created a shift that encouraged and sought the input, expertise and knowledge of family members, close friends and the support of community organizations and volunteers to assist in the intimate and life-giving relationships with residents. Embracing families and drawing them into the open climate of sharing and support served to create a greater understanding of the resident, their lifestyle choices, preferences and experiences. In the knowing of each person as an individual, the possibility to meet each person's needs and tailor their day-to-day experience increased exponentially. Drawing families into the care concerns of each resident also served to enlist the aid of a strong and knowledgeable ally.

Families, in an effort to offer support to their loved ones as well as the organization where their loved one lived, served on councils, lead family groups, created recognition and acknowledgment programs for staff, participated in remembrance services and naturally became a part of the interdisciplinary care conference lending their voice to assist in the personal and intimate life of each resident.

Nursing homes in INHC became porous entities allowing the easy flow between community and nursing home. This is evidenced by homes that opened their doors to community activities and served as home to school and scouting groups, and even created room for Pre-School and Kindergarten so that intergenerational interaction would become the norm instead of the "invisible lives" so often manifest by the warehousing of elders outside of the preview of society.

Read on to hear the stories from our pilot homes, who lead the way in the domain of family and community.
A committee was formed at Golden Empire Convalescent Hospital to look at quality improvement and to create a way for the facility to continuously measure how they are doing. The committee, using a brief card as an outline, created a “How are we doing?” card for family and staff to use. Although use of this card was never implemented, the committee’s efforts showed Golden Empire Convalescent Hospital the necessity of family and staff feedback to measure success. The facility now uses family, resident, and staff surveys to gauge how well they are doing.

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The Indiana Association of Homes and Services for the Aging (IAHSA) wants to support and encourage all of their members on their journey towards implementing person-directed care. IAHSA believes the person-directed care approach should be seen as an obligation to the individuals living in a nursing home setting. Quality improvement is important to IAHSA; they have continuously and consistently geared messages about quality improvement for the providers. IAHSA has made information about person-directed care available through monthly newsletter articles, learning sessions at board meetings, and presentations at two large conferences. IAHSA has been impressed by the individual facility’s initiative to implement their own quality improvement activities based on information and ideas gathered from Quality Improvement Organization meetings.

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Leadership

We recognized that the formal leadership must be actively involved in creating a culture of change. They must be able to challenge the status quo, inspire others with their vision, give a green light to others so they can become a part of the change and give encouragement to others so as to create other leaders within the organization. This type of leadership is not common in long-term care. The high degree of regulation has encouraged something different—it has encouraged maintenance of effort—a fear of trying something new because something new might meet with bad survey results. The type of leader that is needed in ushering in a transformational change is someone who can support and encourage others, ensuring that the resources they need are available and that risk taking is understood to be a part of a change process. An exemplary leader is a leader who has a vision of wanting something better, and who involves others so that they become equally committed and involved in the process. This leader is someone who ensures that the staff and the organization are prepared to support changes.

We recognized that good, solid, participatory leadership during a change process is a key to its success. Drawing from the work of Kouzes and Posner, Eaton, and Collins we taught that exemplary leadership is a participatory process that brings forth the best in everyone. Using self-reflection, out of context scenarios, and skills assessments we challenged the leadership within the organizations to look at themselves first. And across the country leaders stepped up to this challenge.

Because we know leadership is a skill that can be to be learned and then honed by use, we encouraged those in formal leadership roles to help others in their organization to develop and support the growth of leadership within the entire organization. We encouraged a decision making process that included hearing from workers throughout the organization. It is important to talk through areas of potential change to make sure that every aspect of a potential change is

“Leadership isn’t the private reserve of a few charismatic men and women. It’s a process ordinary people use when they’re bringing forth the best from others. Liberate the leader in everyone, and extraordinary things happen.”
closely examined. In a change process it is essential to hear from those closest to the change, to make sure that nothing that needs consideration is being overlooked. This means inviting front line staff and whenever possible residents into discussions. Active engagement across the organization is a hallmark of strong leadership. We also encouraged a revisit to what might have been considered resistance - and encouraged listening to concerns so that they can be discussed and dealt with. We also dispelled many of the myths common in our culture - which leaders are born, that leaders are cool, aloof, and analytical, and that good leaders work alone. Instead, from the research, we showed that the most effective leadership is developed, and nurtured by practice. And that far from being aloof and alone, good leaders are connected and committed to their organizations and to the people who work within them.

“Leadership is a relationship, founded on trust and confidence. Without trust and confidence people don’t take risks. Without risks, there’s no change. Without change, organizations and movements die.”
In 1998, Grace Living Centers decided to redefine its corporate philosophy and bring its 23 facilities together under one name. Grace Living Centers was the chosen name because it reflected the core values of the corporation: to treat each resident with kindness and respect. That same year many employees, residents, and family members from different facilities received training from Dr. Bill Thomas on resident-centered care. The key goals of Grace Living Centers were to improve staff retention and to reduce loneliness, helplessness and boredom for elders at their facilities. Five facility leaders were chosen to join a Leadership Committee and to implement change programs at their facilities. Each facility had its own creative input regarding areas they could improve on and the changes they needed to make. The first facility invited elders to interview prospective staff members before hiring. A volunteer position was also created for residents to greet new admissions to help ease their transition to the home. The same facility now discusses performance numbers with direct-care workers to get their input and ideas for improvement. A second facility created a leadership team, formed neighborhoods within the facility, and created a spa for the residents. The staff at this home is now self-scheduling and the residents remain highly involved in decision making at the facility. The third facility decided to let residents and staff members eat their meals together as an improvement initiative. They too post clinical successes and ask for staff input on areas of improvement within clinical practices. The staff members at this facility no longer have clinical titles; they have shifted to more welcoming titles such as the ‘Mayor of Grace,’ rather than the ‘Administrator.’

A fourth facility embarked on a complicated dietary program to ensure hot meals for all residents. They also implemented a new end-of-life program to better assist the residents and their families in a home-like environment. The fifth facility participating in person-directed care changes created a leadership team for generating change ideas, and currently involves all levels of staff and residents in planning the changes within the facility. This facility also posts quality of care graphs for staff to monitor their progress in improving the quality of care for the elders. Overall the customer and employee satisfaction rate for Grace Living Centers has improved from 60% in 1998 to the mid-80% range for the past year.

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Lahser Hills Care Center, Michigan

Lahser Hills Care Center focused their changes on leadership and self-development. After implementing training and educational programs, the staff are more understanding of all departments within the center. Lahser Hills offered leadership training and outside self-development training for leaders and direct care staff. Now all leaders see themselves as equal caregivers. The effects can be seen in Lahser Hills’ surveys: the facility had its best annual survey in five years and received many positive family evaluations from the satisfaction survey this year. Employee grievances have decreased and the center is working on training the Human Resource department for self-development seminars and bringing information to all employees at the center.

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George Davis Manor, Indiana

George Davis Manor felt that by building leadership and improving staff and resident relationships, a natural improvement would occur in the quality of care and the resident satisfaction within the facility. This improvement is evidenced in the changes George Davis Manor decided to pursue and how successful these changes have been. The first major change was for the facility to focus on their current and developing leaders. The ultimate goal was to emphasize the importance of every staff member through continuous involvement and recognition within the organization. After All-Staff In-Services and other educational trainings, the staff started to use learning circles to solve departmental issues, created a team to remodel the nursing unit bathrooms, and engaged families and residents in the change process. The shift in leadership was not always smooth, but most managers now realize the importance of routinely expressing recognition and praise for the hard work and dedication of their staff. The results from the January 2005 Staff Satisfaction Survey showed a 4% increase in satisfaction among associates receiving recognition or praise in the last week, and there was a 17% increase for associates feeling that their supervisor or someone at work seems to care about them as a person.

Now that staff members at George Davis Manor have an excellent rapport with each other, and can see the value in their diversity, the facility has been able to focus on what makes each resident unique and to develop a plan to care for each elder as an individual. Once again, the core person-directed ideas were discussed and presented at All-Staff In-Service meetings and information was disseminated to family members through the community newsletter. The more the staff got to know each other, the more they were able to see the residents as individuals and to look for what makes them unique. The facility now uses ‘I’ care plans to describe the care needed in the resident’s own voice. Additionally, all staff members and the residents’ family members are encouraged to help create the care plan. The facility as a whole has become more friendly and welcoming, especially for new staff members. There is now a new associate bulletin board with each person’s picture, title, shift, and work area; the bulletin board facilitates an easy transition to working at George Davis Manor. In July 2005, every new associate responded positively when asked if the other associates had been friendly and had made the new hires feel welcomed. George Davis Manor has begun consistent assignments for the nursing staff and has seen the incredible benefits of this change. The direct-care workers better understand the residents they care for and now know their personal preferences and needs.

Staff’s understanding of residents’ personal needs is extremely important for residents suffering from dementia. George Davis Manor no longer labels their residents as ‘resisting care,’ alternatively the staff works on solving the problem behind the resistance. Person-directed dementia care has allowed residents with dementia to make more choices and have more control in their daily care. The facility-helped staff sees their residents as people with needs and strengths. Family members became involved in helping to explain certain behaviors to staff so everyone could understand what the resident was thinking or feeling. Residents with dementia are no longer receiving negative messages from staff and the effects of this positive attitude have been incredible. The facility currently has a 40-50% decline in the use of antipsychotic medication among residents with dementia. Wandering behaviors have decreased significantly and wandering is now seen as a purposeful activity where staff members can join the resident for a stroll and friendly conversation.

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OBRA ’87 provides the regulatory basis for person-directed care. In this pilot, we supported nursing homes in the transformation from institutionalized care to individualized care. Nursing homes in the pilot found that as a result of shifting from institutional to individual routines for waking and sleeping, eating, bathing, and other care practices, residents who had been in long, slow decline began to thrive. Their stories provide the evidence: decreased agitation, medications, weight loss, immobility and depression. Residents have increased appetites, alertness and enjoyment, of their meals and of their days. Homes sharing their journeys in this book report that residents are enjoying a more peaceful living space, bathing with dignity, greater involvement in social activity, and a good night’s sleep. The full intent of OBRA is beginning to be realized.

Since regulations were perceived as a barrier by homes participating in the pilots, the QIOs worked with their State Survey Agencies to ensure that this would not be the case. At the initial training for the QIOs, Karen Schoeneman, of CMS, conducted a session called, “Think Like a Surveyor.” The session presented participants with scenarios that can unfold in a transforming nursing home, such as staff eating family style with residents, pets in the building, spontaneous play and activities that bring joy and risk. In each case, training participants had to think through all the health and safety issues involved, in the same way that a surveyor would. This gave participants experience with thinking through these same health and safety issues as they took on their own changes.

State survey agencies across the country engaged in a number of best practices to support efforts by pilot homes to improve their nursing home culture. These included participation in QIO training sessions and appointing a liaison that was available to field questions and think through regulatory responsibilities with providers as they worked on their changes. The partnership with the state survey agencies has been essential to the success of the pilots.
Insights

Throughout the pilot study, participants continuously shared their insights and advice along the journey to person-directed care. This section contains the direct quotes and revelations of our partners.

Advice From Dynamic Leaders

“Take your people to facilities that are already on the journey. Seeing is believing.”

“Quit looking for a cookie-cutter plan for culture change. Each home will do it their own way and at their own pace. Provide them with the support and information they need and continue to encourage them as they journey.”

“Be willing to ask why we do things a certain way and is there a better way to do them?”

“Seek involvement from facility-level staff before making corporate changes.”

“Think of yourself, your parents, or a family member when asking the question, “How would you like to live?”

“Understand that conflict will happen when the culture change movement begins. Be willing to assist staff to work out their confusion over their changing roles while continuing the movement.”

“Know that before you transfer responsibility to facility staff, you must provide them with both the support (they are truly fearful they will fail) and the training they need to do the job.”

“Seek education and guidance as you begin your journey. If change doesn’t come naturally, study it and talk to others already in the change process.”

“Don’t try to change everything at once. Begin with small steps. For instance, you can’t change all the care plans at once. You could begin with new residents or during your quarterly or annual MDS assessments.”

“Work with team members, ask questions and listen. You’ll get a better perspective and insight.”

“Look for the resident’s strengths. They each have strengths if we learn to recognize them and then it’s easy to build a person-directed approach on that base.”

“Take the time to educate associates and build a good foundation within the entire organization.”

“Emphasize relationships within the entire environment. This is the cornerstone of building leadership.”
“Educate managers about the importance of developing the associates they supervise as being a key ingredient in being a good manager.”

“Allow opportunities for the personal talents of associates to be used by the organization for the benefit of all. Then recognize those talents and efforts.”

“Involve residents, families, friends, and all staff (especially front-line staff). Work with team members. You’ll get a better perspective and insight.”

“Consistently follow up (PDSA).”

“Be flexible and open to input from all directions. It is imperative that the chief operating and consulting staff buy in to the culture change idea – if they do, they soon realize that they are the support and resource people for the residents and facilities. While somewhat scary, allowing staff the latitude to be creative and autonomous will lead to better results for everyone.”

“Take a bath or shower in your own place.”

“Start with one resident and go slow. Keep in mind that the purpose of medical care is to improve residents’ quality of life, not make it worse.”

“Think outside the box! Each facility is chock full of amazing talent. Utilize the talents of the people you work with to help bring about positive change.”

“Get clear direction from your community councils on the areas of personal choice that they want your staff’s support in achieving. Since, there will be many days that you fail on the improvement path and you need to remind the team of the admirable goal that was given to them. It is the staff’s belief in this common expectation that is what keeps them together and focused. It will drive them to forget the frustrations of yesterday and strive to be better today.”

“If your resident community councils are not vibrant and vocal, then perhaps that is where you start.”

“Involve staff in the change and let them take the lead – they won’t go wrong. Get feedback along the way. Don’t be afraid to admit an idea didn’t work, lead the effort to regroup, and start again. Take the blame, and remember to always give the recognition to your staff. Celebrate the successes, no matter how small.”

**Insights From Leaders In The Pilot**

“I thought I understood person-centered care well and that our homes were the ones who had a problem embracing it. However, through participation with the leadership committee, I learned that I was not walking the talk. I had to acknowledge that my style of leadership was largely against person-centered care and I also had to release more of my authority to the facility level.”

“We feel the need for culture change in our heart. However, unless we also believe in it with our head and form a plan to insure its progress, it will never become a reality.”
“Little things mean a lot to associates. It doesn’t take a lot of money to make them feel valued. The spoken thank you, the note of encouragement, or the public recognition at an All-Staff meeting are sometimes more important than a gift.”

“I find that culture change and its principles are becoming more and more a part of my thought process on an every day basis. I, like the other corporate team members, find that I consider each proposed policy, procedure, or other type of change much more closely, looking for a better or different way to accomplish the task from a culture change perspective.”

