Thesis: Systematic Review on Long Term Care Models

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ABSTRACT

Home is a place where our identity constantly develops through connections with the past and is defined by cultural, socio-demographic, psychological, political, and economic factors. Many older adults, near the end of their life, are calling long term care facilities their home. Long term care has experienced rapid growth over the past several decades. Currently, assisted living represents one of the most abundant institutional care settings for older adults. An estimated 36,000 assisted living facilities exist in the United States (National Center for Health Statistics, 2016) compared with an estimated 15,600 nursing homes (National Center for Health Statistics, 2016). With long term care facilities rapidly growing, there have been several different models composed, including medical model, person-centered care, Eden Alternative, and Green House model. These models were developed in order to improve one's quality of life as well as making these facilities appealing to older adults to move into. While making long term care facilities appealing to older adults, artifacts of culture change have regulated care practices, environment, family and community, and workplace practices. While this has influenced long term care facilities, there is still room for improvements in order to improve the quality of life in older adults.

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Introduction:

Over the years, housing as well as care plans have been developed for older adults in a wide variety of options, but there are still ways on improving the options, which can enhance the quality of life for older adults. Long-term care services include a broad range of health, personal care, and supportive services that meet the needs of other adults whose ability for self-care is limited because of a chronic illness, injury, physical, cognitive, or mental disability, or other health-related conditions (HHS). Long-term care services include assistance with activities of daily living, also known as ADL's, meaning dressing, bathing, and toileting, as well as instrumental activities of daily living, also known as IADL's, meaning medication management and housework. Long-term care services assist people in maintaining or improving an optimal level of physical functioning and quality of life, and can include help from other people, special equipment, and assistive devices. Additionally, it is the understanding that long term care settings can provide coordinating personal services, 24 hour supervision and assistance, activities, and health-related services as well as maximizing older adults' dignity, autonomy, privacy, independence, choice, safety, and encourages family involvement (Kane, 1998). Individuals may receive long-term care services in a variety of settings including in the home from a home health agency or from family and friends, in the community from an adult day services center, in residential settings from assisted living communities, or in institutions from nursing homes. Long-term care services provided by paid, regulated providers are a significant component of personal health care spending in the United States (O'Shaughnessy, 2013). Even though all of these services available to the older adult and their family, many believe that long term care facilities feel like

they are living in the hospital before there were regulations from culture change to make the setting feel more like home.

With the variety of services that are offered in long-term care settings, culture change utilized many characteristics of previous medical models of long-term retirement homes for older adults. During this period of developing long-term care facilities into a place where residents can have a good quality of life, it became possible to identify a basic foundation for long-term care. Long-term care started with no nursing home licensing prior to the 1950's (Grabowski, 2014). When state licensing began shortly after, the requirements varied dramatically with many being weak or unenforced. Over the years, state licensing laws began pushing nursing homes toward a mini-hospital model, also known as medical model, making them larger, more institutional, and less home like (Watson, 2009). After many years of trying to regulate the medical model, culture change began to develop. The culture change movement began in the 1990's after the passage of the Omnibus Budget Reconciliation Act of 1987 (Kelly, 1989), which mentioned the requirement that nursing homes meet the physical, mental, and psychosocial needs of each older adult. This culture change introduced person-centered care, which formed a variety of different long term care models. To assist the long term care facilities to develop a person-centered care approach, the artifacts of culture change was developed to form regulations. Throughout this article, we will examine the process of changes as well as go in depth on a few models of person-center care while comparing them to the medical model.

Introduction on Long Term Care Models:

Medical Model

The medical model, which originated in the 1950's, delivered high-quality, standardized care to a large number of individuals. The care provided in long-term care facilities has traditionally been based on a medical model. This is characterized by nursing units with centralized nursing stations and long, doubly loaded corridors with shared bedrooms and bathrooms. Often, the atmosphere feel is institutional and bare, and the setting provides few opportunities for older adults to personalize their environment. Older adults follow a strict routine that dictates when they eat and sleep. The medical model involves the use of medical terminology, which can be challenging for older adults and families (White-Chu, 2009). The medical model also focused on the individual's disease or chronic illness. This was not the ideal setting for older adults, so in the 1990's there were many changes that took place, including the culture change of person-centered care in order to improve these living environments. The culture change movement as well as person-centered care aims to improve resident quality of life and quality of care by relinquishing the traditional medical model of care and emphasizing the deinstitutionalization of nursing home culture (Zimmerman & Cohen, 2010).

