A COMPARATIVE EXPLORATION OF CULTURE CHANGE IN NURSING HOMES: THE RESIDENTS' PERSPECTIVE

by

Louise Marie Murray

A dissertation submitted to the faculty of
the University of North Carolina at Charlotte
in partial fulfillment of the requirements
for the degree of Doctor of Education in
Educational Leadership

Charlotte

2010

Approved by:

_____

Dr. John A. Gretes

_____

Dr. Chuang Wang

_____

Dr. David M. Dunaway

_____

Dr. Dena Shenk

_____

Dr. Grace Mitchell

ABSTRACT

LOUISE MARIE MURRAY. A comparative exploration of culture change in nursing homes: the residents' perspective. (Under the direction of Dr. JOHN GRETES)

The need to provide an environment that ensures both quality care and quality of life for residents of nursing homes has long been recognized. The culture change movement in nursing homes emphasizes both principles. This mixed-methodology research explores the culture change process in nursing homes by evaluating to what extent core principles of culture change: quality of life, resident choice and control, and resident satisfaction, are demonstrated in the behaviors, attitudes, and day-to-day experiences of the residents. Four groups of subjects in two not-for-profit nursing homes, in which culture change is being implemented, participated in this study. Data were collected in the form of surveys and interviews from nursing home administrators, residents, direct care staff, and family members or friends of residents.

The level of the culture change process was found to vary between the two nursing homes and a comparative inferential analysis of the quantitative data as to the resident quality of life, perceptions of choice and control, and level of satisfaction at the two nursing homes showed statistically significant differences in the quality of life domains of privacy and security only. No significant differences were found in resident satisfaction with the nursing home or resident perceived latitude of control.

The analysis of the qualitative data from the four groups of participants identified the major themes in the categories of resident quality of life, perceptions of choice and control, and level of satisfaction. Common themes in the factors reported as essential to quality of life by the residents at both nursing homes were quality of care, relationships,

activities, physical/functional ability, faith, and safety/security. Relationships and faith were again identified as common themes in the factors reported as essential to maintaining control in their lives by the residents at both nursing homes as were attitude and the ability to advocate for oneself. Only one theme common to both residents at both nursing homes was identified as the worst thing about living in a nursing home and as the best thing about living in a nursing home, the noise/behavior of other residents and relationships respectively.

Implications for practitioners include the recognition of the importance of both peer-relationships and relationships with staff to resident quality of life, choice and control, and satisfaction and the process of adjustment to institutional living and the influence of resident attitude towards their living situation. Privacy and security were found to be important factors in the experience of the residents as was quality of care. Recommendations for future research include longitudinal and qualitative studies to explore resident perceptions of ongoing culture change and additional research to provide an increased understanding of the mechanisms by which relationships are formed and maintained between residents and staff in the long-term care environment. Further research exploring resident adjustment to institutional living, both in the short and long-term, would also be of value.

DEDICATION

This dissertation is dedicated in loving memory of my father, Frank Smeathers.

ACKNOWLEDGMENTS

I would first like to thank my Chair, Dr. John Gretes. Thank you for your knowledge and guidance, from which I have greatly benefited. I thank you for your positive attitude, for helping me to keep things in perspective, and moving me ever forward. I really appreciate all your time and support and all you have done for me. I would also like to thank all my committee members. Dr. Chuang Wang, I have learned so much from working with you. Thank you for going above and beyond in the hours you have spent helping me in my work. Dr. Mickey Dunaway, thank you for starting this whole process off for me. You made me realize that I could combine all my research interests into one and embark on a dissertation that would be both enjoyable and challenging. Dr. Dena Shenk, you introduced me to the field of gerontology and helped me take my first steps into academia. I thank you for many years of encouragement, guidance, and friendship. Dr. Grace Mitchell, your enthusiasm and dedication to the Educational Leadership program at UNC Charlotte started me upon this path; I thank you for your friendship and always valuable advice. Thank you for being with me at the end of this journey.

Mike and Sindy, thank you for guiding me through the health care research process. Mike, thank you for answering my endless questions and for telling me, "You can do it!" Much appreciated and much needed. Sindy, the world of geriatrics is a much better place with you in it. Also, my thanks to my good friend Andrea; thank you for being a proof reader extraordinaire and thank you for listening!

Last, but definitely not least, thank you to all my family, especially my much neglected husband, Paul, and children, Christopher and Michael. Thank you Paul for your

consistent and endless support and for helping me to achieve my dream! Thank you all for putting up with me sitting, endlessly reading and typing, when I should have been paying you more attention. Chris, it's your turn to be a UNC Charlotte student now! Also, big thanks to my mother, Ann Smeathers, and all my family, in-law's, and friends in the UK for your long-distance encouragement and support.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1: INTRODUCTION

Overview

As life expectancy increases, and the population in the United States ages, it is becoming increasingly vital that health care is provided in a manner in which the dignity and value of each and every human being is preserved. An essential component of long-term healthcare for older adults and adults of all ages is the skilled nursing facility, or nursing home. While the majority of nursing home residents are aged 65 years or older, this aspect of health care is not limited to this population. The 2004 National Nursing Home Survey revealed that in that year 1,492,200 nursing home residents (1,317,3000 aged 65 and older) received care in the vast network of facilities. These facilities vary in their characteristics with 61.5% being proprietary and 38.5% voluntary non-profit (National Center for Health Care Statistics, n.d.). Risk factors of nursing home utilization are identified as dementia, advancing age, functional disabilities, lack of social support, and the number of prescription medications utilized (Bharucha, Pandav, Shen, Dodge & Ganguli, 2004). Therefore, it is essential that quality care be provided in an appropriate manner for these persons with physical, social, and psychological needs.