“I can’t believe we were bathing our residents in such a humiliating manner and never noticed.”

“Residents (human spirit) can be resilient and very accommodating.”

“Areas not even focused on in our Bathing project have come to light with staff seeking out ways to improve other areas of life here at the nursing center. It is amazing!”

“The more we involved our staff in planning for change and assessing residents, the more enthusiasm they showed, and the harder they worked to make the plan successful.”

Insights From Residents

“Finally, I feel like I am at home.” She stated, “it was such a good feeling to know that they had a say.”

*Thoughts from Residents who were involved in the hiring process:*

“This is our home. We should be the ones who are talking to new staff.”

“We have input into this place and this makes us feel more important.”

“When we hire them they remember us. We do their performance evaluations as well so they treat us better than before.”

“Before we had to take whoever they gave us and they didn’t stay as long. Now we have more say about who comes here.”

“There is more of a personal relationship now between the staff and the residents. It’s not so much like staff and then residents separated but now we are part of the same family.”

“They used to call us patients but we are not patients—we are residents. We feel more like people living at home now.”
Insights About The Pilot

“Being involved in the pilot helped us to make changes in the delivery of services to our residents and staff. By empowering and encouraging high involvement of residents and staff we have improved all of our lives in our home.”

“We began thinking we would work with the staff to help them change, but we were surprised to find that we were the ones that changed.”

“The staff has experienced wonderful and meaningful encounters with the residents. The residents are learning about the staff and the staff is learning about the residents.”

“This resident was a keep-to-herself type of person; and, since the inception of these enhancements, she has become more out-going.”

“We began to realize that you don’t need lots of money in your budget to accomplish person-centered care because culture change really begins in each of us as an individual.”

“They (the Oklahoma QIO) have visited our facilities, as well as our corporate office to help us assemble and evaluate our data. They listened and encouraged us when we felt like we couldn’t continue. They came with us to our meeting with the State Health Department to help us connect with our regulators as we began the journey. We have made more progress with the assistance of Oklahoma Foundation for Medical Quality (OFMQ) in this past year on achieving person-directed care than we did in the previous six years combined.”

“It has been very satisfying and we have learned a lot more about staff and residents.”

“The Executive Director encouraged the team to participate in the pilot project. She arranged for the speakers for the person-centered dementia care training and allocated resources, monies and personally attended the Learning Sessions and All-Staff In-Services.”

“The culture change project with Health Care Excel gave me great information – first, for myself, and secondly, as tools for education and follow through with the staff in our facilities. The open ‘give and take’ of each session encouraged sharing of ideas and culture change projects from other facilities located throughout our state. It was good to hear of the things that worked and the things that didn’t work.”

“I was surprised by the extent to which facilities went forward on their own with QI activities and implementing ideas from the QIO meetings.”

“We were amazed at how quickly some of these changes were able to take place.”

“They said it would take three to five years to implement culture change. That is not what happened in our case.”
Health Services Advisory Group, Inc.

By: Joe Bestic, NHA, BA, Clinical Quality Specialist

In Arizona, the Person Directed Care Pilot Collaborative experience was filled with many successes and lessons learned. At the onset of our state's pilot, Health Services Advisory Group learned that many nursing homes had misconceptions about culture change simply being physical plant transformation. Therefore, Person Directed Care Learning Sessions focused on the three domains of culture change (care practices, workplace practice, environment), which was helpful in building a foundation for the pilot and educating nursing homes about all aspects of culture change. The pilot participants learned that culture change could not exist without each of these important facets.

The Person Directed Care Pilot Learning Sessions also provided an opportunity for nursing home sharing. Via the use of storyboards, each pilot facility shared successes and challenges encountered during their person-directed care journey. These sharing sessions were effective in breaking down trust barriers between other pilot participants. As the level of sharing increased, so too did the pilot nursing homes' investment in one another as a trusted resource.

In addition, participants learned how laws and regulations support culture change. Participating nursing homes were taught that person-directed care could flourish under the current survey process in a variety of ways. The Centers for Medicaid and Medicare Services sponsored a culture change video that was very helpful in making Pilot participants feel that the Centers for Medicaid and Medicare Services and State Survey Agencies are fully supportive of person-directed care initiatives.

The Arizona Person Directed Care Pilot Collaborative was successful due to close collaboration and support from various Arizona stakeholders, including: the Arizona Department of Health Services, Arizona Homes and Housing for the Aging, the Arizona Health Care Association, and Covenant Health Network. Health Services Advisory Group learned that key stakeholder involvement is critical for person-directed care to be successful.
Beverly Healthcare - Murrysville

*By: Hope Rouda, Executive Director*

The most valuable lessons learned from this important project that were taken back to our facilities have focused on communication and staff input. Here are some examples of how communication and staff input have impacted staff retention in my facility and others recently:

One facility with high turnover among new hires (within the first 90 days) is improving their orientation and training programs with little impact initially. True improvement was seen after experienced, long-term nursing assistants expressed a willingness to take on bigger assignments for a period of time; while new hires were trained on a smaller assignment so that it would be less overwhelming and intimidating for the new staff. The idea met with resistance at times by some staff; but overall, was well received since the new hires have stayed on board and turnover has decreased. This change made work easier for all staff resulting in better staffing numbers; but more importantly, the staff feel they are able to provide better care to the residents.

Although we appreciate the hard work of the staff each day, we may not communicate it often enough. The “Beverly Bucks” program was initiated in various facilities to reward employees on a day-to-day basis for big and small things. They can earn enough “bucks” to purchase various items such as water bottles, denim shirts, car blankets, etc. Employees are also encouraged to recognize and thank each other this way. This encourages better team spirit and needs to be consistent and ongoing.

A few facilities are also focused on employee recognition. They are celebrating years of service in a bigger way with special catered breakfasts, picnics, and award ceremonies. As a company, Beverly Healthcare provided direction for each facility to make the celebrations more significant and memorable this year than ever before. The company wanted every employee to be more aware of what a tremendous strength it is to have people who have given so many years of dedicated service and how it impacts the quality of care given to the elders.

Overall, many facilities – mine included – have made more efforts to gain staff input and participation in day-to-day decision-making. We changed the name of our Recruitment and Retention team to the Morale Booster team and have seen increased participation in numbers as well as content. It is a small change and yet staff perceived it in a more real, concrete way that included them. We also started including staff on the interview process. For instance when we interviewed a nursing assistant last week, we included one of our experienced nursing assistants in that interview to get her perspective and allow her to ask questions that we might not think of. This change will screen our candidates better and show current staff that we appreciate their input and involvement.

As you can see, most of these changes are not expensive or difficult to do, but have more to do with a change in mindset and approach. Our challenge now is to see that mindset change filter down through the ranks and to remain strong and consistent rather than a passing phase. We will all benefit from the outcome, but our residents will benefit the most.
Lumetra

By: Irina Lewis, Quality Improvement Advisor

In California, 14 nursing facilities volunteered to participate in the 10-month long Person Directed Collaborative Pilot because of their high level of commitment to improving the quality of residents' lives. The pilot project followed the outline provided by Quality Partners of Rhode Island and engaged participants in three, one-day Learning Sessions, a Collaborative Congress, and homework activities in between sessions. The work included testing and implementing person-directed care change ideas, participating in conference calls, and scheduled site visits with Lumetra's quality improvement advisors.

Lumetra's nursing home team embarked on this project with a great deal of apprehension, recognizing significant gaps in knowledge of person-directed care concepts and a lack of understanding of existing models. Although we felt unprepared to assist facilities in their transformation journey, we relied heavily on materials and facilitation techniques provided at our training sessions with Quality Partners. The content was structured in a way that promoted sharing experiences among participants. We discovered that tapping into the participants' knowledge is a very effective strategy for conducting Culture Change workshops and learned that facilitating highly participatory sessions helps our audience build commitment to the ideas we attempt to impart.

Site visits became a key part of our strategy for assisting participants with engaging facility staff in their person-directed care transformation. During the collaborative, we learned, in many cases, that individuals who attended Learning Sessions were challenged by the task of communicating what they learned and did not initiate the spread of new ideas. For facilities that were just beginning the journey, site visits with Lumetra facilitators became the starting point for discussions of ideas related to adoption of Person Centered Care principles. Participants already on the journey expressed that site visits helped them overcome "frost" and provided new language and tools for continuing their transformation efforts.

Overall, participating in the pilot became very rewarding for everyone. As facilitators, we learned many new approaches and tools that can be applied in our future work. Particularly, we expect that creating and maintaining individual relationships with participants, facilitating sharing and learning with small groups of providers (neighborhoods), and approaching improving clinical indicators by first focusing on organizational culture and quality of leadership are ideas that will serve us well during our 8th Scope Of Work activities.
Florida Medical Quality Assurance, Inc.

By: Hope Caldwell, Consultant

Florida Medical Quality Assurance, Inc. would like to take this opportunity to thank all of the homes that participated in this study and continue to work on implementing culture change strategies in their homes. This pilot study was the beginning of culture change for many of the 14 homes we directly worked with in Florida and we are proud of their participation and commitment to change for all of their employees.

We are especially proud of two participants that were able to overcome state survey results, as well as extensive concerns from employee surveys, to continue working on retention strategies. One of these homes revised employee time off policies, which helped employees that had quit, due to the policy, return to their jobs and be part of the retention committee. We are also proud of participants that were able to “think outside of the box” and overcome their fears of empowering front-line workers to allow decisions to be made at the bedside. One home coordinated the participation of residents and staff in the selection of caregivers; they call it “care partners.”

We also learned from our participation in the study. We learned how to work with the provider more effectively by understanding the difference between sharing interview data and sharing clinical data. The homes in Florida agreed to have the Quality Improvement Organization interview their employees. Sharing the interview data was very different from sharing clinical data because of the emotional component, which makes it difficult for retention team members to hear and absorb. We also learned that specific employees of the home needed to be in the room when the interview data was shared so they could help the team understand employee perceptions. We found that the Activity Director was most helpful with this effort, followed by the Human Resources Director. It is not only important to share the data with the right people, it is also important to share the data in an understandable format, like bar graphs or Radar Charts. Once the data is reviewed, the retention team requires time to share the data with employees and get feedback; only then are they ready to plan.

The greatest enjoyment in our participation came not only from the homes’ successes, but also from being able to directly talk with employees and learn how they felt about their residents and their job. We learned that, no matter what brings a person into the nursing home for employment, their relationship with the resident is what makes them stay and that is why we all work in long-term-care.
Georgia Medical Care Foundation

By: Carolyn T. Roper, Nursing Home Consultant

Georgia Medical Care Foundation (GMCF) is a team of six people: one manager, one quality improvement / education specialist, two clinical consultants, one data analyst, and one communications expert. These six people have studied The Leadership Challenge by Kouzes and Posner and have made valuable changes from their lessons learned.

GMCF has realized how much they appreciate the principles of person-directed care that each team member holds deeply, and how much they appreciate those who work in the nursing home setting. These realizations lead GMCF to make a change in the way they work with their partners. Their main objective was to improve relationships with stakeholders who continue to support person-directed care throughout the state of Georgia. A few of the team’s accomplishments include: forming a Georgia Accord based on the success of the St. Louis Accord; team-members delivering three-hour presentations to the Georgia Long Term Care Nurses Association on person-directed care; sponsoring a speaker on work force retention for the Georgia Nursing Home Trade Association; and speaking to the College of Long Term Care Administrators on person-directed care. These achievements were possible due to fostering strong relationships with stakeholders and partners throughout the state.

It has been difficult to meet with all partners as much as GMCF would like, but overall the number of partner organizations with whom GMCF had personal contact with is increasing at a rate of one per week. Some key partners in helping GMCF with their goals include: Georgia Health Care Association, Georgia Agency of Homes and Services for Aging, State Survey Agency, Georgia Ombudsman’s Association, and DHR-Home and Community Based Services. The key to GMCF’s success has been to involve partners in a way that they too feel responsible for the success of the state and are willing to offer the necessary commitment to supporting culture change.
Illinois Foundation for Quality Healthcare

By: Lee Moriarty, Quality Improvement Coordinator

When we first heard about this pilot project on our SNF/QIO (Skilled Nursing Facilities and Quality Improvement Organizations) monthly phone call, we immediately responded that we wanted to be a part of this pilot via email even before the call was over with! The concept of Person Directed Care sounded interesting but we were not really quite sure what it was. We had already begun attending our State’s Pioneer Coalition Meeting and we had some ideas on what culture change meant, but this, “Person Directed Care” concept sounded intriguing.

As any good Quality Improvement Organization does, we began first by trying to gain further knowledge on the topic. We did Internet searches, spoke with the Pioneer Leaders in our State and began reading any article or book that we could on the topic. The more we read, the more we felt like this concept spoke to our souls. Two of us from the Illinois Foundation for Quality Health Care went to the National Pioneer Meeting last August in Kansas City to find out more. Our lives were changed forever. On the way home, we both realized that our whole attitude changed through the course of those two days. We would never approach anything in regards to long-term-care the same again. All this just made perfect sense--the elder, family and staff need to develop relationships with each other to improve the quality of life and quality of care in nursing homes!

As we began the collaborative, we found that relationship building was very easy with the homes that we were working with. The homes all had wonderful, caring staff that really wanted life to be better for their elders, but they just did not know how to get it happening. By teaching the Quality Improvement methodology that we advocate so strongly, we found that the missing link was found! After our eight homes really grabbed the concept (and were reminded quite a few times over our listserv to use small cycles of improvement by looking at one unit, one issue at a time), the energy started to kick-start the wonderful ideas that everyone had.

Through this process we realized that all nursing homes in Illinois (and for that matter, across the country) are full of staff that possess the same “hearts” as those in our collaborative, but we have stifled them with all this talk on regulations and process improvement. We now have changed our approach for facilitating change in Illinois to include the person-directed care thought process to everything that we do. We have come to define the “person” in the person-directed care as the elder, family and staff member. Relationships are the key and without those we will never have quality in our nursing facilities.

Thank you to everyone who participated in this study, for this life changing opportunity. Without the knowledge that was provided, both through the formal and informal training that we received, none of the wonderful things that have happened over the last year would have had the chance to happen!
Seven Michigan nursing homes joined MPRO to transform care practices and environmental conditions. Together we made a yearlong commitment to create a person-centered culture that would result in transformation of organizational values, structures and practices. MPRO and participating nursing homes used the expertise of BEAM, Bringing the Eden Alternative to the Midwest, to help guide us on our journey.

Participants learned together at full-day sessions, participated in conference calls, and implemented activities in their nursing homes. They also shared their experiences, lessons learned, questions, and concerns with each other, employing a true collaborative style of learning. After months of hard work, Michigan’s homes celebrated their Outcomes Congress in July 2005, with representation from each participating home in attendance.