Person-Centered Care

Person-centered care is a way of thinking and doing things that understands the individuals by using health and social services as equal partners in planning, developing and monitoring care to make sure it meets their needs (Brownie, 2013). In other words, this means putting the individual and their families at the center of making decisions as

well as seeing them as the professional. This effort seeks to transform nursing homes into resident-centered homes that offer long-term care services by changing the physical environment, values, norms, and supporting organizational structure (Zimmerman, 2014). Carl Rogers, one of the 20th century's leading humanistic psychologist, founded the person-centered approach to care. Rogers proposed that a person-centered approach, based on acceptance, caring, empathy, sensitivity, and active listening, promotes optimal human growth (Brownie, 2013). He believed that in order to actualize human growth in late life, individuals should have access to, and opportunities for, ongoing learning, personal challenges, and close and intimate relationships (Rogers, 1980). Furthermore, he argued that human capability for growth does not weaken with age, nor does the need for growth become less significant as we age. Person-centered care is not just about giving individuals and the families whatever they want, but is more so about considering their desires, values, family circumstances, social situation, and lifestyles. Some models of long term care that took on this concept of person-centered care include Eden Alternative and Green House model.

Eden Alternative

A model of long-term that that first took into account of the person centered care approach was the Eden Alternative. Developed by Dr. William Thomas in 1992, the Eden Alternative aims to decrease older adults loneliness, helplessness, and boredom (Tavormina, 1999). Since it originated, many facilities planned on improving the quality of life for older adults and have therefore adapted key components of the model. The Eden Alternative focuses on improving the quality of life of nursing home older adults while creating a homelike setting by permitting the older adults to interact with pets,

plants, and children by empowering staff to bring about these changes (Coleman, 2002). The benefits of implementing this model include decreases in behavioral incidents and use of restraints, as well as significant decrease in staff absenteeism and turnover. A series of behavioral studies conducted before and after Eden implementation at Providence Mount St. Vincent, a large senior-living care facility in Seattle, also found increases in older adults satisfaction and activity engagement (Boyd, 2003; Thomas, 2003). Qualitative interviews conducted at two other facilities in the United States revealed older adults' beliefs that their lives had improved, and that the goals of alleviating their loneliness, helplessness, and boredom had been achieved (Kruschke, 2006; Parsons, 2004). It is important to understand older adults thoughts, but also important to gain an insight on the clinical aspect as well.

In addition to studies of the Eden Alternative on older adults interactions, there was a different study that evaluated clinical outcomes. In a quasi-experimental study by Coleman and colleagues (2002), it explored outcomes after one year of Eden implementation. This study found significant differences including, significantly more falls and a higher proportion of older adults requiring skilled nursing in the Eden home, the hospitalization rate significantly higher at the control home compared to the Eden home and prescriptions for hypnotics higher for Eden, but prescriptions for anxiolytics lower across a number of time points. There were no significant differences found between the sites for rate of deaths, oral problems, cognition, activities of daily living, nutritional approaches, infection rate, or prescriptions for psychotropic and antidepressant drugs. While Coleman and colleagues (2002) found some positive differences for an Eden implemented facility, they concluded that there were no significant benefits in

terms of care and clinical outcomes. With making some improvements from the medical model, there were other models of long term care that took into account the Eden Alternatives advancements.

Green House Model

The Green House Project is an offshoot of Eden Alternative (Thomas & Johansson, 2003). According to William Thomas, the founder of Eden Alternative, the Green House Project is "an attempt to design, build and test a radically new approach to residential long-term-care for the elderly" (Thomas & Johansson, 2003). First, the Green House model opened in 2003 in Tupelo, Mississippi. Currently, there are approximately 140 Green Houses in over 30 states. The concept was developed by William Thomas who imagined a long term care setting where elders could live a meaningful life in a setting that they can call home (The Green House Project, 2016). When looking at the Green House concept, it removes the staff hierarchy that exists in traditional nursing homes. This means that they are allowing those who have the most contact with the elders to make decisions about care.