The report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, by the Institute of Medicine (IOM) calls for a health care reform that provides for the safety of the recipient by providing personalized care while focusing on effectiveness, efficiency, and the timely delivery of equitable services. In order to achieve

this, the IOM provides guidelines for redesign that include care individualized to patient preference, values, and needs, and provision for patient control (Institute of Medicine, 2001a). An additional IOM report addressing quality in long-term care (Institute of Medicine, 2001b) highlights recent improvements in quality of care in nursing homes and quality of life among residents of nursing homes but also acknowledges inconsistencies in the level of care provision and the need for continued improvement in the quality of care provided by such facilities. Thus, the prior model of care used by nursing homes, the medical model, is in need of reform in order to meet the changing needs of the population.

The medical model of care in nursing homes has been described as inadequate and failing to provide humanistic care, especially for persons in need of long-term services (Reynolds, 2003). Indeed, this model of care has been charged with promoting a sense of homelessness among the institutionalized (Carboni, 1990). Many believe that the extant organizational culture is not providing adequate results. Persons who seek care and shelter within this system become disempowered, dependent, and vulnerable (Carboni, 1990). To address these problems, a movement advocating an organizational culture change has arisen and is growing in momentum (Misiorski, 2003; Moles, 2006; Reynolds, 2003; Tellis-Nayak, 2007a).

Organizational culture has been defined as "socially acquired and shared knowledge that is embodied in specific and general organizational frames of reference" (Wilkins & Gibb Dyer, 1988, p.523). Schein (1993/2005) conceptualizes organizational culture as encompassing three elements: socialization, deeply held assumptions, and recognition that an organization can have more than one culture. Therefore, Schein

defines organizational culture as a "pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to members as the correct way to perceive, think, and feel in relation to those problems" (pp. 364-365).

In order for culture to change, the old culture must first be disrupted and a new culture established. Cultural change is a far more difficult task than cultural maintenance and involves planned, deliberate, and substantial changes for organizations (Trice & Beyer, 1993/2005). The culture change movement in nursing homes focuses on both the philosophy and the process of change (Mitty, 2005). It aims to create a culture based upon the values of resident-centered or directed care, customer satisfaction, individualized care, empowerment of both residents and staff, enhancement of quality of life, a sense of community, and choice and dignity (Grant & McMahon, 2008a; Misiorski, 2001; Mitty, 2005; Moles, 2006; Robinson & Rosher, 2006).

Although there are various models of culture change, the core constructs that underlie them are identified by Grant and McMahon (2008c) as being: (1) resident-directed care and activities, (2) a home-like environment, (3) relationships, (4) staff empowerment, (5) collaborative management and shared leadership, and (6) a measurement-based process of quality improvement.

Many examples of this process of culture change are documented in the literature and the benefits, barriers, and challenges to the implementation and sustenance of such a change are identifiable (Appel Doll, 2004; Grant & McMahon, 2008b; Keane & Shoesmith, 2005; Misiorski, 2001; Misiorski, 2003; Moles, 2006; Reynolds, 2003; Robinson & Rosher, 2006). Factors working against change range from regulatory

constraints to terminology to sustainability of the change (Moles, 2006; Reynolds, 2003; Robinson & Rosher, 2006). Leadership, environmental factors, financial constraints, the required initial investment, day-to-day operational issues, and staff and resident buy-in (Grant & McMahon, 2008b; Keane & Shoesmith, 2005; Misiorski, 2001) are all identified as barriers to culture change in this context. Therefore, organizational culture change in this context is a complex concept.

The importance of evaluation in maintaining and improving this process has been established (Misiorski, 2003; Mitty, 2005; Moles, 2006; Reynolds, 2003). However, the lack of empirical research supporting culture change in nursing homes is also clear. Indeed, the IOM Institute of Medicine (2001b) calls for empirical studies that demonstrate the value of models of culture change among nursing homes. Much of the research to date describes the process of implementing such a culture change and the challenges to providing an in-depth evaluation of the process are evident. Prior research has provided little insight into the effects of the culture change process for the residents themselves. As the underlying philosophy of the culture change movement is to improve the quality of the experience of the nursing home for residents, this appears to be a much neglected facet of the evaluation.

Culture change entails a considerable investment for the nursing home facilities that commit to the process and involves significant and long-term changes within the organization (Grant & McMahon, 2008b). Therefore, it is essential that further empirical research is conducted to provide evidence to support such a process. While standardized instruments that will provide facilities with a method of assessing culture change implementation have been newly developed (Center for Medicare and Medicaid Services,

2006), the need for data pertaining to resident satisfaction and quality of life, and the challenges of developing instrumentation to allow for these measures has been highlighted (Kane, 2003a; Rahman & Schnelle, 2008). Therefore, it is anticipated that the findings of this research will serve to strengthen the culture change movement by adding an increased understanding of the resident perspective of both the process and the outcomes. An in-depth exploration of this neglected perspective will give both voice to the residents themselves and provide evidence regarding the value of this growing philosophy of care.