Some of the successes shared by homes as a result of the project included:

- Implementing relationship building practices such as giving welcome packages containing information about staff to new residents, and providing resident biographies to staff.
- Innovations in improving meals for residents such as remodeling dining areas and practices to resemble a fine dining experience.
- Increasing the use of music and aromatherapy in the home resulting in decreased problem behaviors.
- Implementing permanent staffing models so workers and residents could increase personal relationships.
- Initiating 3-, 7-, and 14-day, and monthly calls to new residents’ families.
- Instituting a toll free number for family concerns.

The ultimate goal of this pilot was for the residents to achieve their highest possible physical, psychosocial, and spiritual potential. Early results included decreased staff turnover, improved resident and family satisfaction, census, and positive clinical outcomes. MPRO congratulates all of the nursing homes that participated in the pilot project.
Ohio KePRO

By: Nursing Home Team

“From the Quality Improvement Organization point of view, I would say that I enjoyed getting to know the staff members of the nursing homes we were working with in the pilot in the context of working together on practical applications of culture change to their homes. I was gratified to see the thirst for knowledge about culture change on the part of the participating nursing homes. Whatever changes they implemented as a result could not help but benefit their residents, and I was proud to have a small part in that process. I learned that culture change is a slow process, requiring lots of small steps, but also eminently possible for any nursing home.”

Miriam Rose, M.Ed., Senior Health Data Analyst

“I loved being able to share ideas on how to operationalize person-centered care with our participating homes; I also loved having the resources available to share with other homes across the state that are asking for information on this care philosophy. I have always believed in doing what is right for elders, so being in a position where I can share these ideas with nursing homes really excites me! I am most proud of our team at Ohio KePRO for wholeheartedly embracing the concepts of person-centered care. I learned about the value of vision and teamwork in accomplishing change.”

Leasa Novak, LPN, BA, Quality Improvement Project Leader

“Every meeting and every contact that I have had with nursing homes that participated in the culture change collaborative renewed my motivation for the work that we do as a QIO. Their passion for the work, their sometimes ‘-maverick’ approach to trying new things that will improve their residents’ quality of life (while at the same time, balancing the regulations and how they are staying within them), and the stories of processes, practices, and lives that were changed as a result continue to inspire me.”

Robin L. Reitzel, Marketing Intervention Specialist
“I loved sharing the HOPE that we are in a position to make life in a nursing home a wonderful experience. The potential is enormous! I loved talking about the different, easy ways to implement ideas that can shift the mindset of the staff, that do not cost any money, and that can be started right away. Seeing the acknowledgement and understanding come through the eyes of the administrator and smiles from the DON because “at last” we are doing what we have always wanted to do. The education of the different levels of staff members in a facility is exciting; they are so eager to hear more and learn how they can start to give alternatives to their residents.”

“My biggest learning experience was through the Pioneer Network. How down to earth they were in the approaches to culture change, how practical their tips were, and the volumes of support that they are in a position to offer. I learned that I can make an impact. I can start some changes. I can take hold of practices that are currently used in nursing homes and change them before I get there! I also learned a humble experience – as much as I had always prided myself on being an accomplished nurse and DON, I had not fully let go of the institutional style of managing resident care. I had thought I was so progressive, and in many ways I was. But after learning so much from collaborative work and Pioneer conferences, I realized how very much more there is to do.”

“I am most proud of my relationships with the nursing home staff. There is a bonding that is created when you go through the experience of culture change. One of the things that I felt was a very proud moment was when I entered one of the homes that had been in the RCC collaborative. The change in the atmosphere was so tangible and so different from when I had first been there almost two years before. A resident met me at the door and asked me if I wanted to buy any crafts. Her ‘street’ was going to have a cookout for their ‘care assistants’ and she and her ‘neighbors’ were helping to raise money for the food by selling crafts. At the same time, I heard laughing off in the distance; I noticed one of the residents delivering newspapers – knocking at each doorway and waiting to be given permission to enter. I saw a group of three or four residents conversing in the lounge area; and every resident and staff member that I saw was smiling. Overhead paging had vanished. It was a quiet, calm, but very warm feeling that took hold. I found myself smiling; and, I could not believe this was the same place that I had first seen. What a long way they came without one structural change! It was all the mindset of the staff and the residents that made the difference. I truly had been a part of a culture change in this home.”

Jennifer Brezinski, ADN, RNC, CLNC, Quality Improvement Project Leader
It’s All About Choice...

Staff know how to work hard & have fun too!

Great wall art!

Whole new world... Residents now have a new view of fun too!
It’s All About Choice...

Dignified Dining

“We must not, in trying to think about how we can make a big difference, ignore the small daily differences we can make which over time, add up to big differences that we often cannot foresee.”

~ Marian Wright Edelman

One ecstatic culinary team!

Better beverage selection...

...and dining options too!
It’s All About Choice...

Inviting areas outdoors and cozy spaces indoors for residents and their family and friends.
It’s All About Choice...

Residents enjoy their furry & feathered friends!
It's All About Choice...

Residents enjoy times of festive celebration & quiet reflection

Collage photos courtesy of Morristown Manor and The Cedars. Reprinted with permission.
Creating A HIGH-RETENTION CULTURE

In the next few years, we will see a tremendous push for organizational culture change—toward a person-centered care model. Clearly, the goal is to be much more deliberate about enhancing our elders’ quality of life.

Intuitively, we know that a byproduct of deep organizational culture change is greater staff satisfaction, resulting in lower turnover rates. This change is built on the intrinsic motivation of the caregivers themselves. Stability of staff allows leaders to build the knowledge and skills of the employees allowing for positive change to occur. However, to truly embrace culture change, leaders’ paradigms must shift to include person-centered care of each staff member, with the goal of enhancing the employees’ quality of work life.

In researching the literature to find the links between the quality of caregivers’ work life and the quality of the elders’ life in nursing homes, I have found some clear patterns. It is important to note that the nursing home as we know it today has been around for only 40 years. We lack a significant amount of empirical evidence about what makes those fragile ecosystems tick, from an organizational development perspective. But there is a growing body of research-based evidence showing that leaders of successful nursing homes engage in certain activities related to how they treat their staff that the leaders of unsuccessful nursing homes do not. As the research evidence grows, we will come to know these certain leadership activities to be universal truths—natural laws related to creating a culture of retention, and allowing for person-centered care.

This diagram represents the core components of a strategic framework for creating a high-retention culture. As you can see at the bottom of the model, everyone comes into our profession with some common shared values, such as compassion or a propensity to want to provide service or care. Many refer to their decision to enter our field as a “calling.”

Solid structures are built with a solid foundation. And here, that foundation is a commitment to create a quality of work life for the staff. The pillars reflect broad categories of leadership practices, identified by long-term care professionals and researchers, to have the most positive impact on the employees’ quality of work life in nursing homes.
Consider these pillars the eight areas of action in which you will get the greatest mileage for your efforts.

**Pillar #1: Recruitment**

We simply must do a better job of recruitment. Filling shifts and preventing short staffing has a profound impact on employees’ perception of their quality of work life. When staff are “working short” their stress levels go up, risk of accidents increases, errors occur, tasks such as bathing elders are not done, documentation is neglected and ultimately, elders suffer. We can teach our staff the skills necessary to complete the tasks, but we cannot teach or enforce compassion, friendliness and the work ethic necessary to be great caregivers. When we encounter individuals in the service or hospitality industries who demonstrate these competencies, we should encourage them to consider a career in long-term care.

Some of my best hiring decisions involved hiring individuals with no experience in long-term care. I found some of my most caring CNAs at Burger King. I recruited an energetic, enthusiastic individual from Jamba Juice who turned out to be one of the best recreation directors I ever had the privilege of working with. I found a very compassionate, dedicated person working at a day care center who, after some training, was an amazing ward clerk. Proactivity is the key. These people would have never applied without my encouragement.

The Paraprofessional Healthcare Institute offers a wealth of free resources on recruitment strategies for long-term care professionals. They advocate for the use of referral bonus programs as an effective method of bringing in applicants. In addition, they have found that applicants who are referred by current staff have lower turnover rates than those applicants who responded to the more common method of recruitment, newspaper advertising.

Selection is another very important piece of the puzzle. A key component of the interview and selection process is the all-important facility tour. During the tour we can gain tremendous insight into the personal characteristics of an individual. Make sure to take the applicant to visit with some of the elders and watch how they interact. In addition, pay attention to the friendliness factor, measured by how often the applicant smiles. Consider the “five smile rule.” Be wary if the applicant does not smile at least five times during the tour. After the tour, retrace your steps and ask every employee who saw you with the applicant if they know or have worked with the person. Solicit their input on whether or not they would be a good fit at your facility.

**Pillar #2: Leadership Development**

The best administrators look at themselves as works in progress. When leaders improve, organizations improve. Leaders improve only when they are exposed to new knowledge; when they can examine their own actions against new information to gain perspective on their own effectiveness.

The performance of department heads and charge nurses is the key to our success and to the quality of employee work life. In fact, front-line supervisors make or break our organizations. According to a massive study by Gallup, the employee-supervisor relationship determines 50 percent of the employee’s work-life satisfaction.

Important topics in which department heads need ongoing training include: coaching and counseling (not disciplinary action), conflict management, effective praise, interpreting data, critical thinking and conducting performance appraisals.

Every hour, employees are committing acts of compassion. If we let them know we notice, we will fuel their sense of self-esteem. In fact, nothing is more important to creating a culture of retention than doing rounds.

Unfortunately, we tend to violate some of the basic rules of human resource practice, leading to a lack of staff and, thus, poor clinical care. Clearly, if supervisory behavior is one of the primary reasons people leave long-term care, it must be turned around to become one of the primary reasons people stay.

**Pillar #3: Communication**

Successful leaders in our profession make an extraordinary effort to communicate their vision, values and organizational missions at every opportunity. Be specific when talking about the organization’s values, because in order to achieve your mission, all staff need to understand what your values look, feel and sound like in action. Storytelling is an effective way to communicate your mission and values in action. Stories help to create a picture and an emotional connection for the staff.

Nursing is intrinsically meaningful in terms of its effect on the lives of people. However, it is up to leaders to sincerely and consistently remind staff that their contributions are important and are much more than simply tasks to be performed and documented.

Successful leaders also understand that staff is looking to them to demonstrate their commitment to their words through
action. Leadership presence and visibility on the units and in resident rooms, modeling excellent communication and elder relations, is the key. Every hour, employees are committing acts of compassion. If we let them know we notice, we will fuel their sense of self-esteem. In fact, nothing is more important to creating a culture of retention than doing rounds.

**Pillar #4: Recognition**

Most leaders simply do not do enough to reward and recognize their staff. Recognition is about noticing and acknowledging good results and reinforcing positive performance. Caregivers have a fundamental need to have their efforts on behalf of elders acknowledged and appreciated by their supervisors. Almost 70 percent of the 1.7 million elders in our nation’s nursing homes have some level of cognitive impairment. Thus, caregivers rarely hear from the elders themselves if they are pleased with the care they are receiving. Unfortunately, in some cases, the caregivers are cursed, or worse, physically assaulted by the elders. It is up to the supervisors to fill the void and consistently acknowledge the compassionate care being provided.

When we catch and praise staff members for making an extra effort, working on their day off or simply lending a helping hand to a co-worker, we triple the likelihood that the person will go above and beyond the call of duty again. I do not believe that there are many toxic, mean-spirited leaders working in long-term care. But there are plenty who unknowingly ignore the vast majority of their staff. Recognizing and rewarding good performance takes time and costs money, but not nearly as much time and money as turnover, or worse, a lawsuit that resulted from an incident that occurred when a facility was working short-staffed. A careful review of the literature, recently published by Better Jobs Better Care, places the average cost valuable and important. They come to work because they know they make a difference.

In my work with homes that have adopted the Wellspring Model, I have noticed the high self-esteem among frontline caregivers. Fundamental to the Wellspring Model is the managers’ belief that the best decisions about how care should be given are made by the elders first and the frontline caregivers second—those who know the residents best. Under the Wellspring Model, they empower staff through extensive education, shared decision-making and enhancing their critical thinking skills. In addition, a fundamental component of Wellspring—and the Eden Alternative™—is that facility leadership must commit to primarily assigning staff to the same group of elders every time they come to work.

Unfortunately, primary assignments are not widely used in long-term care. Most providers continue to rotate staff from one group of elders to the next on a monthly basis. However, we cannot deliver person-centered care without primary assignments. Primary assignments empower staff because they allow a relationship to form between caregivers and elders. Studies have repeatedly confirmed that consumers’ perception of the quality of their care is deeply rooted in the quality of their relationship with their caregivers. They value these relationships higher than medical care and the quality of the food.

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Pillar #6: Education

Organizational performance is based on people and only improves when people improve. The majority of facilities are not true learning organizations. In fact, many homes merely follow their state laws related to in-service training. This is not adequate in today’s environment.

The state quality improvement organizations (QIOs) offered high-quality education to skilled nursing facilities nationwide in 2003 and 2004 with great results. Funded by the Centers for Medicare and Medicaid Services (CMS), QIOs are gearing up to offer more education sessions beginning in August 2005, and they will broaden their focus beyond clinical topics to include training on culture change toward a person-centered care model. In addition, the experts on culture change at the Pioneer Network will be offering regional conferences throughout 2005.

When conducting staff training, make sure to incorporate the basic principles of adult education by using real-world case studies, discussions, practice sessions and return demonstrations. Education must be interactive and fun to be effective. In addition, we may need to translate materials into other languages. I have found that the best-performing facilities are not hung up on English-only rules in the classroom.

Obviously, performance improves only if people adopt and implement what they learn in everyday practices. Therefore, department heads and “clinical champions” must be assigned to go out on the floors and help people use the skills and knowledge shared during training sessions. A nursing home rich with opportunities to acquire new knowledge and skills fosters high performance, builds self-esteem and lowers turnover.

Pillar #7: Measurement

According to a study led by Dr. Vivian Telis-Nayak, highlighted in the book, Customer Satisfaction in Long-Term Care: A Guide to Assessing Quality, staff satisfaction is a key performance indicator with a strong correlation with other performance measures that we routinely track. Tellis-Nayak found that staff satisfaction influences survey results, occupancy rates, family satisfaction and, of course, turnover.

Staff satisfaction is not routinely measured in long-term care. In fact, leaders in our profession do a lot of guessing when it comes to staff morale. According to a recent study of homes in California, led by Dr. Robyn Stone of AAHSA’s Institute for the Future of Aging Services in conjunction with the California Association of Homes and Services for the Aging, fewer than half of the facilities used staff satisfaction surveys, and, remarkably, only 60 percent measured turnover.

We must do a better job of measuring the quality of work life of staff and treating that data as importantly as we do our clinical outcome data. After all, quality of work life indicators are the process measures to the clinical outcomes.