Green Houses are purposefully designed to provide elders with a home while they receive skilled nursing care. Green Houses are located on a single campus or are spread throughout the community (Rabig, 2006). Having the wide variety of care options available in one facility allows the older adult to call the facility their home. A longitudinal study of the first greenhouse model revealed higher scores on quality of life measures and fewer residents with depression, on bed rest, or engaging in little or no

activity (Kane, 2007). In order to allow for these significant changes, there were elements that where changed in the facilities environment among other aspects.

A strength about the Green House Model is each older adult has their own private bedroom and bathroom with a main area that holds a fireplace and a dining room with a table where staff and the older adults share meals. They are also resident centered, meaning that the older adults are encouraged to decorate the whole building as they like. The kitchen is open and older adults can eat what they want, when they want to, and some even help with cooking. There are unlocked doors that lead to a safe outdoors space. In sum, the Green House looks and feels like a real home. When comparing Green House older adults to the smaller, off campus nursing home, researchers found that Green House older adults were more satisfied with privacy, dignity, autonomy, and food enjoyment (Kane, 2007). Overall the satisfaction between the older adults and families are positive.

Artifacts of Culture Change

When introducing culture change of person-centered care in long term care facilities, the medical model facilities utilized artifacts of culture change to measure the amount of implementation within a facility. The Artifacts of Culture Change tool was developed to collect concrete artifacts of the culture change process that a facility has and which they do not have. It collected its data by using an assessment tool by rate scale to score the individual facilities to gain an understanding at how many aspects of culture change they have implemented (Bowman, 2006). This tool was broken into various categories including care practices, environment, family and community, and workplace

in order to enhance the living environments to boost the quality of life for the older adults, while giving them a more home like experience (Bowman, 2006). This tool was utilized to assess both the Eden Alternative as well as Green House Models. The following breaks it down by categories and shows the research from both models of long term care as well as other facilities.

Care practice

Some of the common care practices that are evaluated include dining services, pets in the facility, and allowing the older adults to manage their time with individualized daily routine. When measuring the dining services, some aspects that are focused on include menu style meals, availability of snacks, and older adult's choice on food preferences as well as meal times. At Providence Mt. St. Vincent, an Eden home, far less food is wasted due to the older adults choosing foods each meal at fully functioning neighborhood kitchens. The benefit of allowing the older adults choose their food shows an average number of older adults with weight loss in 1995 was twenty and in 2001, only three (Ronch and Weiner, 2003). Not only is the food important for quality of life, but studies have also shown aromatherapies can influence older adults lives. Buckle (1999), in her review of nine studies utilizing aromatherapy to address pain in a range of patients, found that subjects reported positive effects including perceptions of reduction in pain, improved sleep patterns, and improved ability to cope. Kunstler (2004) suggests there is sufficient evidence to demonstrate that aromatherapy can play a complementary role in pain management.

In addition to the meals and aromas, a care practice measurement was evaluated of having pets in a facility. As documented by the Eden Alternative, among many other benefits, animals help eliminate loneliness, depression, and medical ailments, increase socialization and motivates the older adults to become more active (Haleigh's Almanac, 2002). In the Quality of Life study, of the 1,988 older adults in 40 Green House homes, only 2% had a dog, cat or other pet (Cutler, 2006) Even though 2% seems like a low number the Quality of Life study showed many benefits to companion animals including lower blood pressure and pulse rate, 21% fewer visits to the doctor, less depression, and older adults become more active (Kane, 2004). Having pets around can not only benefit the owner, but it also affects the whole living environment for the facility.

When focusing on care practices, there are some strengths and weakness for a facility to be actively attentive to following the care practices as suggested by the artifacts of culture change tool. As noted above, some strengths include increases socialization, appetite, sleeping patterns, and pain management. The weakness or difficulty in implementation of care practices include lack of staff training, being short staffed, cost of food, as well as the staff to older adult ratio in the facilities. The articles of culture change tool lacks the identification of how to implement each question. The following is an example of how this can be considered within care practices and the implementation in resident choice. "Consider a typical staff communication with a resident: "Hi, Ms. Smith, it's time to get up now. Is that OK?" Some would argue that this question encourages resident choice, whereas others would contend that, to the contrary, it merely prompts quick consent. To improve staff behavior in this situation, specific information about how the staff encourages residents to make choices is needed" (Rahman, 2008). Overall, care

practices can benefit the older adults within the community, but in order to make the artifacts of culture change tool stronger, there needs to be clarification on specific ways to train staff to have a universal implementation.