The overall goal of this research is to add to the growing body of literature pertaining to culture change within nursing homes by providing an in-depth evaluation of the change process from the perspective of the long-term care resident. Therefore, the purpose of this research is to explore the culture change process by evaluating to what extent the core principles of culture change are demonstrated in the behaviors, attitudes, and day-to-day experiences of the residents in facilities in which culture change is being implemented.

The research questions to be explored are:

1. To what extent are different valued characteristics of culture change (quality of life, resident satisfaction, resident perceptions of choice and control) identified by long-term care residents?
2. To what extent do valued characteristics of culture change identified by long-term residents vary between facilities at different stages in the culture change process?
3. What are the common elements of the experience of living in a nursing home for the residents?

4. What are the similarities in the common elements of the experience of living in a nursing home for the residents between two facilities at different stages in the culture change process?
5. What are the differences in the common elements of the experience of living in a nursing home for the residents between two facilities at different stages in the culture change process?

Delimitations

This research was carried out at two nursing homes belonging to a southeastern, not-for-profit health care organization. These facilities provide skilled nursing care for adults in need of both short-term rehabilitation and long-term care. Both are committed to the philosophy of culture change and are at different stages in the process. The focus of this study was long-stay residents; residents having resided in the facility for three-months or more. This classification of residents as long-stay residents is based on the prior study of Straker, Ejaz, McCarthy, and Jones (2007).

Therefore, only residents who were identified as residing in the nursing home for a minimum of three-months, were competent to provide informed consent, or for whom proxy consent was obtained, and were physically and cognitively able to participate in research involving both survey and interview methodology, were included in this study. Due to the far greater proportion of females (71.15%) and whites (85.5%) among nursing home residents nationally (National Center for Health Care Statistics, n.d.) it was anticipated that white females would be overrepresented among the sample of residents. Conversely, minorities and males would be underrepresented.

Family members/friends of residents and direct-care staff (certified nursing assistants) were also invited to participate in the qualitative portion of this study. Family members/friends of the residents (who participated in the qualitative portion of the data collection) were only included if they visited the residents on a regular basis, at least once every two to three weeks, to ensure that they had an adequate knowledge of the facility.

Direct-care staff were included if their primary role was that of a certified nursing assistant (CNA) and their most frequent staff assignment was in a role that required their interaction with the residents who participated in the qualitative portion of the data collection.

Limitations

The limitations of this research study are identified as:

1. External generalizability – due to the lack of random sampling and absence of a control group the external generalizability of the findings are limited. However, the findings will be strengthened by studying two nursing homes, at different stages in the culture change process. Therefore, comparisons are made and conclusions drawn as to the effectiveness of the culture change process from the perspective of the residents. However, the findings from this specific sample cannot be generalized to the total population of residents, staff, or family members/friends of these two nursing homes or to the general nursing home population.
2. Sample size – the sample size could not be ascertained prior to commencing the data collection, as it was dependent on the numbers and characteristics of the residents in the nursing homes at the specific time of the data collection. The sample of family members and staff members was also dependent on the numbers of residents included

in the study. As a result of the small sample obtained in this study some statistical analyses could not be performed. In addition, results of the statistical analyses indicated that a larger sample size may have provided more statistically significant findings than were identified using the small sample of residents included in this study.

3. Confounding variables –many confounding variables may impact the validity of the findings. Factors such as the physical and psychological health, personality type, coping skills, and attitudes towards institutionalization of the residents who participated cannot be controlled for and are not explored in this study. Differences between the residents, staff, and family members and friends who met the inclusion criteria and chose to participate or not to participate were also not explored. It is important that such factors are acknowledged for their possible influence of self-reported quality of life, choice and control, and satisfaction with the nursing home.
4. Coincidentally, the researcher began the data collection at both nursing homes within a short time of their annual state inspection. It is assumed that the residents were aware of the state inspection process and may well have been involved. Therefore, any influence this process may have had on the responses of the residents is unknown.
5. Both nursing home administrators were aware of the scope of the study and of the involvement of both nursing homes in the study. They were also aware that their direct supervisor had given support for the research and would be provided with a summary report. While it was repeatedly emphasized that the purpose of the study was not to compare one nursing home against the other, but to provide an analysis based on the level of culture change that had taken place, the administrators'

perceptions of the aim of the research may have influenced their response to the study itself.

Assumptions

Prior to commencing the study the researcher made initial contact with a representative of the health care organization with responsibility for both nursing homes, Nursing Home A (NH-A) and Nursing Home B (NH-B), and received a positive and encouraging response. It was assumed that this response was reflected in the individual responses of the two nursing home administrators. Without this cooperation this research would not have been feasible. Institutional Review Board approval was obtained from both the health care organization review board (overseeing both nursing homes) and from the University of North Carolina at Charlotte, as per their reciprocal agreement (see Appendices A, B, and C).

Definitions

1. Choice and Control among Nursing Home Residents – the individual's degree of perception of their autonomy or freedom of choice (Jang, 1992).
2. Culture Change – while cultures are inherently dynamic, culture change is a deliberate more comprehensive process that involves both the dismantling of the old culture and the creation of a new culture (Trice & Beyer, 1993/2005). "Culture change involves a break with the past; cultural continuity is noticeably disrupted. It is an inherently disequilibriating process." (Trice & Beyer, 1993/2005, p. 383).
3. Culture Change in Nursing Homes

- "a philosophy and a process that seeks to transform nursing homes from restrictive institutions to vibrant communities of older adults and the people who care for them" (Mitty, 2005, p. 47)
- "the effort to transform long-term care institutions into communities where elders work and thrive" (Misiorski & Kahn, 2005, p.137).