I suggest that leaders also track their number of shifts worked short on a daily basis. This is an important measure of your exposure to risk.

Pillar #8: Process Improvement

Process improvement is not a program. It is a continuous, never-ending business strategy focused on continuously collecting data, looking for opportunities to improve processes within systems in order to improve quality outcomes and quality of life. Generally, staff are miserable working within broken systems. However, if employees are given the opportunity and a forum, they will amaze us with their creativity in solving broken systems.

Pillar seven is collecting data on the quality of work life of staff. Under pillar eight, we must apply the same process improvement approach to this information as we do to clinical data. Recruit a multidisciplinary team to address the employee satisfaction surveys. Let them analyze the results to critically think through why staff responded to certain questions in a negative manner. Let this team develop the action plan, implement the plan and study the results.

“Striking at the Root”

Clearly, recruitment and retention of caregivers is a complex problem that requires multifaceted solutions. However, it must become a top priority. It was Henry David Thoreau who said, “For every thousand hacking at the leaves of evil there is only one striking at the root.” The root cause of many of the challenges we face in long-term care stems from our lack of focus on our most important asset—the living angels we call our staff.

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Resources


The Pioneer Network, Rochester, N.Y. www.pionernet.org
TEAMWORK Achieves Lower Pressure Ulcer, Pain Levels

New Processes Target Indicators

Marla Fern Gold and Jan Shuxteau

Canadace Litwin remembers one patient clearly.

“She was unhappy with everything. She complained about the food. She complained about the sun going up. She complained about the sun going down. It was too hot, too cold; you name it, she complained about it,” says Litwin, director of nursing (DON) at Magnolia Manor, in Spartanburg, S.C.

The patient became so difficult to deal with, she says, that a physician finally prescribed psychotropic medication so that staff could provide treatment.

The Multifacility Collaborative

As it turns out, the patient did not need behavior medication. What she did need was a thorough pain assessment and appropriate pain treatment. The facility found this out through its participation in the Centers for Medicare & Medicaid Services’ (CMS) quality improvement organization (QIO) pain collaborative, a groundbreaking public-private partnership between CMS and several...
of the nation’s largest nursing facility providers, including Sparks, Md.-based THI, owner of Magnolia Manor.

Through the pain project, the facility began focusing on detecting and treating pain more aggressively. This patient began receiving aromatherapy and touch therapy, as well as over-the-counter pain medication. “We started with aromatherapy at night, thinking that maybe if she slept better, it might help her mood. Once we started touch therapy, her mood became 100 percent better. She rarely complains about anything [now], and she’s off all behavior medications,” says Litwin. The facility had always prided itself on treating pain, but what staff learned through the pain collaborative has taken the facility much further toward eliminating pain and improving quality of life in all areas for its patients.

**Partnerships Show Improvement**
The pain collaborative was one of several national CMS-nursing facility partnerships that grew out of the Nursing Home Quality Initiative (NHQI), a 2002 federal program, supported by the American Health Care Association (AHCA), that targets improvements in quality of care and service to long term care patients.

According to Sandra Fitzler, AHCA senior director of clinical services, the NHQI required the development of measurements of quality indicators (QIs) for public reporting, as well as mandatory public reporting. The project also initiated QIO-nursing facility partnerships to target specific QIs and develop tools to measure, improve, and evaluate progress using the tenets of continuous quality improvement (CQI) as the foundation for change.

Quality Partners of Rhode Island, which oversees all nursing facility-QIO partnerships, was the lead QIO for the corporate pain collaborative, a partnership that yielded more than a 45 percent improvement in pain management at the conclusion of the two-year project. The use of a standardized pain scale to help patients convey their level of pain improved dramatically, from 41 percent to 74 percent of the 163 participating facilities, according to Laura Palmer, project director with the Colorado Foundation for Medical Care, the other QIO involved in the pain collaborative. In addition, she says, notification of pain to physicians improved by 20 percent, while the addition of non-drug therapy to plans of care increased by 23 percent.

In almost all of the QIO partnerships, QIs improved dramatically, according to participants. For instance, in another CMS-nursing facility partnership, a group of 68 nursing facilities in Minnesota showed a 45 percent improvement in detection and management of chronic pain, and almost 20 percent improvement in post-acute pain management. A QIO project focusing on restraints showed a 33 percent reduction in their use, compared with a 23 percent decrease nationally in the use of restraints. Other QIO projects targeted pressure ulcers.

While the huge drop in QI percentages is laudable on its own, the peripheral benefits of the project are having even greater ripples. “We started this to address pain, but it could have been about anything,” says Mary Wescue, Maine and New Hampshire district director of clinical operations with Louisville, Ky.-based Kindred Healthcare. She says the processes learned to identify, treat, and evaluate pain treatment can be applied to any QI or work process.

And in many cases, they already have.

**One Facility’s Experience**
Affixed to the wall in every resident
room at the Voorhees Center, in Voorhees, N.J., is a poster with a “thumbs up” symbol and a “thumbs down” symbol. In addition, each poster contains simple pictures of faces: smiling, frowning, grimacing, and crying. Developed as part of its QIO “homework,” this simple tool has been instrumental in helping facility staff effectively treat patient pain, according to Alina Torregosa, DON at the 190-bed facility, owned by Genesis Healthcare, Kennett Square, Pa.

“Every worker in the facility, including maintenance and housekeeping, has been trained to look at these symptoms,” she says. It’s easy to use, requires little explanation, and reminds all staff to constantly be on the lookout for signs of pain.

Before the facility became part of the pain collaborative, its chronic pain QI score was 14. At the last quarterly report, the score was 1. “What the collaborative brought us is a focus on pain and doing more on the preventive side,” says Torregosa. “Before, we were more reactive. Now, we’re proactive. We do something before the pain comes in, assess for pain, and determine what measures are necessary.”

In each of the QIO partnerships, continuous review of data was the first step toward change.

The Paper Trail

Brentwood Rehab Center, a Kindred facility in Yarmouth, Maine, that participated in the pain collaborative, initially conducted a pain audit using the minimum data set (MDS) pain questions. “The building thought they were doing a great job of managing pain, but found that 66 percent of their patients had moderate pain daily,” says Westue. That data review was the impetus for change for the facility, she says. “When the data was in their face, they could not look the other way.”

At Parkview Care Center, in Wells, Minn., the focus on data has improved documentation, according to Jean Steinhauer, DON. “As part of weekly summary charting, we are looking at pain flowsheets at least once a week to see if we’re improving pain or if we need to improve or change or increase pain medication and other interventions,” she says.

In addition, the facility has improved the pain flowsheet to measure pain prior to and after administering pain medication, as well as regular audits to ensure that the facility is meeting pain management criteria.

At Bethany Good Samaritan Village, in Brainerd, Minn., the facility began reviewing monthly census reports showing which patients were triggering for pain and which patients were consistently being treated for pain. “We realized that if patients are triggering ‘yes’ on both, they needed to be on chronic pain management,” says Kelly Peterson, assistant DON. “We needed to throw away concerns about dependence or the idea that patients need to tell us if they are in pain. If a person’s acting differently—not eating well, grimacing, shouting when we reposition them—they are probably communicating that they are in pain.”

The new focus on data collection
and review recently identified a jump in the facility’s chronic pain scores. As a result, Peterson says, “We’re going to take a look at that. Until now, we had consistently dropped in the percent of residents who had experienced chronic pain. Right now, we are trying to figure out why we crept up and what we need to do about it. Is it staffing-related, education?” says Peterson, who is also the facility’s quality improvement coordinator.

**Information Exchange**

The power of the partnerships is also evident in the exchange of expertise that happens on a regular basis. Hudson Memorial in El Dorado, Ark., credits the Arkansas Medical Foundation, the state’s QIO, with helping staff to reduce restraints among its 108 residents. “We’ve dropped from 18 percent to 3.7 percent in the 18 months that we’ve been working with our QIO,” says Teresa McInvale, assistant DON.

“The foundation sends someone every four months to check on what we’re doing and give us help and training. This person is good at coming up with alternatives that we haven’t thought of. One of our patients continually tried to push his fists down his throat, so we put him in wrist restraints. We tried everything we could think of to lessen his restraints. It was a lady from our QIO who came up with the plan to put his hands in children’s boxing gloves. It’s been a great idea. The gloves don’t restrict his movement, but they are padded and won’t allow him to choke himself.”

Teamwork among the QIO and staff from every department accounts for much of Hudson’s success in reducing restraints and in meeting other goals, such as the reduction of pressure ulcers, according to McInvale. “We have a restraint team, called the Liberty Bells, that meets monthly to discuss each patient and look at ways to reduce down to the least restrictive restraints. We get advice from the QIO and a lot of encouragement. They’ll say, ‘Try it. It’ll work,’” says McInvale.

Qualis Health, the Seattle-based QIO for Washington, was instrumental in providing the tools and training that allowed Pinewood Terrace Nursing Center of Colville, Wash., to reduce the percentage of long term care patients in pain from 15 to zero.

“In 2003, 15 out of our 89 residents—17 percent—were assessed with moderate to severe pain. That was something we needed to change,” says Pinewood Administrator Gail McDowell. “Our first task was educating our own staff to eliminate judgmental attitudes about pain and pain medication. Some medical professionals still believe that patients who report pain and ask for medication are just complainers. But the truth is that people heal faster if they are without pain. They participate more readily in therapy, move more freely, and do the things that help them heal faster.”

Westue, of Kindred, also found that myths about pain medication had hindered facilities from aggressively treating pain. “Many nurses still believe, ‘The resident can’t have pain because I just medicated them. They just want attention.’” The QIOs in her collaborative—Colorado and Rhode Island—had a hospice nurse speak to facility nurses about pain. “It was very eye-opening. Two of our nurses went right to the facility after the meeting and started assessing patients,” she says.

To combat persistent pain, the facility turned to scheduled pain medication administration. “The results were unbelievable. People were sleeping through the night, even on the Alzheimer’s unit; behaviors decreased; resident-on-resident altercations
She pointed out that patients are more likely to get hurt when they try to get out of railed beds on their own.

decreased. That was very noticeable within two weeks," says Westue. An unintended side effect was that since patients were sleeping so much better at night, they were awake more during the day. “We realized we needed a whole new set of activities,” Westue says.

Out-Of-The-Box Thinking
Another CQI tactic that QIO consultants focused on was thinking beyond conventional wisdom, trying new approaches until finding ones that worked. That’s what Pinewood did to lower restraint use.

“Our biggest success story of restraint reduction is the elimination of siderails on patients’ beds,” says McDowell. “A Qualis speaker told us that she had done away with siderails at the facility she administered. She pointed out that patients are more likely to get hurt when they try to get out of railed beds on their own. They don’t want to buzz and wait for a nurse, so they crawl out the end of the bed or try to slide through the rails.”

Pinewood replaced all railed beds with new low beds. They put thick, soft mats next to the beds of patients at risk for falling out. And they talked to patients and their families about why the change was being made. “At first there was some concern, but now they see how well this works. Our patients are much happier,” says McDowell.

Tackling Pressure Ulcers
In Fredericksburg, Texas, Barbara Radke, administrator of Windcrest Nursing & Rehab Center, received advice and encouragement about reducing pressure ulcers from her state QIO, Texas Medical Foundation (TMF). The Texas organization provided hands-on assistance through educational training, data sharing, on-site consultation assistance, and publications. The result was a statistically significant drop in the number of pressure ulcer cases—from 10.4 percent to 7.8 percent—over the past 18 months in targeted facilities.

At Windcrest, TMF’s efforts resulted in facility and methodology changes. “After beginning work with TMF, one of the first things we did was to review our protocols for pressure ulcers,” says Radke. “We changed all our mattresses to pressure mattresses and instituted hydration processes.” Staff members then attended training with a supplier to ensure that all staff knew the proper way to use the equipment.

Windcrest now conducts weekly skin meetings, checking variables that could cause problems. “We try to get a total picture. Diet is a big part of the protocol for skin issues. If someone is underweight, we know they may be at risk for skin problems. We may modify their diet and add supplements,” says Radke. “We look at everything: reliance on restraints, wheelchair padding, the length of the patient’s fingernails—whatever could cause a wound. The main thing is to look at many factors.”

A New Look At Pain Medication
Another area where conventional wisdom was turned on its ear was in the area of pain medication administration. In fact, most facilities involved in the QIO pain projects report that their use of scheduled Tylenol has increased dramatically, while orders for PRN (as needed) pain medication are dropping.

The evidence supports the wisdom of the change, according to providers. Following scheduled use of Tylenol, most facilities report that the incidence of pain or noncompliance with treatment has dropped precipitously.

Stratus (Minnesota’s QIO) consultants helped staff at Parkview Care Center change their views about PRN pain medication. “Before the initiative, if we just had PRN in the chart, sometimes the patient would be overlooked for signs of pain,” says Steinhuwer. “As part of the project, we looked to get more scheduled doses as well as educated nurses to understand that to manage pain, patients needed treatment before they had pain. We continue to remind staff that it takes the medication longer to work if a patient already has pain.”

Now, when a new patient comes to the facility, the staff will evaluate whether to change PRN orders prior to admission.

At Bethany, PRN orders were changed to scheduled doses as well. Says Peterson, “We started giving a lot of Tylenol in the morning before people got up, to prevent pain. Right away, we started seeing a huge change in quality measures in pain management.”

At Arlington Good Samaritan Center, in Arlington, Minn., patients identified with pain are given Tylenol routinely prior to physical or occupational therapy, with similar results, according to Carol Maier, DON.

Working with Stratus, Arlington cross-checked information on the MDS, reviewing patients who were resistant to care and patients who triggered for pain, to make sure that resistance to care was not being triggered by pain. At first, she says, these audits would find a handful of pa-
tients that triggered. Now, they rarely do, which tells the facility that they are treating pain earlier.

As a result of the project, Arlington looks at pain as a “fifth vital sign.” Now, anytime we are taking vital signs, we also question the patient about pain and look for signs in our nonverbal patients,” says Mader.

**Changing People’s Perspectives**
A stumbling block for Mader and other providers has been to persuade physicians to change PRN orders to scheduled doses of pain medication. Says Torregosa, “Some doctors still won’t put people on scheduled pain medication, so we’re fighting with them. Some still look at pain medication as only when necessary, not as a standard treatment, and we’re trying to change that.”

McDowell is not afraid to champion this new approach, even if it means going toe to toe with other professionals. “We admitted a very old lady with dementia after she had her leg amputated above the knee. Her doctor had prescribed only a very mild pain medication to be administered every six hours,” says McDowell. “Because of our QIO education, we knew that the medication was not strong enough for post-surgical pain and was only good for four hours.

