Being Who We Say We Are

"Culture Change" Helps Two Long-Term Care Centers Align Practice with Their Sponsors' Values

BY PATRICIA KRASNAUSKY

Ms. Krasnausky is president and CEO, St. Cabrini Nursing Home, Dobbs Ferry, NY, and Cabrini Center for Nursing and Rehabilitation, New York City.

As administrators of nursing homes around the country take steps to change their facilities' cultures and restructure social and architectural environments that seem inadequate to resident and staff needs, the leaders of Cabrini Center for Nursing and Rehabilitation (CCNR), New York City, and its sister facility 25 miles to the north, St. Cabrini Nursing Home (SCNH), Dobbs Ferry, NY, have discovered together that the changes they need to make are clearly linked to their existing mission and values.

CCNR and SCNH are skilled nursing facilities (SNFs) sponsored by the Missionary Sisters of the Sacred Heart of Jesus. Both are long-term care facilities that also have short-term and subacute care beds, dementia special-care units, and hospice care. Each operates a home care program, and a medical-model adult day care program. Together they serve approximately 1,000 elderly or chronically ill people each day.

The Missionary Sisters of the Sacred Heart of Jesus, founded by St. Frances Xavier Cabrini, are represented in the United States by the Stella Maris Province. The congregation's provincial and her council, as corporate members of each sponsored institution, have implemented a comprehensive program of mission integration and board and senior management formation. As a result, each institution has not only a well- developed mission statement but also a set of values, identified by its staff through a focused process, and operational standards called *The Mission Standards for Cabrinian Institutions.*

The Culture of Nursing Homes

With the inception of the Medicare and Medicaid programs in the 1960s, access to nursing home care by the elderly, frail, and chronically ill was greatly expanded, especially to those who could not previously afford such care. The nursing home construction boom that followed produced facilities that were designed, organized, and staffed on a hospital–acute care–model. Insofar as that model is primarily focused on a person's physical deficiencies, the emphasis was on treating a diagnosis or curing an ailment–on *quality of care* rather than on *quality of life*–as well as on accomplishing this in the most efficient and economical manner possible. What had been previously homelike "rest homes" were forced to choose between complying with the new Medicare and Medicaid standards if they sought reimbursement, on one hand, or, on the other, remaining as they were but taking only those residents who could afford to pay the homes' fees out of pocket.

With the best of intentions, even the traditional providers of care, the religious and community groups, tended to adopt, or fall into, the hospital model. Systematic methods of service delivery have replaced more homelike dining. Medication, treatments, meals, even leisure activities and religious services are dictated by the traditional staffing model of three shifts each day. The time to rise and the time to sleep are, likewise, often dictated by the staff schedule rather than resident preferences. Concern for patient preference and freedom of choice take a back seat to policies that address safety and health. Shared rooms, long halls, central nursing stations, and bland surroundings–all components of the medical model–have dominated the environment that we call "home." Along with environmental design, systems, and schedules came a paternalism that can be summarized as "staff knows best." Overall, the Medicare and Medicaid regulations themselves seemed to dictate such methods and environments.

A new emphasis, and possibly a catalyst,

emerged with the Nursing Home Reform Act (which was part of the Omnibus Budget Reconciliation Act, or OBRA, of 1987). One goal of that legislation was the promotion of quality of life for nursing home residents through regulations that mandated, among other things, reduced use of physical and chemical restraints and the formation of resident and family councils. This was a step in the right direction, but improving quality of life cannot be done through regulations alone. Many providers were bewildered by the new quality-of-life emphasis, finding it nearly impossible to comply with it while at the same time maintaining a high quality of care, which was *also* mandated. Some providers failed to grasp the quality-of-life concept and often met the letter of the regulation without understanding the spirit of it.

> They learned that the traditional medical model is traumatic for both residents and staff.

The ethicist Arthur Caplan has written, "It is the small decisions about the content and order of one's daily life that, when added together, determine something of fundamental ethical importance, whether one is in a nursing home or some other setting—the quality of life."[1] However, many providers felt powerless to overcome past practice, federal policy, and other regulatory barriers in order to create environments in which resident choices were not only respected but also promoted.