Environment

Environment seeks to create a meaningful relationship between the person and her or his living environment. At Brookhaven in Findley, Ohio, the child day care takes place in the Green House model where the environment was built with input from older adults, asking what they wanted in a children's space where they would visit regularly. The result was family living spaces with comfortable chairs and tables for use by adults and children together (Norton, 2005). In addition to the family living space, the older adult's personal space is just as important. One feature of the medical model that people have expressed that they do not want is to share a room with a stranger. As such, private rooms were given a higher score in this tool, also reflective of the commitment of the home to make structural changes, give up shared rooms for private or the foresight of original construction into private rooms. Many Green House facilities as well as some of the Eden Alternative facilities dedicated to culture change have eliminated all or the majority of shared rooms for private ones. The Quality of Life study showed that those facilities deemed to have high quality of life had the most private rooms and that the older adults who were interviewed greatly preferred private rooms to shared rooms (Kane, 2003). An environmental feature in addition to living space that is becoming more popular is the elimination of overhead paging. Fairport Baptist Home, a Green House home, reports that it improves the working environment, creates a more normal living environment by

significantly decreasing white noise throughout the facility and this in turn has decreased the older adults agitation, especially of those dealing with dementia (Brokaw, 2006).

In addition to the indoor environment, the outside can have an immense impact on an older adults quality of life. Of the 131 unit environments in the Measures, Indicators, and Improvement of Quality of Life in Nursing Homes study, 55.7% had no outdoor services. Of those older adults who were physically able to go outdoors, 32% do so less than once a month (Cutler and Kane, 2006). "Beyond therapeutic benefits, being outdoors arguably is positively associated with improved perceptions of quality of life. Yet outdoor space, outdoor amenities, and access to outdoor space have often been ignored in the design phase or simply value engineered out of a project due to cost when in reality outdoor spaces are especially important to persons sequestered in institutional settings. When outdoor spaces are available to nursing home residents, most often the accessibility and functionality of those spaces are ignored (Cutler and Kane, 2006)." Research shows that several hours of outdoor activity in the morning greatly reduced unwanted behaviors later in the day and reduced psychotropic medications 40 % as reported by Gold in 2004 (Cutler and Kane, 2006). All of these aspects are an important aspect to increasing the quality of life for older adults as well as the interaction's they have with other individuals.

When analyzing the environment domain of the tool, some of the strengths that can be observed include decreasing the aggravation, behaviors, and medications for older adults. These aspects can all benefit the environment of the facility, while creating a more home like feel. Even though the implementation of the environment portion of the tool including a children space, outdoor space, and elimination of background noise are positive, these are difficult to put into practice in facilities. The environment is probably

the number one aspect that facilities should put into consideration, yet this is the number one characteristic that is lacking. Specifically, the artifacts of culture change tool in the environment section lacks resources and specifics on how to implement each item. An example of this is question 33 when asked if an exercise room is available to older adults (Bowman, 2006). This question can depend on the directors point of view meaning what equipment is required, is it just have weights available or does this mean access to an exercise bike. Also, it does not take into account the times that it is available to the older adults and if a staff member is assisting. Another example of this is when considering the outdoor space. There are many facilities that have beautiful outdoor spaces for the older adults and families to use, yet they are locks most of the time. Overall, in order to enhance the environment section of the tool, it needs to take into consideration the availability and access the older adults has to the different areas of the facility.

Family and Community

Family and Community seeks to embrace and draw family members into a shared partnership of supporting and caring for the older adult. It is essential to include the families of the older adults as much as possible, so one aspect that is significant is having a guest room in the facilities for families to utilize. At Teresian House and Providence Mt. St. Vincent have guest rooms. Teresian House reports it is used by families who come from out of town as well as families of older adults passing away. Older adults visit their families in the guest room and even parties are held there (Brecanier, 2005). This can also be utilized for families when they are transitioning the older adult into the facility.