4. Direct Care Staff – for the purposes of this study direct care staff will be defined as staff members whose primary role is that of a certified nursing assistant.
5. Facilities – used to denote nursing homes and/or long-term care facilities.
6. Latitude of Control – the residents' perceptions of both their degree of choice and the importance of choice regarding specific activities within the nursing home (Hulicka, Morganti, & Cataldo, 1975).
7. Long-Term Care – "health care and social services needed by those who have lost the capacity to care for themselves because of a chronic illness or condition" (Moody, 2006, p. 269).
8. Long-Term Care Nursing Home Resident – for the purposes of this research this term refers to any resident who has lived in the facility for three (continuous) months or more.
9. Medical Model – a model of care in nursing homes that emphasizes hospital-like environments, a focus on task and institutional routine, and a lack of privacy for residents (Kane, 2003a).
10. Neighborhood Model – a nursing home environment that offers small residential units, with dining and communal areas. This model typically offers a more localized system of decision making (Mitty, 2005).

11. Nursing Home – also known as a nursing facility or skilled nursing facility.
12. Organization – a "dynamic system of organizational members, influenced by external stakeholders, who communicate within and across organizational structures in a purposeful and ordered way to achieve a superordinate goal" (Keyton, 2005, p.10).
13. Organizational Culture – "pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration that has worked well enough to be considered a valid and, therefore, to be taught to members as the correct way to perceive, think, and feel in relation to those problems" (Schein, 1993/2005, pp. 364-365).
14. Quality of Life Among Nursing Home Residents – a multidimensional construct and a "product of at least four factors: the residents' health status, social situation, personality, and the care and environment of the nursing home" (Kane, 2003a, p.35).
15. Residents – persons residing temporarily or permanently in a nursing home.
16. Resident Satisfaction – resident self-report of his/her level of satisfaction with the nursing home as a place to live.

Summary

The information provided in this chapter details the need for and purpose of this research and the specific research questions to be tested. Appropriate terminology is also defined. It is clear that the medical model of nursing home care does not fully meet the medical, social, and psychological needs of those in its care and the culture change model offers an exciting alternative. This alternative is not without challenges, however, and studies outlining its effectiveness are much needed.

The literature review contained in Chapter Two provides a detailed description of nursing homes and the limitations of the medical model of care, the culture change model and process, and theoretical and empirical research pertaining to the culture change model. The barriers and challenges to this culture change model are explored as are the reported benefits of the implementation of the model for organizations, staff, and residents.

Chapter Three provides a detailed outline of the proposed mixed-methods methodology and the instruments to be utilized. The research design and process utilized to answer the research questions pertaining to (i) the identification of valued characteristics of culture change among long-term care residents, family members, and direct-care staff and (ii) the variation of these characteristics between the residents at two different nursing homes at different stages in the nursing home process is provided.

Chapter Four presents the quantitative and qualitative findings. Descriptive statistics as to the level of culture change at each nursing home are provided. A comparative inferential analysis of the quantitative data regarding the resident quality of life, perceptions of choice and control, and level of satisfaction at NH-A and NH-B is reported in both narrative and tabular form. The analysis of the qualitative data from the four groups of participants is presented with a review of the major themes identified in the categories of resident quality of life, perceptions of choice and control, and level of satisfaction.

Chapter Five provides an analysis and discussion of the findings. The implications of the findings to the existing body of literature and their relevance to prior research are outlined. Recommendations for further research are made.

CHAPTER 2: LITERATURE REVIEW

The literature reviewed in this chapter provides a detailed synthesis of organizational culture (both the characteristics and assumptions) and organizational culture change as a concept and a process. Potential barriers and challenges to this process are also identified. Nursing homes as organizations are described, as are the traditional and culture change models of care and their potential effects on the nursing home residents themselves. The theoretical and empirical research exploring the culture change model in nursing homes is identified and outlined.

Organizational Culture

An organization is "a dynamic system of organizational members, influenced by external stakeholders, who communicate within and across organizational structures in a purposeful and ordered way to achieve a superordinate goal" (Keyton, 2005, p.10). Organizations are manifestations of culture (Meyerson & Martin, 1987). Any organization with a shared history and experiences will possess an organizational culture or, alternatively, a collection of organizational subcultures (Schein, 1990). Organizational culture is a complex and dynamic concept. As Schein (2004) articulates, "culture is to a group what personality or character is to an individual" (p.8).

Schein (1993/2005) provides a definition of organizational culture that encompasses group learning, adaptation, and integration. Thus, Schein's definition of

organizational culture serves to illustrate the many facets of this concept:

> "pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration that has worked well enough to be considered valid and, therefore, to be taught to members as the correct way to perceive, think, and feel in relation to those problems." (pp. 364-365)

There is both diversity among organizations and diversity among disciplinary approaches to the exploration of culture within organizations (Schein, 1990). The exploration of organizational culture involves both identification of the superficial manifestation of culture and an in-depth understanding of the relationships and meaning of these manifestations (Martin, 2002).