“We became advocates for this patient, urging her doctor to change the medication. At first he refused because the patient hadn’t complained. Well, the truth was that she was incapable of complaining. Our DON stepped in on behalf of the patient and convinced the doctor to reconsider.

“Our QIO training gave us confidence that we knew what we were doing, and we didn’t hesitate to stand up for our patient,” says McDowell.

**Pressure Ulcer Prevention**
“If you have pressure ulcers, you have no quality of life. All you can do is lie there without moving,” said an elderly, bedridden lady, the subject of a video about the 18-month collaborative to reduce pressure ulcers between Parkview Nursing and Rehabilitation Center in Wilmington, Del., and Quality Insights of Delaware, the state’s QIO.

“This lady’s story brought us all to tears,” says Parkview Nursing DON Lorraine Foster, who recently showed the video at a QIO learning session in Dallas. The resident came to Parkview Nursing after surgery on a Stage IV pressure ulcer. She also had a bad heart condition, and she was immobile. In the film, she tells about having to lay her dish on her abdomen to feed herself lying down.

But this story ended well. Trained and assisted by Quality Insights, Parkview nursing staff teamed up to heal the wound. “All of our wound care interventions are interdisciplinary,” explains Foster. “They may involve dietary to make sure a patient gets food he or she likes, dieticians to recommend health supplements, rehabilitation to help a patient with positioning and mobility, the activities department to stimulate interest, and housekeeping to make sure everything is clean.

“In this case, we put every discipline in place. As the patient improved, her quality of life improved. She became interested in our bell choir and played bingo. With the help of our activities department, she wrote a life journal that her family treasures. Her son speaks movingly on the film about how happy his mother became.”
All staff have been taught to watch for signs of Stage I pressure ulcers, when the skin is just red, but unbroken.

The effort toward reduction starts upon admission to our facility,” says Michael Royette, DON. “We do a full body assessment. Areas of concern are identified, and we begin preventive measures, including putting pressure-relieving mattresses on all the beds. The QIO helped us develop processes to identify problem areas and to formulate solutions.”

Value Of Staff Empowerment
Empowering all staff—not just the nursing department—to play an active role in the patient’s care is a basic building block of CQI, and one that is instrumental for change, say providers.

At Hudson Memorial, the housekeeping department and certified nurse assistants (CNAs) are key team members. “They are the ones who see patients most often because they are in and out of the rooms. They notice day-to-day changes and hear a lot of patient complaints,” says Debbie King, DON at Hudson Memorial, El Dorado, Ark. “Based on everything the team knows, we consider the needs of each individual. Should we increase nutritional supplements for someone, provide a special bed, or change their medication? We put in writing how to address each patient’s needs.”

Pain management also takes the efforts of the entire staff, says Torregosa. “A lot of elderly residents think that if they complain, then they are in the neck,” she says. As a result, the Coloradoan and Rhode Island QIOs encouraged staff at Voorhess—especially housekeepers and hairdressers—to look for signs of pain and to report possible pain directly to nurses. “We’ve seen where the patient will tell the nurse they feel good, then go to hairdressing and tell the hairdresser that their arthritis is bothering them and that they cannot sleep because of the pain. Now, the hairdresser will contact the nurses and let them know.”

Similarly, staff at Parkview Care Center in Minnesota use the FLACC scale (face, legs, activity, crying, con-
solability) for nonverbal patients. The scale follows a simple rubric for assessing pain, which any staff member—from CNAs to maintenance—can administer. Beyond that, ongoing training encourages all staff to immediately report signs of pain to nurses.

**Searching For Behavioral Clues**
In many cases, staff learned through their QIO partnerships that many unwanted behaviors are the result of underlying issues that patients cannot express. For instance, wanderers may be searching for something, while patients who strike or yell at caregivers may be in pain. “I knew from previous experience that a lot of residents are treated for behavior when they should really be treated for pain,” says Peterson of Bethany Good Samaritan. “We begin to think of the person as physically or verbally aggressive, but truly, they have pain that won’t go away, and they cannot communicate this to us.”

To determine whether patients on antipsychotic medications were actually in pain, Peterson relied on techniques taught at QIO training—reviewing loads of data, including identifying which patients were being treated with psychotropic medications and how many of these patients were also on pain medications. What the facility found was that many more people were on psychotropic medications than on painkillers. “So we asked ourselves, ‘Did these people get assessed really well?’”

Part of that, Peterson says, was to look at each patient’s history. “Did they have a back injury years ago, and before they were admitted, were they treated for back pain? If so, that pain does not go away because they’ve been admitted with a hip fracture or dementia or breast cancer.”

“We ran queries off the MDS to tell us, by station, which patients have pain and compared those results with patients on psychotropic medications.” At Dover Rehab, in Dover, N.H., all patients on antipsychotic medications were assessed. For two months running, no targeted behaviors were triggered, so staff discontinued these medications. As a result, 46 percent of antipsychotic drug use at the facility was discontinued, according to Wester.

At Dover and other facilities, many of the patients taken off antipsychotic drugs were later prescribed antidepressants along with pain medication.

The focus on identifying and treating pain before it becomes severe has had dramatic effects, according to McDowell. “We admitted a patient with chronic rheumatoid arthritis who had fallen and broken a shoulder. She was on routine medicine for arthritis...”

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but because of our new emphasis on pain treatment and our assessment of her condition, we concluded that her regular dosage should be increased to reduce the acute pain in her broken shoulder. I'm convinced that she healed faster and was able to return home more quickly because of the approach we took," says McDowell. At Las Palmas Healthcare Center, in McAllen, Texas, the use of restraints has gone from 20.6 percent to zero since working with the state's QIO. Says Administrator David Williams, "When we removed restraints, the biggest thing we had to conquer—especially with patients who have Alzheimer's or dementia—was our own sense of insecurity. We knew Alzheimer's patients tend to wander, and we thought they needed someone with them 24 hours a day. But we found out that many will simply wander in the building, staying in a general area with no real problems. And by getting rid of restraints, we are allowing these patients their rights and their freedom." In his case, Williams found that the staff did not even need to search for clues to patients' wandering behaviors; simply removing the restraints and providing safe wandering paths was enough. To prevent nonambulatory patients from getting hurt, Las Palmas places body alarms on patients who are likely to forget that they are unable to stand. "If patients who can no longer walk do try to stand, we are alerted by their alarms before they complete the process. We're right there; we can stop them," says Williams.

The Next Step: Culture And Staffing
In August, CMS and the QIOs are poised to select another 15 percent of the nation's nursing facilities to implement best practices on two new topics: culture change and staff retention. These efforts, which will again include individual nursing facilities as well as corporate providers, will start with the same building blocks as the last set of endeavors. First, leaders will be trained to audit their facility's processes and procedures and evaluate current data. In an ongoing pilot project with eight corporate providers, Quality Partners of Rhode Island has had corporate leaders question frontline caregivers about working short-staffed and the impact it has on the staff-resident relationship. "There have been some real 'ah-ha' moments," says David Farrell, project manager. "They've gone in and questioned CNAs, asking them, 'What's it like
when you’re fully staffed?” One CNA said, ‘When you’re fully staffed, you can give [a patient] a backrub, talk to them, make them more comfortable. You can take the time to be more human.’ That’s a really interesting quote,” says Farrell, “because what it does not say is that when the facility is understaffed, staff have to shut down a piece of their hearts.”

Applying Lessons Learned
For many of the facilities that participated in the last round of QIO training, the work has just begun as well. At Bethany, the CQI tools learned during its partnership with Stratus are now being used to target nutrition and weight loss. After reviewing data on weight loss in one area of the building, Peterson’s team determined that more residents needed help eating. “It took a lot of time to figure out what the problem was. We looked at a lot of data.” As a result of the investigation, the facility added lots of ancillary staff to the feeding program, and the numbers have begun to improve.

Arlington has moved on to pressure ulcer prevention, starting with a knowledge audit of nurses and CNAs. Mader says the audit included questions about identifying the first sign of a pressure ulcer, use of equipment to treat skin breakdown, and the treatments staff could initiate without doctors’ orders.

Next, the facility is cycling education in the area of urinary tract infections and antibiotic use.

Apart from the Stratus partnership, Arlington embarked on a five-meal-a-day plan to promote hydration and weight retention while cutting back on the facility’s reliance on supplements.

At the start of the program, 22 patients received supplemental nutrition. Staff took almost every patient off supplements and began to monitor weights closely. “In the first four months, we only had to resume supplement use to five or six patients,” says Mader.

While facilities across the nation report success in their efforts to improve QI percentages through their work with QIos, the battle to continuously improve quality of life goes on.

“The main thing I took away from the pain collaborative,” sums up Paul Owen, a restorative touch therapist with Magnolia Manor, “is that my job, and everyone else’s job, is going to be easier if everyone isn’t in pain. It’s a quality of life issue for everyone.”

Marla Fern Gold, Annandale, Va., and Jan Shuter, Hendersonville, Tenn., are freelance writers.
New Strategies For Enhancing Employee Growth

Lynn Wagner

Evolving ‘culture’ boosts empowerment, professional development, and retention and puts educational opportunities in easier reach.

Steve Shields doesn’t use the everyday language of long-term care. Words like staffing, beds, working the floor, even the term nursing home, “takes the person out of the language,” he says.

At Meadowlark Hills, a continuing care retirement community (CCRC) in Manhattan, Kan., reformed language is part of a deeply transformed culture, where the focus is on restoring the person to the center of community life. Staffing, for example, has been redefined as “how we organize ourselves around elders living the lives they would like to live and becoming the people they want to be,” says Shields, chief executive officer (CEO). The term “nursing home” isn’t used because it refers to a place “where people go to be nursed by nurses,” Shields says. At Meadowlark, the preferred term is “healthcare households,” where 305 of its 350 residents live.
“A healthcare household is where you go to continue living” and receive a range of services, including nursing, Shields says.

**A Positive Impact On Staff**

While workforce stabilization was not the sole, or even the central, objective of Meadowlark's foray into culture change back in 1997, it has been one of its significant—and early—outcomes. In the first year, staff turnover plummeted from about 80 percent to 30 percent and has held in that range ever since. Over time, however, the impetus for staff departures has shifted. In the first year, turnover was largely due to the consolidation of dietary and housekeeper aides, a move that created temporary turmoil, says Shields. Now, staff are more likely to leave for educational pursuits. Last year, a record number of employees returned to college for degrees in nursing, therapy, and other related fields, Shields says.

Founded in 1979, Meadowlark has become a national and international model for culture change. With visitors from 42 states and 14 countries, the CCRC has had to create a “tour coordinator” position.

Meadowlark residents live under a single roof, but the community is divided into distinct houses, each with a porch light, mailbox, front door, doorbell, and foyer. Staff work in self-led teams assigned full-time to each household. Teams
are responsible for their own scheduling, hiring, and firing, and individual members are empowered to make decisions that facilitate residents’ choices. Most teams are led by certified nurse assistants (CNAs), and it’s not unusual to find a registered nurse (RN) running a vacuum, or a licensed practical nurse (LPN) making an oncall. Shields says. The goal is “rampant normacy,” he adds.

“We all know who to turn to for disciplinary specialization,” but most daily activities revolve around ordinary life, says Shields, who is also a board member of the Pioneer Network, a grass-roots organization in Rochester, N.Y., dedicated to transforming the culture of aging in America.

Titles aren’t used much, if at all. Even the CEO hesitates when asked for his own title. “I’m not called that very often,” he says.

While few facilities have achieved Meadowlark’s level of transformation, or attracted such attention, a growing number of long term care providers are widening their lens to focus more broadly on the workforce shortage by redesigning their operations and creating an environment in which staff and residents feel valued, fulfilled, and have opportunities to enhance their potential.

**Education As Recruiting Tool**

Like Meadowlark, some facilities are pursing culture change initiatives with an agenda and underlying philosophy that goes well beyond targeted reductions in turnover and vacancy rates.

Other providers are focusing on education, growing their workforce through intensive professional development and a new generation of educational programs designed to meet the needs of long term care staff returning to school. Providers in a few key states are forming partnerships with state agencies, other providers, and community colleges to build curriculum and fund higher education programs for long term care staff. “We have created a culture of education,” says Katherine Lemay, administrator of the Notre Dame educational center in Worcester, Mass.

Notre Dame, a 123-bed nursing facility, is one of 10 members of the Intercare Alliance, a local coalition of nursing facilities that have partnered with Quinsigamond Community College to purchase and design an LPN program exclusively for their own staff. So far, the program has graduated 18 LPNs, another 24 have begun training, and a third group is preparing for prerequisite courses.

The facility’s educational center, headquartered in a previously unused area of an assisted living building, is a central teaching and study site for alliance students. The center hosts career ladder training for CNAs, English as a second language classes, and prerequisite coursework for prospective LPN students. The center has three classrooms, a reading area, conference room, and a computer lab with 10 donated computers.

Alliance members fully fund tuition and materials costs for students and must agree to send at least one student through each of the 10-month LPN programs.

To ensure that students devote sufficient time to the program, they are not allowed to work more than an average
of 20 hours a week throughout the school year, says Karen Langenelli, administrator of Holy Trinity Nursing and Rehabilitation Center, another alliance member. Facilities continue to pay their employee benefits, and the college provides a dedicated advisor who offers crisis and career counseling to help students manage the "competing demands of work, family, and school," Langenelli says.

Between the college and individual facilities, "we do a tremendous amount of hand-holding and support," Lemay says.

Students have a strong incentive to complete the training: a 50 percent salary hike, or roughly a $10,000 a year raise, when they advance from CNA to LPN. In exchange, graduates agree to stay with their employer for two years.

Investment in the program has been a win-win for students and their sponsors, Lemay says. "It makes good business sense because we would rather invest resources to help staff become nurses than pay agency, overtime, and turnover costs, she says. In addition to long-term savings, the educational effort has closed a yawning workforce gap.

"We now have virtually no difficulty recruiting CNAs or nurses simply because of word of mouth," Lemay says. "Our employees recognize that we offer opportunities that other organizations don't. This is a very valuable recruiting tool. We have people calling all the time looking to work at our facilities because of the educational opportunities we provide."

An Escalating Crisis

Long-term care providers acknowledge that a sluggish economy has, in recent years, eased the CNA shortage.

Nationwide, however, the picture remains grim and is expected to worsen in future years as the elderly population grows, along with the demand for long-term care services. Overall, nearly 96,000 full-time health care positions remain vacant in nursing facilities across the United States, according to an October 2004 report from the National Commission on Nursing Workforce for Long-Term Care. The average annual turnover rate for RNs remains high, at 49 percent, while turnover among CNAs stands at 71 percent, the commission reported. The panel, spearheaded by the American Health Care Association and convened by George Washington University, reported a 15 percent vacancy rate for staff RNs, a 13 percent vacancy rate for LPNs, and an 8.5 percent vacancy for CNAs. The current need is expected to escalate in the next decade, when the federal Bureau of Labor Statistics predicts a 41 percent increase in the demand for long-term care services. Between 2002 and 2012, that will translate to about 800,000 new long-term care jobs, including 130,000 staff RNs, 85,000 LPNs, and 582,000 CNAs, the commission reported.