When observing the family and community sections of the artifacts of culture change tool, a strength is making the facilities aware of making interactions with not only the family members, but also children and the surrounding community. The tool also features many benefits for the older adults family members like special bedrooms and dining areas, as well as places that the families and older adults can cook homemade recipes. These features can really make an older adult feel like home as well as allow them to regain their independence. Unfortunately, under family and community the tool lacks some key elements like providing events the invites families monthly or quarterly to the facility as well as key communication between staff members and family members. Surprisingly, the tool has the least amount of questions under the family and community section, yet this is a key element in caring for the older adult as well as providing socialization.

The Eden Alternative teaches that children give the older adults the opportunity to give care, and help to diminish loneliness and boredom. Participation in activities with small children lowers the older adults' agitation levels (Ward, 1996). In addition to the small children visiting the home there are various other approaches that make the community a better place to live. Homes that have successfully integrated various approaches have been named generative communities, the first example being the original Eden home in New York, Chase Memorial Home. "More than 200 birds, four cats, two dogs, dozens of plants, a child care centre, a garden, and a visiting school-children's program help create what founder Dr. Bill Thomas and his wife Judy call 'a holistic environment….' One of the principles they enacted is that people need to give care as well as receive care to feel valuable…. Compared to a nearby control facility, the

Thomas's documented statistically significant reductions in mortality and in illness as well as drug use" (Eaton, 2000). These are all aspect that have increased the older adults health and made them feel more at home. Not only are children and animals important to the living environment, but a critical aspect is the employees that are utilities to help the older adults in their ADL's and IADL's.

Workplace & Staffing Outcomes

Workplace Practice entails management practices that affect a culture of retention. Increase in census is another positive outcome experienced by culture changing homes. According to the data, from the CMS Nursing Home Data Compendium 2005, the average occupancy rate in 2004 was 84.2 %. A two year study of Eden homes showed an 11% increase in census (Ransom, 1998). An increase in private pay census has been experienced by pioneering homes as reported by the Pioneer Network (Culture Change in LTC, 2003). The occupancy of the individual facilities play an important part of the amount of staff that a building can employ. As noted above, improving census in a facility is always going to be a strength, yet maintaining it can always be a struggle for facilities. Unfortunately, facilities often experience waves of high and low census meaning that facilities can be full for years then unexpectedly experience a dramatic drop and take years to fully recover. Therefore, to fully establish an accurate result of the effect this tool or a long term model of care has on census, there needs to be longitudinal data available.

Turnover in staff at nursing homes utilizing the medical model is high and has traditionally been high. Industry statistics show turnover to be 100% for CNAs, 66% for

RNs and LPNs, 50% for Directors of Nursing and 25% for Administrators (Wunderluch, 2001). Culture changing homes have experienced the opposite. In 2004, seven facilities in Michigan that had adopted The Eden Alternative reported an average staff turnover reduction from 72% to as low as 9%, the average being 15% (Steiner, 2004). Turnover at Providence Mt. St. Vincent reduced from 50 to 22% from 1992 to 2003. Big Fork Valley, formerly Northern Pines Communities, adjusted turnover rate declined from 52 to 13 % with the implementation of communities from 1999 to 2000. The communities celebrated 100% retention of all employees in all positions during the first 6 months of 2000, only three months after transition (Bowman, 2005). The staffing in the facilities is significantly important as having the same staff continually care for the same older adults, that is when relationships form, staff get to know the older adults needs and preferences, and staff pick up on older adults changes in condition (CMS satellite broadcast, 2002, Misorski). Consistent staffing correlates to low turnover and nurses prefer it (Eaton, 2001). From the Kane study, those facilities determined to have high quality of life implemented permanent CNA staffing. Similarly, self-scheduling has been found to resolve scheduling issues and results in staff being more responsible to each other and to their residents (Eaton, 2001). Overall, keeping the staff happy can play an important impact on the older adults quality of life.

One of the biggest strengths of the artifacts of culture change tool is the utilization of the staffing questions that are asked. The tool focuses on allowing the staff members to consistently work with the same older adults. This is very important in order to establish meaningful relationships that will last a lifetime. One weakness to this is staff burnout, if the hallways are not staffed according to older adults level of care and

behaviors. This tool does not taken the older adults level of care into account while using this tool.