Unless the complexities and less visible aspects of culture are identified an adequate understanding of organizational culture cannot be achieved (Schein, 2004). Schein (1993/2005) introduces three additional elements in his definition of organizational culture: socialization, behavior, and the diversity of cultures within an organization. These facets, as well as levels of organizational culture and underlying assumptions, illustrate the many factors that must be considered when exploring complex organizations.

Socialization, Behavior, and the Diversity of Cultures

The influence of socialization on organizational culture is apparent in the discussion of learning within organizations. Schein (2004) postulates that there is a continuous, although not always conscious, process whereby new members of the organization interpret the meaning of the norms and assumptions of the organization,

guided by existing group members. The culture of an organization is apparent in its collective behavior and the behavior of individuals within it (Schein, 1996). While Schein (2004) does not include overt behavior in his definition of organizational culture, he acknowledges the influence of organizational culture in individuals' reactions to events, in their feelings, perceptions and thoughts. These reactions then serve, in conjunction with situational factors, to determine overt behavior.

From a broader perspective it is also acknowledged that one organization may encompass more than one culture or consist of a series of subcultures. These subcultures may arise from factors such as specific occupational or professional culture and socialization (Martin, 2002). Martin also conceptualizes culture in organizations as being integrated, differentiated, or fragmented. The integration perspective sees organizational culture as sharing an organization-wide consensus, the differentiated perspective as having an inconsistent, subcultural consensus, and the fragmented perspective as having no consensus or a lack of consistency of consensus.

Levels of Organizational Culture and Assumptions

Schein (1990) conceptualizes organizational culture as occurring at three levels; artifacts, values, and the basic foundational assumptions of the organization. Artifacts are at the surface of an organization and consist of visible organizational structures, language, the climate or visible behaviors, and organizational processes. This level of organizational culture is both the easiest to observe and the easiest to understand (Schein, 2004). Schein describes organizational beliefs and values as the transformation of individual values into a shared system of organizational values of beliefs. If these values and beliefs prove useful and effective then they may then be transformed into a shared

assumption. Therefore, the values are socially validated by the actions of the group and the results of such actions.

These beliefs and values can be instrumental in predicting the behaviors of organizations and individuals within them but may also be abstract and difficult to interpret (Schein, 2004). Schein also describes the importance of an in-depth understanding and acknowledgement of the basic assumptions of an organization's culture. The assumptions of an organization determine how it will adapt to external events and internally integrate and relate to human nature, actions and relationships, to the nature of reality and truth, and to the nature of our environment, such as concepts of time and space (Schein, 2004). The assumptions that assume the greatest importance and priority within an organization form the core of the culture and serve to guide both thoughts and actions (Alvesson & Sveningsson, 2008).

The results achieved by an organization are determined by the actions and behaviors of the members of the organization. These actions are based upon beliefs and in order to change or broaden beliefs new experiences must be introduced. Without consideration of all these components of culture a cultural shift or change will not occur (Connors & Smith, 1999). The success of efforts to change organizations is grounded in these factors.

Organizational Culture Change

As Wilkins and Gibb Dyer (1988) state an important neglected consideration of many culture change theories is knowledge of the nature of the culture to be changed. Indeed, Keyton (2005) cautions that when contemplating a change in organizational culture, it is important that leaders do not make the assumption that all members share the

same perceptions of the organization or share the same view as their own. Keyton asserts that leaders should undertake an in-depth exploration of their organization prior to such efforts. Schein (2004) describes the assessment of organizational culture as a difficult process for a variety of reasons. The author cites the fact that human subjects and systems as objects of investigation provides for a complex task. Schein states that it is difficult to determine the manifestations of organizational culture from the many other factors that may influence such investigations. Martin (2002) states that some researchers study the manifestations of culture, some examine the breadth of such manifestations, and some focus on a depth of understanding. Perspectives of practitioners and academics may also vary (Keyton, 2005). Therefore, it appears that in order for culture change to occur within organizations it is essential that there is an understanding of all the facets, both those that are visible and those that are not as easily observed, of the existing organizational culture.

The Culture Change Process

Cultural change within organizations is an ever present factor (Keyton, 2005). Trice and Beyer (1993/2005) assert that organizational culture change and innovation is a difficult process that is more difficult to achieve than cultural maintenance. The authors define culture change as "planned, more encompassing, and more substantial kinds of changes than those which arise spontaneously within cultures or as part of existing efforts to keep an existing culture vital" (p.383).

Research as to whether cultures can actually be changed is inconclusive (Alvesson & Sveningsson, 2008; Sathe & Davidson, 2000). Trice and Beyer (1993/2005) assert that often it is the definition of culture change itself that provides for confusion. Their work clearly identifies that culture change is not an easy process and they describe

culture change as a slow, long, disequilibriating process that involves a discontinuity with what has been before and breaking down of the old culture and systems. Keyton (2005) views organizational culture as a dynamic phenomenon that is built through the interactions of the organizational members and influenced by both internal and external factors. It is composed of many, diverse factors and is both shared among and debated by its constituents. Therefore, it follows that culture change is not a product or an event but a process.

The method by which this process occurs varies from organization to organization and from situation to situation. Trice and Beyer (1993/2005) describe three types and four dimensions of culture change. In this conceptual framework culture change can be: (1) revolutionary or comprehensive in that the effort involves the entire organization, (2) based upon subcultures or subunits within the organization, and (3) a cumulative, comprehensive reshaping of the organization that is a gradual and incremental process.