The panel, which is completing its final report, is comprised of representatives from providers, nursing, labor, and consumer groups, as well as educators and state and federal agencies. A draft executive summary of the report includes a series of recommendations for expanding the workforce and calls for collaboration among a wide range of long-term care stakeholders to effectively address the issue. The commission's recommendations include the creation of:

- Partnerships among long-term care organizations, educational institutions, and state agencies to increase the supply of nurses in long-term care;
- New funding streams from government agencies and long-term care providers to support nursing degree programs and CNA recruitment and retention initiatives, including career ladders and continuing education, and
- A state clearinghouse for resources to help individual facilities interested in strengthening their workplace to improve retention through culture change, better nursing management, career ladders, and professional development.

Recommendations For Providers

The panel directed several recommendations to long-term care providers, urging them to make dramatic workplace changes to make long-term care a more appealing and satisfying career for nursing staff. Specifically, the commission said providers should:

- Implement systemic culture change and work redesign to stem turnover and strengthen retention. For example, providers should foster resident-centered care that "addresses the holistic needs of the care recipient and strengthens the relationships between caregiver and residents," the report said. Facilities should also adopt information technology to reduce paperwork, facilitate care planning, and give nurses and frontline staff more time for hands-on care;
- Transform nurse supervision from the traditional hierarchical approach to coaching and mentoring, including new training programs for supervisors, peer mentoring for supervisors and frontline caregivers, and the development of self-managed work teams;
- Create opportunities for nursing staff to grow professionally by offering career ladders to become RNs, LPNs, and senior-level aides; supporting professional and personal growth through tuition support and flexible hours for educational pursuits; developing dis-
nce learning programs; and providing “career lattice” opportunities such as geriatric nurse assistants, dementia specialists, and medication aides.

• Work collectively to develop partnerships with local community colleges and other educational institutions, as well as local workforce investment boards, to provide training and support for long term care nursing; and

• Develop a long-range plan for increasing wages and benefits—including health insurance, child care, and transportation—of frontline nursing staff to improve retention.

The commission’s work signals broad recognition that the shortage in long term care nursing is a critical issue, says Irene Fleschner, senior vice president for clinical practice and outcomes management at Genesis HealthCare Corp. in Kennett Square, Pa., and one of the panel’s 30 members. “It’s going to take a lot of efforts in a variety of different directions” to solve the problem, she says. “There is not a one-size-fits-all solution.”

At the same time, “all workers need the same thing: respect for the contribution they make and a living wage,” Fleschner says. “The most promising opportunities lie in looking at the workplace and trying to transform it” by making it resident-centered, she adds. “That’s the major issue. I don’t think it will be in of itself a solution, but it is part of the solution.”

A New Cultural Norm
The biggest challenge of Meadowlark’s culture change was “unlearning what had been taught” and unraveling what Shields calls an “assembly line” model of care, rooted in the Industrial Revolution.

That traditional model, in which life revolves around a schedule and everyone wakes up, eats, and bathes at the same time, was replaced with resident-directed lifestyles. People now create their own schedules, sleeping when they want to sleep, eating when they want to eat.

The job of nursing and non-nursing staff is to help residents identify and fulfill choices—from everyday routines and recreational activities to more expansive life goals. In this model, every staff member is “called on to be a leader,” Shields says. “Everybody has to learn what being a self-led team means, what accountability means, what being counted on means.”

The federal government is working to encourage broad adoption of and training in nursing facility culture change through a collaborative venture with quality improvement organizations (QIOs)—groups that work with nursing facilities as consultants and educators, under contract with the Centers for Medicare & Medicaid Services (CMS).

Genesis is one of eight long term care companies participating in the national collaborative, launched last October by the lead QIO, Quality Partners of Rhode Island.

Quality Partners is working with other QIOs around the country to educate them about culture change in nursing facilities and at the same time is training and educating corporate executives to approach workforce stability from the standpoint of “organizational culture,” says David Gifford, MD, chief medical officer.

Workers leave health care settings primarily because they don’t feel valued and care practices don’t make sense to them, says Gifford. Addressing workforce issues is “intimately related to care delivery.”

“We’re coming from the vantage point that organizational culture and the relationships people have—employees to employees, staff to families, employees to residents—are the building blocks from which everything else flows,” Gifford says. “To put a workforce stability program in place when you haven’t addressed the underlying culture is not sustainable.”

Conversely, a true “resident-centered culture should lead to stability of the workforce,” he adds.

Go To The Source
Providers that want to begin culture change should start by asking their staff what frustrates them most about
their job and the workplace, Gifford advises. Quality Partners has developed a staff survey instrument for corporate participants that avoids the use of the word “satisfaction,” in an effort to focus instead on employees’ experience and sources of frustration, giving them wide latitude to describe them.

The survey, dubbed VOTE (voice of the employee) includes questions such as: How does your facility focus on resident needs; do residents direct their own care if they are able; how does management work with staff in your facility; is staff recognized for their part in taking care of residents; and do the staff prepare their own work assignments, says Mary Tess Crotty, vice president of quality management at Genesis. “It asks questions I’ve never seen on an employee satisfaction survey,” she says.

Once employee survey data are gathered, management must be willing to act on staff input, Gifford says. This may require changes at the corporate level in the way that leadership relates and responds to staff, he says.

Nevertheless, providers must be willing to make those changes and respond to survey data in order to effectively address turnover. The goal is to allow employees to identify their frustrations, empower them to form teams and come up with solutions, and create an environment in which that can freely occur, Gifford says. Some changes can happen quickly, such as improvements in an orientation program, he says. Changes to care practices, such as dining or bathing, however, take longer to implement and spread throughout the organization, he adds. “There are no short-term fixes to a long-term solution. This is a journey. You don’t get bumed from A to Z.”

**Taking Charge**

Quality Partners is providing leadership by hosting conference calls and training sessions among corporate leaders, which focus on how to create and facilitate change. The sessions are learning opportunities that give executives a chance to share experiences about what works and what doesn’t. The QIO is also distributing educational materials on the Web.

CMS has funded the culture initiative for 18 months, and in that time Gifford hopes to see a reduction in CNA turnover among participants.

As Genesis rolls out culture change in 19 of its nursing facilities, the QIO training is helping it become more aware of worker issues and their needs, what motivates people, “and what care practices make it difficult for people to do and enjoy their jobs,” says Crotty. For example, “mess waking and getting everyone out of bed at the same time for breakfast is a process that doesn’t work for staff or residents,” she says. “Yet we cling to it.”

Crotty is introducing the company’s individual facility executives to culture change in much the same way the QIO training is being conducted, facilitating conference calls and providing guidance, as opposed to imposing mandates or corporatewide policy.

One approach that she does encourage facilities to implement is primary assignments, in which CNAs are assigned to a designated part of the building rather than rotating throughout the facility. Primary assignments aren’t necessarily permanent, but they bring consistency to caregiving and “strengthen the bond” between residents and staff, Crotty says.

At its core, culture change means “putting the person before the task,” she adds. “Caregivers know a resident’s desired routines, can anticipate them, and make them happen.” That level of involvement cannot be achieved “if a CNA comes to work, looks at a list of assignments, and goes down them in order,” Crotty says.

Care practices that trigger the most frustration among staff include dining, bathing, activities, and dying, she adds. A model of care that brings caregivers and residents closer together will ultimately produce a more satisfying experience in those areas and beyond, for both staff and residents, Crotty says.
Improving Nursing Home Culture Final Report

Relationships are "the foundation of a quality experience for workers and the person receiving the service," she says. "We are trying to find ways to honor that so management doesn't think a CNA who is talking to a resident is a CNA not doing her job. That's one whole aspect of the job."

**Working The WIB Connection**

In Modesto, Calif., providers are in their third year of training with the Stanislaus County Workforce Investment Board (WIB) and a local community college to fund CNA career ladder and nursing programs for long term care staff. In the first two classes of licensed vocational nurses (LVNs)—a licensure designation equivalent to LPN in other parts of the country—38 of the 60 enrollees graduated, and a third class started in January, says Terry Plett, county director of employment and training.

WIBs are funded through the federal Workforce Investment Act (WIA), and their role is to create employment opportunities for disadvantaged workers and the unemployed. Plett worked with local chapters of the California Association of Health Facilities (CAHF) to expand an existing LVN program specifically for CAHF members. WIB funds paid $7,500 per student, while providers gave in-kind support in the form of supervision, materials, and paid relief time, Plett says. With only two dropouts, the results clearly show that the students selected by participating facilities were motivated, they wanted to be there, and [their employers] wanted them to be there," Plett says.

CAHF’s Executive Director Ken Merchant has been building workforce coalitions since 2000, when then-Gov. Gray Davis promoted CNA training and invested $25 million in partnerships to advance the effort. Merchant makes presentations throughout the state to local WIBs, which are largely comprised of local business leaders, on the value of long term care as an employer in the community. In five years, what began as a push for career ladder training for CNAs has evolved to encompass LVN programs.

Typically, long term care providers purchase an entire degree program, funding as much as half of the cost, Merchant says. They also agree to flexible scheduling for students and often provide mentors to help shepherd working students through the educational process. The balance of program funds comes through WIB, community colleges, and a patchwork of state and local sources.

"There is a broad array of resources available to help industries like ours," Merchant says.

**Giving Students A Boost**

Ultimately, the goal in California is to develop an educational pipeline that allows a CNA to move steadily forward and become a registered nurse without ever changing jobs, Merchant says.

Though it’s "tough work," establishing educational programs pays off through improved staffing and quality of care, says Rick Mendlen, vice president of operations for Kenyon S. Shea & Associates in San Diego, which operates eight area nursing facilities.

The company, which has been a partner in several grant programs, currently participates in a WIB grant that gives financial aid to CNAs working on their LVN licenses by paying them an additional two days worth of their hourly wage for every week in which they work two days in a nursing facility. The benefit allows them to go to school full-time and work part-time without giving up essential income. Kenyon S. Shea continues paying fringe benefits for students, provides mentors, and adjusts their schedules to accommodate classes, Mendlen says.

The company also offers needy students a $1,000 scholarship, which covers about half of the tuition and materials cost. WIB picks up emergency expenses, such as a car breakdown or last-minute babysitting needs, that could otherwise derail students with no financial cushion.

There is almost nothing more satisfying than talking to an LVN now earning $19 an hour who worked as a CNA at $11 an hour a year earlier, Mendlen says. Staff are deeply “appreciative of companies that give them that opportunity,” he adds.

“It gives you chills.”

**Measurable Results**

Massachusetts has also been a pioneer in partnership development for long term care nurse education. Fueled by a series of state grants for CNA career ladder training that started in 2000, WIB support, and private funding by providers, the CNA vacancy rate in the state has dropped from 16 percent in 2000 to less than 5 percent currently, says Carolyn Blanks, vice president of
labor and workforce development at the Massachusetts Extended Care Federation (MECF). Nearly 25 percent of MECF’s members, 150 nursing facilities, have participated in state-funded career ladder programs, which so far have trained 3,500 CNAs, Blanks says. The impact is showing up in retention rates: In 2000, 58 percent of CNAs stayed at their job for a year or more; in 2004, that segment rose to 71 percent.

Career ladder training “takes CNAs deeper into their role,” to broaden their knowledge base of elder care, says Marilyn Webb, director of the Extended Care Center for Excellence (ECCE) at Holyoke Community College. The college has partnered with Loomis Communities, a CCRC in South Hadley, Mass., and Heritage Hall East, comprised of four nursing facilities and one assisted living facility in Agawam, to offer CNA professional development. Entry-level courses cover areas such as teamwork, communication, and aging, while more advanced training covers rehabilitation, dementia, and body systems, Webb says. Every completed step in the training is accompanied by a pay increase.

Webb was initially hired last year by Loomis to operate its career ladder program and manage the state grant that funds the training. Under the employment agreement between the college and CCRC, she still spends part of her time at Loomis.

When career ladder training started, she says, the CNA retention rate—which measures the segment that stays for at least a year—was in the range of 40 to 50 percent, Webb says. Now, it’s around 80 percent, an improvement she attributes to “educating staff, making them feel more skillful, and improving teamwork capabilities.”

A typical class has 10 to 20 employees and is open to CNAs after 90 days. Training is funded through a combination of state grants and WIB support, Webb says, and the college is currently raising the bar on opportunities for CNAs by preparing eight candidates for LPN training. The goal at ECCE is to create a “hub” that offers long-term care providers, their staffs, and communities “continuity and an opportunity to grow,” as opposed to “working in silos, where one nursing home doesn’t know what others are doing,” Webb says.

Looking To The Future
At Heritage Hall East (HHE) the educational pipeline is so advanced that the community is looking ahead to a long-range goal of producing educators for RNs—a shortage that has created a nationwide bottleneck in nurse training, says Ira Schoenberger, senior administrator.

A total of 16 CNAs from HHE have become LPNs, and another nine are enrolled in the program and expected to graduate in June. The facility has received $300,000 in educational grants from the state and workforce investment groups, Schoenberger says, funds that he describes as the “spark plug” that gets things moving.

The grant covered just 10 percent of tuition costs for the current group of LPN graduates. HHE fully funded the last semester and paid students for half of the time they spent in class. To cover the balance, students take out loans or get individual grants.

What sustains the program is the support network available on HHE’s campus, says Barbara Corrigan, director of career development. HHE helps students find and apply for financial aid. In addition, it has created a learning resource center that is open from 8:30 a.m. to 5:30 p.m. Staff “can come in anytime and talk to us about education,” Corrigan says.

The center also offers computer-based learning, which allows staff to engage in “self-directed learning” for GED preparation and courses in English as a second language.

“We have created a whole structure in which employees who want to go back to school are counseled and advised on how to do that,” Corrigan says. The management team meets regularly to help coordinate and adjust employee schedules, giving them maximum flexibility to attend classes and succeed in completing whatever program they enter, she adds.

A Gratifying Retention Increase
HHE began opening educational doors in 2001 with CNA career ladder training. At the time, HHE struggled like many long-term care providers with CNA and licensed nurse retention. Since then, retention has risen dramatically, to about 83 percent, up from 70 percent when educational programs began. Furthermore, HHE has not relied on temporary CNA staffing for the past two years. By growing its own nurses, Schoenberger expects to eliminate agency use of licensed nurses.

The long-range goal, he says, is to create ladders in which CNAs become LPNs, then advance to RNs who ultimately get their master’s degrees and return to school as faculty.