Overall Reports

Based on 319 surveys that were completed from 2010 and 2011 on various facilities, the artifacts of culture change benchmark report states the following information seen in table 1 (Pioneer Network in Culture Change, 2011). Table 1 shows the various sections and the average score of implementation. As seen in this table, staffing outcomes and census have the highest rate, while the environment has the lowest.

Table 1

Artifacts Average Totals by Section

SECTION	AVERAGE SCORE	MAXIMUM SCORE	PERCENT COMPLETE
Care Practice Artifacts	35	70	50.00%
Environment Artifacts	102	320	31.88%
Family & Community Artifacts	15	30	50.00%
Leadership Artifacts	9	25	36.00%
Workplace Practice Artifacts	32	70	45.71%
Staffing Outcomes & Occupancy	48	65	73.85%
Total Scores	**241**	**580**	**41.55%**

(Pioneer Network in Culture Change, 2011)

In addition to the overall scores, some aspects of the artifacts of culture change assessment that had 100% completion rate by all facilities include accessible bathroom sinks, decorate rooms, snacks, outside conferences, walking paths, extra lighting scores, special dining rooms, job development, community group meetings, sinks with paddle handles, activities led by other departments, temp control in individuals rooms, birthdays, room refrigerators, and accessible bathroom mirrors. On the other hand, there are various

aspects of the assessment tool that many facilities have not yet implemented including day care center on site, older adults having pets, warm towels for bathing, massages, baked goods, aromatherapy, staff not having uniforms, private guest room, and self-scheduling. Some reasons as to why these changed are more difficult for the facilities to implement is because of state regulations, implementing more paperwork, and budgets. These are all aspects that can be improved in the facilities in order to create an improved living environment for the older adults.

Conclusion

The movement away from the medical model of care to one that accepts a person-centered care approach like the Eden Alternative and Green House models of care are impacting the future of long term care for older adults. When observing the Eden Alternative, their model showed a significant decrease in behavioral incidents, pressure ulcers, infections, and a significant decrease in staff absenteeism and turnover. The reasons that this could have occurred is because the Eden Alternative focused on providing a homelike environment by allowing pets and encouraging children in the facility. When analyzing the Green House model, it showed the older adults more satisfied with privacy, dignity, autonomy, and food enjoyment, yet a decrease in the staff's satisfaction. This would make sense since the Green House model's of care houses less residents when compared to traditional nursing homes, therefore the older adults receive more one on one time with the staff. On the other hand, the staff's satisfaction decreases most likely because the there are less staff members in a Green House and they act as universal workers. Being a universal worker means that the staff is not only providing the older adults with activities of daily living, but also cooking, housekeeping,

meeting with families, and managing the facility. When comparing these models, there are benefits as well as negative aspects to each long term care model. Therefore, there is not one model that has been implemented that holds all the answers to being the best for staff, families, and older adults.

A strength of the Artifacts of Culture Change Tool is that it measures visible changes resulting from an underlying change in culture. However, in the same sense that visible artifacts provide anthropologists and sociologists with only a partial glimpse into societies, the Artifacts of Culture Change Tool provides only a partial picture of the extent of implementation (Sullivan, 2013). Therefore, this tool is beneficial for facilities to utilize, but it is also based on the directors viewpoint and how they want to implement the tool. The tool overall lacks the specifics needed for a universal implementation.

In future studies, researches should still utilize the artifacts of culture change assessment tool as a guideline in order to gain an understanding of how long term care facilities continue to change. A starting tool may be to get a few facilities to commit to the aspects of culture change that did not have any implementation like having an onsite day care, warming towels for bathing, aromatherapy, and baked goods available daily to see the different results in the older adults behaviors, family satisfaction, and staff retention rates. Doing this would allow individuals to know if these aspects do benefit the older adults and just how much influence they are in terms of an older adults quality of life.

Facilities that commit to the studies should also be open to being analyzed by using the artifacts of culture change tool multiple times over a period of time. Having

some longitudinal data on the artifacts of culture change tool could should the impact this tool has truly made on the implementation of culture change in long-term care facilities. This could also benefit other facilities by encouraging them to change models or the way of managing a long term care facility if there is significant longitudinal data. Some of the suggestions that the artifacts of culture change tool needs to take into consideration include making sure the management team is open to changes, having unannounced visits from surveyors, and making the commitment to becoming a person-centered community.