The amount of change is also seen as occurring at one of four dimensions: (a) pervasiveness or the degree to which the activities within the organization will be affected by the change; (b) magnitude which represents the gap between the old culture and the new; (c) innovativeness or the degree to which the new culture represents new ideas or behaviors; and (d) duration which refers to the length of time the process occurs over and the sustainability of the change that occurs (Trice & Beyer, 1993/2005). Trice and Beyer identify cumulative, comprehensive reshaping of the organization as perhaps the easiest model to implement and sustain. This model will usually require a high level of pervasiveness, a moderate level of magnitude and innovativeness and a high level of duration.

Sathe and Davidson (2000) describe both linear and cyclical models of culture change. They conclude that both models are effective and the choice of model is determined by the type of change envisioned. When culture change is envisioned as a "top-down" process, they propose a more linear approach and when a "bottom-up" change is envisioned, a more cyclical approach may be appropriate. They also acknowledge the need for empirical research supporting such comparisons. Kotter and Sclesinger (2008) use a situational approach to culture change methodology stating that the chosen approach to culture change will be dependent on the anticipated strength and type of resistance, the comparative position of those who are initiating the change, the need and support for the change, and the risks and potential benefits involved.

Barriers to Successful Culture Change

As Trice and Beyer (1993/2005) indicate, culture change does not only involve the creation of a new culture but also the destruction of the old. Therefore, it is not unexpected that resistance to such change would be encountered and obstacles to the process to be overcome. Indeed, many barriers to organizational culture change have been identified and are summarized in Table 1.

These barriers may occur at many different points during the culture change process and at many levels of the organization. Human factors, both individual and group, may manifest themselves in the form of resistance to culture change and present a barrier to the successful implementation and maintenance of culture change (Kotter & Schlesinger, 2008; Trice & Beyer, 1993/2005). As Connors and Smith (1999) discuss, attempts to change organizational results, or the behaviors and actions of the members of the organization, will not be successful unless the beliefs of those individuals change.

Table 1

Potential Barriers to the Culture Change Process

Organizational Characteristic	Barrier
Leadership Factors	(1) failure to establish a sense of urgency in order to illicit the support of others (Kotter, 2007) (2) failure to establish a strong enough coalition of support (Kotter, 2007) (3) the lack of vision and/or poor communication of a guiding vision (Kotter, 2007) (4) failure to recognize and removal of obstacles to the vision (Kotter, 2007) (5) lack of short-term planning, and a failure to consolidate and build upon successes (Kotter, 2007)
Individual Factors	(1) human resistance to a change in the status quo (Kotter & Sclesinger, 2008) (2) perceived personal threat (Kotter & Sclesinger, 2008) (3) misunderstanding and a lack of trust (Kotter & Sclesinger, 2008) (4) discrepancies in the situational assessment of leadership and employees (Kotter & Sclesinger, 2008) (5) dependence and the need for security (Trice & Beyer, 1993/2005) (6) fear (Trice & Beyer, 1993/2005) (7) cynicism and skepticism about organizational change (Stanley, Meyer & Topolnytsky, 2005)
Organizational/Group Factors	(1) social disruption (Trice & Beyer, 1993/2005) (2) limited resources (Trice & Beyer, 1993/2005) (3) discrepancies in the perceptions and goals of leadership and employees (Trice & Beyer, 1993/2005) (4) the availability of alternative organizational frames (Wilkins & Gibb Dyer, 1988) (5) the level of commitment of those who must participate in the change process (Wilkins & Dyer, 1988) (6) the flexibility or fluidity of the existing culture or organizational frame (Wilkins & Gibb Dyer, 1988).

Therefore, in order for culture change to be effective changes in the beliefs and values of individuals must occur and this process of adjustment may prove confusing for

some (Trice & Beyer, 1993/2005). It is essential that leaders recognize that the culture of the organization and its transformation cannot be separated from their leadership (Schein, 2004). As Schein concludes in order to manage and guide organizational culture leaders must be motivated, possess the emotional strength and skills needed, and be able to enlist the support of others.

Indeed, Kotter (2007) explores culture change efforts from a leadership perspective and identifies several failures of leadership that provide barriers to successful culture change efforts. Wilkins and Gibb Dyer (1988) provide a broader, organizational perspective that takes into account the need for appropriate alternative organizational frames that allow organizational members to experience other methods of operating. They also point out that if organizational members are steadfastly committed to the existing culture then cultural change will be difficult and a sense of commitment to the new structure may be hard to elicit. Additionally, the fluidity of the organizational frame will influence the change process. An existing system that is complex, inflexible and rigid will mean that the group must work hard to simplify, introduce and adapt to change strategies, and to self-monitor the process in order to be open to alternative organizational frames (Wilkins & Gibb Dyer, 1988).

Consideration and identification of the barriers to the culture process offers insight into the intricacies of the process. The importance of an adequate understanding of the underlying theoretical principles of organizational culture and organizational culture change is paramount. Leadership, strategy, planning, and careful implementation all contribute to the success of the process, but there are many barriers to be negotiated. The diversity of the experience and process for those involved is evident in the discussion

of these challenges. The assessment and evaluation of the culture change process and its outcomes also offers many challenges to the practitioner and the researcher. In applying these principles to a specific institution, for example the nursing home industry, the wide range of perspectives to be reflected upon and the many confounding factors to be considered are clear.