HHE is combining education with culture change, Schoenberger adds, and is starting to look for ways to measure its impact on quality and workforce stability.

“If staff are involved in decision making and hiring, which we allow, if we empower teams to be involved in the outcomes we are looking for, we will have good quality care and longevity of staff,” he says.

Lynn Wagner is a freelance writer based in Shepherdtown, W.Va.
Culture change sweeps nursing homes

(Lawrence Eagle-Tribune; 8/28/05)

By Stephanie Akin
Staff Writer

NORTH ANDOVER — When Anna Russo moved into a nursing home, the last thing she and her family thought she would be doing was driving for one of the first times in her life — let alone behind the wheel of a monster truck.

But a week ago, Russo, 95, sat with hard rock music blaring as she rammed repeatedly into a light post.

"Good! Good!" she said, laughing as she reversed and banged the post again.

Russo didn't mind that it wasn't a real truck she was driving, or that her wheelchair kept her from operating the pedals herself. The exercise, on a computer virtual reality program the nursing home introduced this month, was simply fun.

Fun is not something Russo or her family associated with nursing homes when she moved to the Sutton Hill facility in North Andover as a last resort eight months ago. But with field trips to local restaurants, ice cream and cookie get-togethers, social organizations like the Red Hat Society, and now the virtual reality program, the Sutton Hill home has been defying the family's expectations.

"It's become more of a home than a place for someone who can't get along alone," said Russo's son, Fred Russo, 63. "Don't get me wrong. Home is better. But it's not a bad second place to be."

Change throughout the industry

Sutton Hill is one of hundreds of nursing homes across the country changing the way they do business. These homes are on the forefront of something they say is about to grow even bigger as new federal regulations enforce more nursing home oversight.

They call it culture change, person-centered or resident-centered care. But in the facilities trying it, the changes are similar. They start with atmospheric improvements, such as scrapping overhead paging systems or repainting a bathroom wall. They change the way they serve meals so people can eat breakfast when they want to or have access to a toaster in the morning. They assign staff members to the same groups of residents and start referring to hallways as "neighborhoods."

The Sutton Hill virtual reality program is an extreme example of a program designed to entertain residents, as well as provide exercises in hand-eye coordination and mental acuity. Residents can also use the system to design their own Web page and send e-mails to friends and family.

Taken in parts, such improvements seem small. But as a whole, they make a big difference, observers say.

"You often think of residents sitting in front of a television set, slumped in their chairs, dozing off in the hall-
ways,” said LaVrene Norton, executive leader of Action Pact, a national organization that works with nursing homes trying to institute culture change. "You think, 'My God, this is what happens when you get old.' But that's caused by a sense of personal loss."

If you give nursing home residents more of a sense of control and excitement in their daily affairs, Norton said, their lives will become meaningful again.

And it's not just the residents who will benefit, observers say.

Staff turnover rates of 70 percent cost nursing homes $2.5 billion a year, according to a study published in October 2004 by Better Jobs Better Care, a national research program paid for by The Robert Wood Johnston Foundation and The Atlantic Philanthropies.

If nursing homes can find better ways to support their residents and their staffs, culture change advocates say, they could save a lot of money.

Over the next three years, 2,500 nursing homes across the country will begin culture change initiatives as part of a 2002 national initiative to improve nursing home quality. Those homes will measure resident and staff satisfaction and staff turnover rates, providing numbers culture change advocates hope will encourage the rest of the country's 16,121 licensed nursing homes to follow suit.

Most nursing homes were built in the 1970s and 1980s as huge physical plants, sometimes with as many as 400 beds, Norton said. They were designed to get things done as efficiently as possible.

Staff members were assigned to work with different residents every day, so it was difficult for residents and employees to develop relationships.

Giving residents control

Meals were prepared in industrial-sized kitchens. When they were served, assembly-line style, residents were required to be prepared and in assigned seats at the same time.

Often in these homes, Norton said, the management dictated what time people got up in the morning, when and what they ate, when they went to bed — almost every aspect of the day was regulated.

"Can you imagine living in your own home and not being able to go into your own kitchen?" Norton said.

Nursing homes working with a culture change model try to find ways to give residents access to refrigerators, to serve meals buffet-style so residents can follow their own schedules and eat what they want, to break up floors and hallways into communities so residents and staff have more of a chance to interact on a regular basis.

Such neighborhood structures also give staff members more time to spend with patients and more of a sense of pride in their job as they see the daily impact they have on the people they serve, culture change advocates say.

The Sutton Hill facility started by redoing the bathrooms.

They covered stark, white bathroom walls with peach and sage paint, moved white, wooden shelving units into the corner and filled them with plush cream and pastel-colored towels. They decorated with large mirrors with
gilded frames and leafy plants, flowered shower curtains — touches people would put in their homes. They spent less than $1,000 for each tub room, said Karla Rossi, executive director of Sutton Hill.

Sutton Hill has since completed similar redecorating projects throughout the 142-bed facility. Televisions sit on cherry-stained shelving units; the hallways are lined with paintings by local artists; residents, staff and visitors can relax on a massage chair in a new “living room.” This is the first phase of a five-year plan at Sutton Hill.

Norton, of Action Pact, said such changes are not only cosmetic. Cozy touches in a bathroom can make bathing less frightening for residents with dementia. Decorations throughout the building can give residents more of a sense of being at home.

Eva Owen, 85, who has lived at Sutton Hill for four years, said access to a new refrigerator with an ice maker made a huge difference for her. So many people used the water fountains and faucets before, you could never get a cold glass of water when you wanted one, she said.

Selma Abriatis, 97, said she appreciates the staff because they don’t talk down to her, as many do when speaking to elderly people. She said she thinks they treat her with respect because they know her.

"I tell people it will never be as nice as home," she said. "But you will not find any place as nice as this."

Sutton Hill also extended renovations to the staff, giving them quiet places to retreat during the day such as a staff break room with tied-back drapes, a flat-screen television, and a new refrigerator and kitchen unit.

"If you’re taken care of, you can be a better caregiver," spokeswoman Dina Lynch said.

Attitude makes a difference

Other nursing homes in the area are starting similar programs.

Penacook Place in Haverhill, which instituted a culture change program two years ago, replaced overhead paging systems with silent buzzers for staff members to give the building a less institutional feel. They started serving coffee from percolators during breakfast so residents could smell the coffee brewing when they came into the dining room in the morning. They gave residents a place outside their rooms to display photographs and personal mementos so staff and visitors could get a sense of residents' personalities and history.

"It’s looking at the attitude of how we approach things," said Charlie Carrozza, chief operating officer at Penacook Place. "How would someone be treated in their home?"

The nursing home at Mary Immaculate Health Care Services in Lawrence is in the first stage of its culture change renovation, putting in wallpaper, framed artwork and softer lighting. After the physical changes are completed, the management plans to overhaul the way the home schedules residents' time so people have more choices throughout the day.

"It sounds simple, but we have to dismantle everything we’ve done in the past," said Barbara Grant, president and CEO of Mary Immaculate.

None of the nursing homes mentioned above intends to pass its reorganization costs on to consumers, most of whom they said pay for their services through Medicare and Medicaid.
Because culture change can start with such small adjustments, there are no numbers to track the philosophy's spread, said David Bell, spokesman for Massachusetts Extended Care Federation, an organization that represents Massachusetts nursing homes, assisted living facilities and retirement communities.

Bottom-line issues

But Bell said nursing homes have plenty of reasons to try new methods.

With the increasing popularity of alternatives to nursing home care, nursing homes have more competition than ever before. The number of assisted living facilities in Massachusetts has almost tripled in last 10 years, going from 62 units in 1996 to 178 in 2004.

Over the same period, nursing homes throughout the state lost record amounts of money. Massachusetts nursing homes lost more than $258 million between 1995 and 2001. Between 1998 and 2003, 103 nursing homes closed throughout the state, according to a policy brief released in 2003 by the Massachusetts Senate.

New federal regulations make it more difficult for acute rehabilitation facilities to take patients, so more people recovering from knee or hip replacements are going to nursing homes for short-term stays. Many of those patients, who are generally younger, demand better service than long-term residents, said David Farrell, project manager of Quality Partners of Rhode Island, a nonprofit organization that supports improvements in the health-care industry.

In order to compete for a growing elderly population, including the baby-boomer generation of savvy consumers, nursing homes will have to rid themselves of old, unpleasant stereotypes, observers say.

Although they are losing money, most nursing homes are willing to make costly improvements today in order to survive in the future.

Rossi, at Sutton Hill, said customers have become more demanding about what they are looking for. Families don't want to put their loved ones in nursing homes, so they look for the most homelike environment they can find to ease the transition.

"Our feeling is that if we don't (make changes), we won't be in business much longer," she said.

The average profit margin for a nursing home nationwide is 2.2 percent, or just over 2 cents on the dollar, Farrell said. If nursing homes can reduce turnover, which saves them a lot of money, they are more likely to be in the black, he said.

Farrell said a hidden reason for high industry turnover is the high number of workplace injuries suffered by certified nursing assistants, especially when they are waking and bathing residents who lash out.

According to the Occupational Safety and Health Administration, nursing homes had 79,000 lost-time injuries in 2002, and nursing home workers are more likely to be injured on the job than construction workers, policemen, firemen, coal miners and manufacturing-plant employees.

"Culture change teaches homes to move away from strict, institutional policies that try to fit residents' needs and preference into strict schedules," he said. "When you move away from that paradigm, it helps mitigate the potential for residents to strike out at the staff."
Sutton Hill, for example, has more than 90 percent staff retention, Rossi said.

There are some unpleasant aspects of living in a nursing home that no new models could change.

Fred Russo said his mother has been depressed lately because a friend she made at Sutton Hill died, the third acquaintance to die in her eight months at the home.

But even so, Anna Russo has begun to think of Sutton Hill as her home.

When new residents arrive, she sells them on the features of the place, Fred Russo said. And when the family takes her out on weekends, she starts looking at her watch by 7:30 p.m., saying it’s about time she got home and ready for bed.

"I almost hate to take her back," Russo said. "But she’s always ready."
Residents of the Eunice Smith Home in Alton are among those benefiting from a federal program designed to bring better care and control to those in nursing homes. The Eunice Smith Home, which had $3 million in revenue last year, is on the campus of, and operated by, BJC HealthCare's Alton Memorial Hospital. The home is one of eight sites in Illinois involved in the Person-Centered National Pilot Collaborative to improve care in nursing homes by training staff members to implement "person-centered" care.

In person-centered care, the nursing facility strives to be flexible in meeting the needs of individual residents rather than following an institutional schedule. The resident is allowed to make more of the choices they would have had at home, such as when to wake or shower, or what to wear.

"I want this to be a place where people come to live their lives, not a place where they come to die," said Marsha Klug, coordinator of the Eunice Smith Home's person-centered care program and Memory Lane Alzheimer's Residence.

The Illinois Foundation for Quality Health Care (IFQHC), based in Oakbrook, Ill., is one of 21 state-based quality improvement organizations providing training in the pilot project. The Illinois pilot program is being funded as part of the IFQHC's three-year, $4.8 million contract to improve nursing home quality. That contract ends in July.

"The Eunice Smith Home was selected because their new Alzheimer's residence program demonstrated that they already had a strong commitment to the homelike culture change we are hoping to introduce," said Leslie Kolb, quality improvement manager for nursing home care at the IFQHC.

The Memory Lane Alzheimer's Residence is a 22-bed unit opened in October 2003 in a renovated wing of the Eunice Smith Home. New dining and kitchen facilities were designed to be more flexible and allow activities for residents, such as baking. A screened patio is being built to allow residents to be outside.

Klug said she does not expect an Alzheimer's patient to adapt to an institutional setting. Instead, Klug wants the Memory Lane staff to get to know the residents and the family and friends currently on their minds.

"I think the new program is fantastic," said Irma Maupin, whose sister-in-law is a resident at Memory Lane.

Seeing Alzheimer's unit residents as family members was not hard for Klug. Her mother has Alzheimer's, and her aunt died from the disease. A registered nurse with 26 years' experience as a health educator, Klug says she had a heartfelt interest in making the new Memory Lane residence a comfortable home. As recommended by the person-centered pilot program, Klug has begun training the Memory Lane staff and has permanently assigned the nine nurses and 12 certified nurse assistants on her staff to individual residents. She plans to expand the training to nurses in other units of the Eunice Smith Home, as well as housekeeping and maintenance staff. Eunice Smith Home is a 62-bed facility, including Memory Lane.

"I am encouraged and proud of the fact that not one person has left since the Alzheimer's unit opened in 2003," Klug said. "That is very uncommon in long-term nursing care."
Illinois included in nursing home program

By KATE CLEMENTS
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SPRINGFIELD – Illinois is one of about 20 states recently selected to participate in a federally funded pilot program aimed at making long-term care facilities less institutional and more like homes.

"Right now, research has shown that most people would rather die than move to a nursing home," said Janet Severance, a gerontologist and assistant professor at Midwestern University in Downers Grove. "If they change their way of thinking to really focus on the person, rather than the institutional setting, it is not only better just for the resident, but it's also better for the employees and the families and for everyone in the community who cares about elders."

In the "culture change" model, as some folks in the industry call it, the patients are cared for in a homelike environment; their rooms contain their own furnishings and decorations; there are choices of what and when to eat; and the overall atmosphere is less institutional than a standard nursing home, said Benneta Sevier, quality improvement coordinator for the Illinois Foundation for Quality Health Care.

"The patients are happier because they are getting their needs met, and they have choices," Sevier said. "It gives control back to residents."

Such a culture change typically results in more active patients, a reduced reliance on anti-depressants, healthy weight gain among residents, and lower staff turnover rates, she said.

The Illinois Foundation for Quality Health Care, which is funded by the federal Centers for Medicare & Medicaid Services, is seeking five to eight nursing homes around the state to volunteer for the yearlong pilot program, Sevier said.

The program, called "Improving Nursing Home Culture," will start in November, and includes quarterly education sessions and individually-tailored training for the participating nursing homes. There is no cost to participate, just an investment of time and a willingness to commit to the process, Sevier said.

"The goal is for these homes to begin the culture-change journey," she said. "They would be like the leaders in the state and will be able to share with other homes in their area."

According to Tammy Wacker, regional ombudsman for the East Central Area Agency on Aging, most homes in this part of the state already have a head start when it comes to culture change.

"What we've found was that even though people are not calling it culture change, it's still going on," she said.

Common changes Wacker has seen include allowing pets to live in facilities, offering family-style or buffet dining, allowing residents to bring beds or other furniture from their homes, and eliminating staff...
uniforms. "These changes don't cost a lot of money, but they make a huge difference," she said.

The East Central Area Agency on Aging, which covers 167 long-term care facilities in 16 counties, has created a database to track the various culture improvements each one is making, Wacker said. The agency then uses that database to match area nursing homes looking for tips or ideas on improving dining or atmosphere with nearby homes that can help them.