As mentioned above, one of the suggestions was to making sure the management team is open to changes. This is an important aspect because it is one of the biggest barriers to the implementation of culture change. Scalzi (2006), conducted a study of 3 nursing homes undergoing a culture change initiative, reported that one barrier to change was when nurses felt excluded from the culture change process; however, homes that had a "critical mass of change champions" were enabling. Unfortunately, many long term care facilities cling tightly to the hierarchical model, thinking that the authoritative "top-down" approach will prevent survey deficiencies or fines (Anderson, 2003). As part of the empowerment process that the management puts forth, the human resource department can play an influential role in terms of both management philosophy and quality improvement. This is an important reason as to why facilities deter change within a facility, but if a staff member is trained properly and management does their part in following up on the non-department heads, then there would not be a hierarchical model.

When utilizing the artifacts of culture change tool, there are also some weaknesses that can hinder its implication. One of the biggest challenges is the tool is lengthy, which can prevent facilities from using it. A suggestion is to shorten the tool or

have facilities utilize only the areas of their weaknesses. An example of this can be if a facilities is seeing a lack in staff members forming a relationship with the residents or families, then focus on the family and community artifacts of the tool. Another weakness that this tool lacks is it does not encompass every workplace element, nor does it illustrate everything that makes a person centered facility. Some elements that it lacks include, general training skills for staff, producing goals, how cross-training works, front-line staff making decisions, incentive pay for performance, and flattening supervisory hierarchy (Bishop,2014). All of these aspects are important in order to please both the older adults and staff members. There is still room for advancements, but overall older adults are more inclined to enjoy a quality of life with quality food, better living environments, and familiar faces with less staff turnover when implementing aspects from the artifacts of culture change.

References

Anderson, R., Issel, L, and McDaniel, R.(2003). Nursing homes as complex adaptive systems: Relationship between management practice and resident outcomes. *Nursing Res*. 52: 12–21.

Barkan, B. 2002. The Way of the Champion. *The Pioneer Network Live Oak Group.* Rochester, NY – El Sobrante, CA.

Bishop, C. E. (2014). High-Performance Workplace Practices in Nursing Homes: An Economic Perspective. *The Gerontologist, 54*(Suppl 1). doi:10.1093/geront/gnt163.

Bowman, C., & Schoeneman, K. (2006). Development of the artifacts of culture change tool. *Centers of Medicare & Medicaid services. Edu-catering, LLP.*

Bowman, S. (2005). "Wireless gains ground." *Culture Change Now*, 3, 13.

Brecanier, Sr. Pauline. Input into the artifacts of culture change project, Aug. 2005.

Brokaw, Garth. CEO Fairport Baptist Home, Fairport, NY personal correspondence, April 2006.

Brownie, S. (2013). Effects of person-centered care on residents and staff in aged-care facilities: a systematic review. *Clinical Interventions in Aging*, 8, pp. 1-10. Retrieved from http://dx.doi.org/10.2147/CIA.S38589.

Buckle, P., & Li, G. (1999) Current techniques for assessing physical exposure to work-related musculoskeletal risks, with emphasis on posture-based methods. *Ergonomics,* 42:674–95.

Coleman, M. (2002). The Eden Alternative: Findings after 1 year of implementation. *Journal of Gerontology: Medical Sciences*, 57, M422–M427.

Cutler et al. (2006). Assessing and comparing physical environments for nursing home residents: Using new tools for greater research specificity. *The Gerontologist*, 46 (1), 42- 51.

Eaton, S. (2000). "Beyond unloving care: Linking human resource management and patient care quality in nursing homes." *International Journal of Human Resource Management*. 11(3), 591-616.

Eaton, S.(2001). What a difference management makes! Nursing staff turnover variation within a single labor market. Appropriateness of minimum nurse staffing ratios in nursing homes, report to congress: Phase II final, Chapter 5. Baltimore, MD: Centers for Medicare and Medicaid Services (CMS), 1– 61.

Grabowski D. C., O'Malley A. J., Afendulis C. C., Caudry D. J., Elliot A., Zimmerman, S. (2014). Culture change and nursing home quality of care. The Gerontologist, 54(Suppl. 1), S35–S45. doi:10.1093/geront/gnt143.