Culture Change

In recent years, new approaches have been undertaken by some nursing home providers to personalize nursing home care and to restore autonomy to the homes' residents. The Pioneer Network (formerly known as the Nursing Home Pioneers) traces its origins to 1995, when four creators of novel approaches to culture change in nursing homes came together at the National Citizens Coalition for Nursing Home Reform in Washington, DC. The four, identified by the coalition as "culture change pioneers," went on to form today's Pioneer Network.[2]

The network's credo is that in-depth systemic change requires:

- Change in governmental policy and regulation
- Change in individual and societal attitudes toward aging and elders
- Change in elders' attitudes toward themselves and their aging
- Change in the attitudes and behavior of caregivers toward those for whom they care[3]

The Pioneers' approach focuses care on the resident, rather than the institution, and generally aims to create an environment in which residents live in dignity and comfort and retain control of their lives. They learned through experience that the traditional, authoritarian medical model is traumatic not only for residents but for staff as well, and they were willing to take the risks involved in an attempt to bring about change.

The network's collective efforts to show the positive resident and staff outcomes that can be achieved have caught the attention of federal nursing home regulators, who today describe the Pioneer Network model as a preferred approach to care. Some examples of programs influenced by the Pioneers and similar groups include the Eden Alternative, Resident Centered Care, Resident Directed Care, the Ideal Nursing Home Program, Person Centered Care, the Neighborhood Concept, Wellspring, Live Oak, and SAGE.[4]

These programs share a commitment to new nursing home cultures that are life affirming, satisfying, humane, and meaningful. Their efforts encompass the full spectrum of elements that make up the environment: organizational, psychosocial, and physical. Emphasis goes beyond quality of life to *quality of living.* Most describe their approach as a journey rather than a program, because of the amounts of time and effort necessary to achieve the goals.

Our Journey

Look I am doing something new, now it emerges; can you not see it? Yes, I am making a road in the desert and rivers in the wasteland.

—Is 43:19

In January 2000, the administrations of both CCNR and SCNH decided to make the "jour-

ney" to culture change. To create and sustain environments that promote dignity, comfort, and autonomy for residents, and that inspire staff to be their most caring, creative, and effective was, we believed, what we had always hoped to achieve. We had, like other mission-driven organizations, written these concepts "in stone" in our mission statements. The concepts were, moreover, reflected in the values chosen by employees as part of the two facilities' mission integration process (see **Box,** p. 53). Even so, it was clear that we had not yet reached our goal.

The first step of this challenging passage was visiting and examining some Pioneer Network homes. CCNR and SCNH staff members visited Providence Mount St. Vincent, Seattle; Fairport Baptist Home, Rochester, NY; and Teresian House, Albany, NY. We also attended the first national Pioneers gathering in 2000, studied the relevant literature, participated in seminars, and held conversations with "culture change leaders." From the models we saw, we planned to choose the one that best fit the needs of our own communities. In reality, when the time came we chose to borrow aspects of various models, which resulted in an approach that was uniquely our own.

To move ahead with this ambitious project, we knew that we would have to achieve "buy-in" from the boards of trustees. To that end, we incorporated Pioneer Network concepts ("resident-directed care," as we then called it) in the strategic plans of each facility. These strategic plans were adopted by the boards in 2001, an action that guaranteed implementation of the new approach. In addition, the Cabrini Mission Foundation, our sponsoring congregation's fundraising arm, provided our project with enthusiastic support, both moral and financial, the latter in the form of a grant. With this backing in place, we assembled a steering committee that included representatives of the two facilities' departments of administration, nursing, human resources, social service, mission integration, and planning. The steering committee hired a consulting firm, the Brookdale Institute on Aging, Hunter College, New York City, led by Judah L. Ronch, PhD, to help guide us toward our objectives.

By the fall of 2001, the steering committee had, with the consultant's aid, begun to define for itself what resident-directed care might look like on a day-to-day basis. What we especially liked was an image of those employees who would naturally perform their duties in respectful and loving ways, and do so outside of the formal care system—that is, the rules, policies, and schedules of care—as "positive deviants" (to borrow a phrase social scientists sometimes use to describe good role models who emerge despite difficult situations). It was a pleasure for us to realize that both CCNR and SCNH were *already* honoring such "positive deviants" through their monthly Values in Action Awards, which acknowledge individual employees who exemplify the mission and values of the homes by going above and beyond their job descriptions and duties. Clearly, we had a group of employees who might be the natural leaders for change as we moved ahead.