It is not just in East Central Illinois where these changes are happening, but also in homes all over the state, said Todd Shackelford, facilitator of the Illinois Culture Change Coalition. "We're probably one of eight states in the nation that is kind of on the cutting edge of this," he said. "But we need to grow it, and we need to get it going in all facilities."

The Illinois Culture Change Coalition is a part of the Pioneer Network; an organization of culture-change advocates that is having its first statewide seminar in Springfield on Oct. 6 and 7.

"We are grouping together to collectively share and learn and educate about deep system changes within long-term care facilities to totally deinstitutionalize them and make them more community-centered and person-centered," Shackelford said.

The Illinois Department of Aging, with help from the Illinois Department of Public Health, has awarded grants to the Illinois Culture Change Coalition for various educational and outreach efforts and for research.

Severance is beginning some of that research with a grant to study all of the nursing homes in Illinois and describe what they are doing to make their facilities more resident-centered.

"We hope that this will provide some baseline data so as nursing homes keep changing and struggling with changing over a few years we can show really great improvements in nursing home care," she said.

For more information about the Illinois Culture Change Coalition, e-mail Shackelford at toddsciagingnetwork.org.

Putting Absenteeism In Perspective

When faced with excessive call-offs, long term care providers should look to flaws in their own systems rather than blaming employees.

Putting absenteeism is a critical element in solving the problem of staff retention and, in so doing, delivering the highest potential quality of care. And while the root causes of absenteeism may differ, there are clear “dos” and “don’ts” for addressing the problem.

A first step is to recognize that company-wide attendance problems are more than likely a sign of a dysfunctional system—not dysfunctional employees. Thus, when managers react to the problem by getting tougher on violators, they are, in essence, failing to acknowledge their own ineffective organizational and leadership practices.

The ‘Not-To-Do’ List

An analysis of a recent collaborative on absenteeism found that many facilities have policies and systems in place that actually promote excessive absenteeism. Examples include:

- **Incentives to worse behavior.** Many organizations encourage their staff to waive their right to benefits for a higher hourly wage. While this appears to save the organization money, it actually leads to higher costs in the long run. If staff members have no health insurance, they are less likely to seek medical treatment until it is too late. Or, if they have no sick pay or vacation pay they have accrued, they have nothing to tie them to the facility. A spell of illness for this individual is the equivalent of a financial catastrophe.

- **Offering bonuses to the remaining staff on a shift that is working understaffed.** Staff tend to game this system and start making arrangements for whose turn it is to call out so that the others may get extra pay.

- **Rotating scheduling overtime and double-time on the monthly schedule.** In facilities where the scheduling of staff for overtime (OT) and double time (DT) is the routine, individuals scheduled for OT and DT have a strong financial incentive to keep the facility understaffed. After all, they are making more money. Therefore, they see new employees who appear on the schedule and take their OT or DT shifts as a threat to their income. In these situations, they may treat new staff poorly.

- **Rotating staff from assignment to assignment.** Rotating staff, as opposed to primary assignments to the same group of patients, leads to absenteeism. The days after the rotation. Primary assignments allow the staff to form a relationship with the patients and their co-workers on the unit. These bonds create accountability and peer pressure to come to work as scheduled.

- **Use-is-or-lose it sick pay.** This policy encourages staff to use it. A better approach is to offer to pay the employees a portion of the accrued sick pay as a reward to those with the best attendance records.

- **No sick pay until second day of absence.** Under this policy, staff are not entitled to sick pay unless they are off sick for at least two consecutive days. The problem: It encourages employees to call off for two days instead of one.

Developing An Effective Program

Fortunately, the problem of absenteeism is not an intractable one. Systems can be developed in ways that motivate staff to avoid call-offs that are not an absolute necessity.

First and foremost, it is important to collect data for each individual employee, each department, and the entire facility both for absenteeism and the number of shifts worked short-staffed. Usually, having a person (and one back-up) coding and tracking absenteeism works best. This individual would track individual and facility trends (by day of the week, by unit, by shift), average number of call-offs per employee per quarter, and total number of call-offs per month.

This single point person would then review all of the attendance records monthly and alert supervisors of trends (both positive and negative) by making a copy of employees’ attendance records and sending them to their supervisors.

The point person would also make a copy of each employee’s attendance record on a quarterly basis and include in the employee’s paycheck in order to provide him or her with regular and consistent feedback regarding attendance. These simple processes display to the staff that preventing short staffing is a priority.

Some facilities have adopted a “no-fault” attendance policy that takes the guesswork out of trying to qualify or justify the legitimacy of absences. There is no need for the employee to get a physician’s note in order to justify an absence. Absences, for any reason,
are all treated the same. This promotes fairness and trust.

Absence should be a standard agenda item during general staff meetings, where those with the best attendance records are publicly rewarded. Providers might consider a drawing for a prize (free movie tickets, for example) that includes only those staff members with perfect attendance during a specified period of time. It should always be stressed that attendance is critical to the safety and well-being of the patients.

Improvement should also be rewarded. Leaders must seek out staff who have improved their attendance habits and let them know those efforts are appreciated. In all cases, leaders are the key, and they must set the example by having excellent attendance records themselves.

**Building Trust**

Leaders should avoid waiting for a violation of the attendance policy by intervening at the first sign of a problem. This is not for disciplinary reasons, but to express concern for the welfare of the employee. The first meeting should take the form of a conversation in order to explore how the leader can help the staff member to solve a problem. Expressing genuine care and concern for the well-being of staff members goes a long way toward resolving problems and gaining trust.

In Susan Eaton’s landmark study, “What a Difference Management Makes,” she found that the vicious cycle of turnover and vacant shifts in low-performing facilities was primarily due to a lack of trust among the workers and between the leaders and the frontline staff.

Often, she found, staff members would not cover shifts for one another because they could not trust that the favor would be reciprocated. This resulted in many vacant shifts. At the same time, the leaders did not trust the staff and the reasons staff gave for calling off. The staff picked up on the lack of trust from the leaders and behaved accordingly.

Employee assistance programs, such as transportation vouchers and free or reduced-price meals, are not widely offered in long-term care facilities, but they have proven to be very effective where employed. The annual cost of such programs to a facility has been estimated to equal the cost of turning over one certified nurse assistant ($3,500).

Offering staff a comprehensive wellness program, for example, has also proven an effective strategy to curb absenteeism. Providers might consider
offering staff free vitamins, discounts to health clubs, stress counseling, smoking-cessation classes, or educational speakers on women’s issues. All of these suggestions indicate that leaders value staff members and their welfare.

**Scheduling For Success**

Scheduling of staff in long-term care is complex. The practices related to scheduling can either contribute to or help prevent absenteeism. In Susan Eaton’s study, she found that one of the most common reasons for terminations in skilled nursing facilities was not work performance but conflicts related to showing up at work on time. She identified some significant differences in practices and systems in the low- vs. high-turnover facilities.

In high-turnover, low-quality facilities, the scheduling of staff was clearly not a priority of the leaders, Eaton found. Scheduling was often random or delegated to a receptionist. Yet, surveys found that work schedules were a critical factor in the lives of certified nurse assistants and nurses, both on and off the job.

Eaton’s research found that schedules in low-turnover facilities were posted well in advance, giving staff members sufficient notice of any open shifts or changes to the schedule. By contrast, in the high-turnover facilities, staff viewed the scheduling procedures as both haphazard and chaotic. Changes were made to the schedule without sufficient notice and often, from the staff’s point of view, without justification.

It is interesting to note that both the high- and low-turnover facilities in Eaton’s study had full-time scheduling coordinators. However, these individuals often lacked the required skills to master the job. One common error was an inability to correctly identify the number of vacant full-time positions. As a result, some facilities were turning away full-time applicants in the belief they only had part-time positions available.

Schedules that have staff covering the same units on the same days of the week have been proven to lower absenteeism. Rotating schedules, such as four days on and two days off, can leave employees guessing as to when to schedule personal appointments. By contrast, primary days allow staff to plan their lives accordingly, leading to fewer call-outs.

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**For More Information**

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Partners

Abbey South, FL
Ambassador Good Samaritan Center, MN
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Cambridge Care Center, CO
Cape Heritage Rehabilitation & Nursing Center, MA
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Care Inn of Seguin, TX
Caribou Memorial Hospital & Living Center, ID
Carrollwood Care Center, FL
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Cedar Ridge Healthcare Center, IL
Centers for Long Term Care of Salina, KS
Centers for Medicare & Medicaid Services, MD
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Fountainview Center for Alzheimer’s Disease, GA
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Franklin Woods Center, MD
Friendly Acres Retirement Community, KS
Genesis HealthCare Corporation, PA
George Davis Manor, IN
Georgia Medical Care Foundation, GA
Golden Empire Convalescent Hospital, CA
Golden Oaks, OK
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Life Care Center of Scottsdale, AZ
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Limestone Heritage, GA
Logan County Manor, KS
Loomis House, MA
Loveland Good Samaritan Village, CO
Lumeta, CA
Lutheran Home at Topton, PA
Lutheran Home, IN
Lutheran Home, MN
Lyons Good Samaritan Center, KS
Manorcare Health Services, FL
Maplewood Glen Senior Living Community, WI
Maravilla Care Center, AZ
Mary Immaculate Nursing & Restorative Center, MA
Marywood Nursing Care Center, MI
MassPRO, MA
Meadowlark Hills Retirement Community, KS
Medallion Retirement Community, CO
Medical Review of North Carolina, NC
Medicalodge of Dewey, OK
Medicalodge of Fort Scott, KS
Medicalodge of Gardner, KS
Medicalodge of Rochester Hills, MI
Medina Valley Health & Rehabilitation, TX
Mennonite Manor, KS
Mennonite Memorial Home, OH
Mercy Center Nursing Unit, PA
Mercy Retirement & Care Center, CA
Meriden Center, CT
Meridian Nursing & Rehabilitation Center, KS
MetaStar, WI
Milford Center, DE
Miller Center, IL
Morristown Manor, IN
Morrisville Center, VT
Mountain Ridge Center, NH
MPRO, MI
Namaste Alzheimer Center, CO
Nazareth Living Center, MO
Neville Center at Fresh Pond for Nursing & Rehabilitation, MA
North Point Skilled Nursing Center, KS
Northcrest Nursing & Rehabilitation Center, OH
Oak Mountain Village Healthcare, GA
Ohio KePRO, OH
Oklahoma Foundation for Medical Quality, OK
Orlando Lutheran Towers, FL
Palm Manor, MA
Parke View Care & Rehabilitation Center, ID
Parkway Medical Center, KY
Passavant Retirement Community, PA
Peabody Retirement Community, IN
Peake Healthcare Center, GA
Penacook Place, MA
Pennybyrn at Maryfield, NC
Pine Meadows Healthcare, KY
Pine Valley Healthcare & Rehabilitation Center, WI
| Pinewood Terrace Nursing Center, WA       | Stratis Health, MN |
| Plazza West Regional Health Center, KS    | Sumner on Ridgewood, OH |
| Pleasant View Center, NH                  | SunBridge Healthcare, NM |
| Pleasant View Home, KS                    | Sunset Estates of Purcell, OK |
| Porter Place, CO                          | Sutton Hill Center, MA |
| Portneuf Medical Center, ID               | Syringa Home, ID |
| Portneuf Valley Hospital & Rehabilitation Center, ID | Tabor Hills Healthcare Facility, IL |
| Presbyterian Home for Central New York, Inc., NY | Texas Medical Foundation, TX |
| Primaris, MO                              | The Cedars, Inc., KS |
| Progressive Care Center, CO               | The Gardens at St. Elizabeth, CO |
| Provena Sacred Heart Home, IN             | The Heritage of Old Capitol, GA |
| Provena St. Joseph Medical Center, IL      | The Heritage of Santa Rosa, FL |
| Quakertown Center, PA                     | The Home Association, Inc., FL |
| Qualis Health of Idaho, ID                | The Jewish Health & Rehabilitation Center, NY |
| Qualis Health of Washington, WA           | The Madison Center, WV |
| Quality Insights of Pennsylvania, PA       | The Manor of Farmington Hills, MI |
| Quality Partners of Rhode Island, RI       | The Retreat, GA |
| Renaissance Health Center, OH             | The Rosewood Care Center, TX |
| Retama Manor North, TX                    | The Sarah Community: Anna House, MO |
| Richland Care Center, Inc., MO             | The Scripps Home, CA |
| Ridgeview Elder Care Rehabilitation Center, PA | The Terraces, AZ |
| Ridgeway Health & Rehabilitation Center, SC | The Venturan, CA |
| Ridgewood Center, NH                      | The Village at St. Edward, OH |
| Rose View Center, PA                      | The Villas at Sunny Acres, CO |
| Rosewood Boarding & Care Center, TX        | Timberlake Care Center, MO |
| Royal Oaks Manor, CA                      | Tonganoxie Nursing Center, KS |
| Saint Martha’s Manor, PA                  | Toomsboro Nursing Center, GA |
| Salem Lutheran Home, CA                   | Tulsa Nursing Center, OK |
| Salina Presbyterian Manor, KS             | UHS-Pruitt Corporation, GA |
| Salisbury Rehabilitation & Nursing Center, MD | University Heights Health & Living Community, IN |
| San Joaquin Gardens Health Center, CA     | Veterans Home of California, CA |
| Sarah S. Brayton Nursing Center, MA       | Villa Pueblo, CO |
| Sardis Oaks, NC                           | Village Manor, KS |
| Sava Senior Care, GA                      | Vivian Teal Howard Rehabilitation Health Care Facility, NY |
| Scenic View Health Care Center, GA        | Wachusett Manor, MA |
| SEM Haven Health & Residential Care, OH    | Warm Beach Senior Community, WA |
| Severna Park Center, MD                   | Washington County Health Center, PA |
| Sherwood Oaks, PA                         | Waterman Village, FL |
| Sierra Health Care, CA                    | Waters Edge Extended Care, FL |
| Silver Stream Center, PA                  | Wellstar Health System - Paulding Nursing Center, GA |
| Skyview Center, CT                        | Westminster Terrace, KY |
| St Francis Extended Health Care, WA       | Westminster-Thurber Community, OH |
| St John's Home, NY                        | Wheatland Nursing Center, KS |
| St. Camillus Health Center, MA            | White River Lodge, IN |
| St. Catherine LaBoure Manor, FL           | Wilkes Health Care Center, GA |
| St. Elizabeth Healthcare Center, IN        | Wish-I-Ah Care Center, CA |
| St. Joseph Village, KS                    | Woodbriar of Wilmington, MA |
| St. Mary's Manor, WI                      |                           |
| St. Paul Health Center, CO                |                           |
| Stone Oak Care Center, TX                 |                           |