Haleigh's Almanac. Texas Long Term Care Institute, Southwest Texas State University. San Marcos, TX, 2002.

HHS. LongTermCare.gov. Washington, DC. Retrieved from http://longtermcare.gov/the-basics/what-islong-term-care/.

Kane, R. (1998). *Heart of long-term care*. New York: Oxford University Press, New York.

Kane, R. (2003). Definition, measurement, and correlates of quality of life in nursing homes: toward a reasonable practice, research, and policy agenda. *Gerontologist.* 43:28–36.

Kane, R. (2004). Measures, indicators, and improvement of quality of life in nursing homes: Final report. *Centers for Medicare and Medicaid Services.*

Kane, R. (2007). Resident outcomes in small-house nursing homes: A longitudinal evaluation of the initial Green House program. *Journal of the American Geriatrics Society*, 55(6), 832-839. doi: 10.1111/j.1532- 5415.2007.01169.

Kelly M. (1989). The Omnibus Budget Reconciliation Act of 1987. A policy analysis. Nursing Clinics of North America, 24, 791–794.

Kunstler, R., Greenblatt, F., Moreno, N. (2004). Aromatherapy and hand massage: Therapeutic recreation interventions for pain management, Second Quarter.

Misiorski, Susan. "The pioneer network: Innovations in quality of life," CMS satellite broadcast, September 2002.

National Center for Health Statistics. (2016). *Nursing home care.* Retrieved from http://www.cdc.gov/nchs/fastats/nursing-home-care.htm

Norton, L. (2005). "Rethinking the nurses' station." Culture Change Now, 3:11 -17.

O'Shaughnessy, C.(2013). The basics: National spending for long-term services and supports (LTSS), 2011. Washington, DC: The George Washington University National Health Policy Forum. Retrieved from http://www.nhpf.org/uploads/announcements/Basics_LTSS_02-01-13.pdf

Pioneer Network in Culture Change. (2011). Tools for change: Artifacts of culture change benchmark reports. 1 (1). Retrieved from www.artifactsofculturechange.org.

Rahman, A. N., & Schnelle, J. F. (2008). The nursing home culture-change movement: Recent past, present, and future directions for research. *The Gerontologist, 48*(2), 142-148. doi:10.1093/geront/48.2.142

Ransom, S. (1998). The Eden Alternative: Creating human habits in Texas nursing homes. *Texas Journal on Aging*, 1(1), 8-13.

Rogers, C. (1980). Way of Being. Boston, MA: Houghton Mifflin Company.

Ronch, J. & Weiner, A. (2003) Culture change in long term. *Journal of social work in long-term care.*(2) The Huff Press.

Scalzi, C., Evans, K., Barstow, A. (2006). Barriers and enablers to changing organization culture in nursing homes**.** *Nurs Adm Q*. 30: 368–372

Steiner, J. (2004). Successful Edenization through education. *Nursing homes*, 53(3),46-49.

Ward, C. (1996). The effects of participation in an intergenerational program on the behavior of residents with dementia. *Journal of Activities, Adaptations and Aging*. 20 (4), 61-76.

Watson, S. (2009). From almshouses to nursing homes and community care: Lessons from Medicaid's history. *Georgia State University law review,* 26 (3), 13. Retrieved from http://readingroom.law.gsu.edu/gsulr/vol26/iss3/13.

White-Chu, E. F., Graves, W. J., Godfrey, S. M., Bonner, A., & Sloane, P. (2009). Beyond the Medical Model: The Culture Change Revolution in Long-Term Care. *Journal of the American Medical Directors Association, 10*(6), 370-378. doi:10.1016/j.jamda.2009.04.004

Wunderluch & Kohler. (2001). IOM Committee on Improving Quality in LTC. Improving the quality of LTC. Washington D.C..

Zimmerman, S. & Cohen, W. (2010). Evidence behind The Green House and similar models of nursing home care. Aging Healthz, 6, 717–737.

Zimmerman, S., Shier, V., & Saliba, D. (2014). Transforming Nursing Home Culture: Evidence for Practice and Policy. *The Gerontologist, 54*(Suppl 1). doi:10.1093/geront/gnt161.