We began to see that the desired culture for CCNR and SCNH would be one in which all employees demonstrated, in their day-to-day working relationships, the values they had themselves identified. To acknowledge the importance

Mission Statements

St. Cabrini Nursing Home (SCNH)

It is the mission of St. Cabrini Nursing Home to promote human dignity and respect of the residents and all those associated with the Home. This is accomplished through the efforts of religious and lay collaborators who provide quality care in an environment that is consistent with the Sponsor's healing ministry and with the applicable State and Federal mandates. St. Cabrini Nursing Home strives to use its available resources for persons to receive individualized care and concern through holistic efforts that are provided in a just work place in which collaborators minister and demonstrate respect for life in all its stages. The community of St. Cabrini Nursing Home, through its example and accomplishments, has as its purpose to provide innovative leadership in the areas of quality geriatric services, education, research, and public policy decisions affecting the continuum of long term care, so that society is better able to meet the growing needs of residents, their families, caregivers and advocates.

Cabrini Center for Nursing and Rehabilitation (CCNR)

Cabrini Center for Nursing and Rehabilitation is a skilled nursing facility sponsored by the Missionary Sisters of the Sacred Heart of Jesus. As an integral part of the Catholic health care mission in New York, it seeks to promote the teachings of the Gospel of Jesus as exemplified in the life of St. Frances Xavier Cabrini. Cabrini Center strives to communicate the compassionate, healing love God has for all, but especially for the poor and the suffering. Based on the belief that each person is made in the image and likeness of God and from this derives his/her dignity, each person is assured of quality care rendered in a compassionate manner with a responsible use of available resources. In synergy with its Cabrinian affiliates, it provides a continuum of health related services to the frail, the elderly, and the dying. A witness of true Christian values will be evidenced by all those responsible for the care and operation of Cabrini Center.

of the staff, and the staff-resident relationship, we adopted the phrase "person-centered care" (thereby replacing the previously used "resident directed care"). This new emphasis is amplified in the vision statement we wrote: "St. Cabrini Nursing Home and Cabrini Center for Nursing and Rehabilitation will be communities of residents and employees who live and work together in an atmosphere of respect and love, allowing members of the community to reach their greatest potential and experience joy." We like to summarize the statement as "Living Our Values Effectively," or LOVE.

The "effectively" is intended to remind us that our task now is to "break open" these familiar values, so that we can better understand their meaning and live them out resourcefully, creatively, professionally, and in a well-organized manner. If we do that, we will indeed be no more and no less than who we say we are, demonstrating our integrity as value-driven organizations in the Catholic and Cabrinian tradition.

Our journey along the path toward "person-centered care" has been hard work.

Into Action

Our journey along the path toward "person-centered care" has been hard work, and has consumed a few trees along the way. In the spring of 2002 we sent questionnaires to randomly selected groups of residents, their families, and employees at both facilities to assess perceptions of the care given and the living or working environment. Respondents were also asked to describe which aspects of the current care were going right, which were going wrong, and how things might be improved. Currently we are conducting a second survey. The Brookdale Institute consultants will tally the results, compare them with those from the 2002 study, and tell us whether we have succeeded or failed in reaching our goal.

In addition to sending out questionnaires, we conducted focus groups to obtain input from residents and staff on what was needed to achieve "person-centeredness." Using a guided interview format, facilitators asked participants to visualize how our two facilities would look and feel if they were truly person-centered and reflective of our values. From these sessions came a list of changes we would need to make that happen: systems, policies, supplies, space for privacy, architecture, communication, education, schedules, activities, and foods.

Staff members have suggested, among other things, improved communication across work shifts, more flexible work schedules, education for families on realistic expectations concerning long-term care, and more time to socialize with residents. Residents have suggested, among other things, the creation of a library, more outings, and more attention to preferences concerning food and dining companions.