The Nursing Home Organization

Organizations are diverse, complex and dynamic entities. Organizations must adapt to meet the social, business, and environmental changes that are occurring around them. While the function of nursing homes within the health care system has changed drastically, changes in the structure and characteristics of nursing homes have not kept pace (Decker, 2005). As Scott-Cawiezell, Jones, Moore, and Vojir (2005) identify, much work remains in the exploration of the culture of nursing homes as organizations and as to the impact of such culture on the ability of these organizations to initiate and sustain change and improve quality of care.

In exploring this concept, we must be aware of the history, current structure and desired characteristics of change of these organizations. It is important to clearly define the effects of both the old and desired culture on the organization as a whole, the staff, and most importantly in the context of this study, the residents. Potential barriers to such culture change must be acknowledged and addressed in any change process in order to optimize the chances of success. These factors will be discussed and current literature identifying the efficacy of culture change will be outlined and synthesized.

Past, Present, and Future of Nursing Homes

The modern day nursing home is a direct descendent of poor houses, alms houses,

and county homes that provided care to those with no financial resources. In the United States, nursing homes became licensed entities under the Social Security Act and large facilities were built under the auspices of Medicare/Medicaid laws (Robinson & Gallagher, 2008). Indeed, Fahey (2003) identifies Medicaid payments systems for long-term care and the availability of federal funding, to provide capital financing, as major influences in the growth of the nursing home industry. Fahey also implicates demographic changes and public policies that discouraged the use of acute hospitals and minimized the use of state mental institutions in the growth of this industry. As Thomas (2003) states, this trend towards facilities with a large number of beds was driven by the need to contain costs, provide a standardized service, and to provide a level of safety for the residents. As these organizations have grown, so too have the depth of hierarchy and the level of bureaucracy within them (Thomas, 2003).

The medical model of care has been the traditional core concept in the long-term care industry. In the context of nursing homes it gives rise to the priority of institutional and regulatory needs above the individual needs of residents (Ragsdale & McDougall, 2008). Ragsdale and McDougall describe the outcomes of this model of care for the residents to be a "lack of individual choice, personal decisions, privacy, and dignity" (p.992). The medicalization of nursing home care gives the medical professionals control and authority not only of the medical care of those who reside there but also over most aspects of their everyday lives (Redfoot, 2003). This model of care in the nursing home also views aging and chronic illness as being "passively experienced conditions" and devalues the needs of older people within a system based on medical diagnosis and acute care (Ronch, 2004, p.66).

In her foundational work exploring the experience of homelessness among older adults living in nursing homes, Carboni (1990) concluded that an older adult who is institutionalized in a nursing home experiences many of the same detrimental consequences as a person who becomes homeless. She argued that persons living in a nursing home may feel as if they do not belong, uprooted, disconnected, powerless and dependent. Therefore, although their physical needs may be attended to, these negative consequences of institutionalization may result in psychological pain and suffering for the residents. Reynolds (2003) in his discussion of policy and nursing home culture asserts that the medical model of care can have negative outcomes for the resident as it neglects to value their basic human needs; to be treated with "kindness, courtesy, and consideration" (p.397).

Calkins (2002) pointed out that this model of care is typically focused on the input of the system which is the "efficient provision of care to frail and impaired individuals" (p.42). The author argues that this model needed to be changed to a model that emphasizes not the input but the output (the quality of life of the residents) of the system. As Ragsdale and McDougall (2008) emphasize, interventions that address quality of life, choice, dignity, and individuality are often neglected in nursing homes and new models of care must be designed to address these needs. Thus, the inadequacies of the medical model in this health care setting and the need for change are clear. This is especially vital when considering the characteristics and circumstances of the individuals spending time in nursing home care.

The Nursing Home Resident

The nursing home population represents a vulnerable group within the health care

system. While not all nursing home residents are older adults, the vast majority are in fact aged 65 years and older. For example, of the 1,492,200 persons resided in nursing homes in 2004, 88.3% were aged 65 and older and 45% of the older adults were aged 85 years and over. The majority of all residents are white and female (Centers for Disease Control, 2008). Despite the fact the nursing home utilization rates are decreasing among older adults, the numbers of older adults residing in nursing homes is increasing due to the rapid population growth among older adults (Federal Interagency on Aging-Related Statistics, 2008). As may be anticipated, persons residing in nursing homes often have functional disability and assistance needs.

The 2004 National Nursing Home Survey reported that 43.1% of nursing home residents have bladder and bowel incontinence, 97.3% received help with at least one activity of daily living such as bathing, dressing, eating, transfers, and toileting, and over 40% of all residents received extensive assistance and are totally dependent in their mobility (Centers for Disease Control, 2008). Additionally, nursing home residents have been demonstrated to spend the majority of their day sitting (69%), in their rooms (43%), and in passive activity such as sleeping, which consumes over 36% of their day (Harper Ice, 2002). Therefore, while providing for extensive medical and functional needs, these facilities have been found to neglect the psychosocial needs of those in their charge (Forbes-Thompson & Gessert, 2006; Harper Ice, 2002; Ryvicker, 2008; Socco, Rapattoni, & Fantoni, 2006).