A theme seen frequently in both resident and staff responses was the necessity of giving residents choices. Staff members emphasized their own needs for appreciation and respect from management, residents, and resident families. Using this information, members of the steering committee and others in the facilities have begun to address some of the issues raised, such as staff appreciation events, private space for staff on the nursing units, improved bathing facilities for resident comfort (and for staff members who help residents bathe), and more activity choices for residents.

As it happens, SCNH is currently preparing for a major modernization project that will enable it to incorporate many of the ideas submitted by

Self-Identified Staff Values

The staffs of the two long-term care centers identified the following as the values they would most like to see exhibited and honored in their workplaces:

SCNH: Respect, Compassion, Empathy, Cooperation, Loyalty, and Pride

CCNR: Excellence, Compassion, Respect, and Consistency

the focus group participants, as well as some that have been successfully incorporated in Pioneer Network institutions. Preliminary architectural drawings for the SCNH project were distributed among the facility's nursing units in an effort to get further input from staff, residents, and visitors. A more modest renovation, intended to address similar issues, is under way at CCNR.

In 2003 we began an education program at both facilities, led by our own trained staff, using a "train-the-trainer" methodology. A grant from New York's Department of Health is helping us to educate staff members, collect and evaluate data, and disseminate results. Additional funds from our local labor union allow us to replace employees while they are in training. To date, more than 500 staff members have, in groups of 15 to 20 people apiece, have participated in these all-day conferences

These sessions teach staff the person-centered care philosophy, thereby enabling them to:

- Understand how the two facilities' values (which they had themselves previously identified) support person-centered care
- Identify practices that promote person-centeredness
- Identify policies and practices that hinder it
- Recommend changes that will promote and support the person-centered care philosophy

Back to Our Roots

What began as an exploration of the "culture change" concepts of the Pioneer Network movement has become the renewal of a way of living and a working out of our values. Returning to our "roots"—our mission and values—has been a journey but not a true culture change for us.

In effect, we are simply going deeper into the meaning of our principles and ideals, translating them into concepts and words that are meaningful to employees and others today. In doing so, we are rediscovering the integrity to which those words and concepts call us—that is, to be who we say we are as Catholic Cabrinian institutions made up of people who are striving to provide care that is person-centered, just as Jesus was person-centered.

We can say, as did T. S. Elliot in *Four Quartets*, "We shall not cease from exploration and the end of all our exploring will be to arrive where we started and know the place for the first time."[5] □

NOTES

1. A. L. Caplan, "The Morality of the Mundane: Ethical Issues in the Daily Lives of Nursing Home Residents," in R. A. Kane and A. L. Caplan, eds., *Everyday Ethics: Resolving Dilemmas in Nursing Home Life*, Springer Publishing, New York City, 1990, pp. 37-50.
2. A history of the Pioneer Network can be found at www.pioneernetwork.net/index.cfm/fuseaction/showhistory.cfm.
3. *Everything Challenged . . . Everything Gained: Second Annual Conference of the Pioneer Network*, Rochester, NY, August 2001.
4. See W. H. Thomas, "Evolution of Eden," *Journal of Social Work in Long-Term Care*, vol. 2, no. 1-2, 2003, pp. 141-157; G. E. Bond, F. E. Fiedler, C. V. Keeran, et al., "The Neighborhood Concept as a Model for Long-Term Care," *Journal of Long-Term Care Administration*, Summer 1996, pp. 27-32; M. A. Kehoe and B. Van Heesch, "Culture Change in Long-Term Care: The Wellspring Model," *Journal of Social Work in Long-Term Care*, vol. 2, no. 1-2, 2003, pp. 159-173; B. Barkan, "The Live Oak Regenerative Community: Reconnecting Culture within the Long-Term Care Environment," *Journal of Social Work in Long-Term Care*, vol. 2, no. 1-2, 2003, pp. 197-221; C. K. Boyd, "The Providence Mount St. Vincent Experience," *Journal of Social Work in Long-Term Care*, vol. 2, no. 3-4, 2003, pp. 245-268; M. O. Gould, "Resident-Centered Care," *Health Progress*, November-December 2001, pp. 56-58, 72; S. Reese, "Putting the Resident First," *Contemporary Long Term Care*, May 2001, pp. 24-28.
5. T. S. Eliot, *Four Quartets*, Harcourt Brace, New York City, 1943, Part V.