The decision to relocate to an institution is often not a matter of choice for individuals (Scocco, et al., 2006). Forbes-Thompson and Gessert (2006) assert that when undergoing the profound life change of being admitted to a nursing home, most residents

are at risk of suffering. This risk does not diminish during their nursing home stay. The authors also indicate that the institutional structure and practices may indeed compound this suffering of residents by threatening the residents' sense of meaning, personal freedoms, social roles, relationships, and personal independence.

Choice and Control among Nursing Home Residents

Langer and Rodin (1976) postulate that the social environment in which older adults find themselves greatly influences perceived levels of control and this level of control can in turn influence well-being. As such, nursing home residents must balance their identities as independent self-directing adults and as dependent persons in poor health (Langer & Rodin, 1976). Opportunity for control can assist residents in maintaining their sense of self (Ryvicer, 2008). With institutional life comes the risk of loss of privacy, personal identity, community belonging, and spiritual relationships (Forbes-Thompson & Gessert, 2006). Choice is an essential component of perceived control (Langer & Rodin, 1976). Indeed, Kane et al. (1997) demonstrated that nursing home residents regard both personal choice and control as important in their day to day lives and are unsatisfied with the existing level of choice and control available to them in the nursing home.

The importance of choice and control among nursing home residents has been explored in relation to self-concept and life satisfaction, correlations of perceptions of resident choice and control between residents and nursing home staff, and in the context of identifying interventions that may increase choice and control for residents (Hulicka et al., 1975; Kane et al., 1997; Morganti, Nehrke & Hulicka, 1980). The work of Langer and Rodin (1976) demonstrates that when given more personal responsibility in their lives,

older adults in a nursing home setting become more actively involved and generally appear happier. In a follow-up study these effects were shown to persist over time and those residents who had taken part in the intervention, to increase their sense of self-responsibility, had lower rates of physical decline and mortality rates (Rodin & Langer, 1977). Conversely, low levels of control over their daily lives appear to have detrimental effects for nursing home residents.

Hulicka et al. (1975) explored choice and control among female nursing home residents and female community dwelling older adults using both individual perceptions of the degree of choice available and the importance attached to the degree of available choice. The authors found these scores to be correlated with self-concept especially among the institutionalized women. Additionally, institutionalized elders perceived themselves as having less overall choice in their daily activities than their non-institutionalized peers (Hulicka et al., 1975). Indeed, choice and control in the institutional environment often becomes perceived as unimportant by residents who have restricted levels of choice in their everyday lives (Boyle, 2004). Indeed, Boyle postulates that care interactions with staff, in their efforts to provide for resident safety, may serve to decrease the self-determination of the resident.

Quality of Life among Nursing Home Residents

Quality of life (QOL) is a multidimensional construct and among nursing home residents is a "product of at least four factors: the residents' health status, social situation, personality, and the care and environment of the nursing home" (Kane, 2003a, p.35). Clearly, factors other than the nursing home environment play a part in the well-being of the resident. For example, Gaugler, Leach, and Anderson (2004) found that the type of

long-term care facility and family relationships and context were significantly associated with resident self-esteem. Race, medical condition, and age were also found to play a part. The authors identified facility-level characteristics important to resident well-being as the facility being family-orientated and encouraging family involvement.

On a positive note, nursing homes provide an increased opportunity for activities and social interaction when compared to other long-term care settings such as assisted living and family care homes (Gaugler et al., 2004; Prunchno & Rose, 2002). Accordingly, residents' self-assessments of QOL encompass many characteristics (including meaning, dignity, autonomy, functional competence, relationships, and spiritual well-being) and has been identified as being associated with both resident and facility-level characteristics (Degenholtz, Kane, Kane, Bershadsky, & Kling, 2005).

The assessment of QOL in the context of the nursing home is a complex task and broad domains must be used to encompass all the facets of life in a nursing home. Kane (2003a) outlines the many challenges in ascertaining QOL among the nursing home population and states that the determination of this aspect of the residents' well-being is often given low priority. Diversity in this concept by race/ethnicity and culture must also be acknowledged (Kane, 2003a).

Nursing Home Resident Satisfaction

Straker et al. (2007) state the importance of the consumer viewpoint in quality improvement initiatives health care. Such information is widely collected among nursing homes and a variety of instruments are used to achieve this (Castle, 2007). In a single-state study, the majority of nursing homes (86%) were found to use resident satisfaction surveys, 30% of those primarily for corporate reasons (Castle, Lowe, Lucas, Robinson, &

Crystal, 2004). Indeed, in 2003, 24% of states were found to be using consumer satisfaction surveys in their nursing homes and several other states were conducting research or implementing pilot studies pertaining to the use of such studies (Lowe, Lucas, Castle, Robinson, & Crystal, 2003). Therefore, residents reports of their level of satisfaction with the nursing home in which they reside are commonplace and assessed in a variety of different ways, using many different instruments. However, these instruments have been criticized for often focusing on the needs of the facility and not the needs of the residents (Robinson, Lucas, Castle, Lowe & Crystal, 2004).

Robinson et al. (2004) in their interviews with nursing home residents identify six domains of essential content for resident satisfaction surveys: activities; care and services; caregivers; environment; meals; and well-being. The authors found that existing instruments tend to focus on these domains, but often more from the perspective of the nursing home such as treatment, social involvement, activities and well-being domains that include privacy, trust, and security. This research revealed several areas which residents determine as important to their level of satisfaction that are not typically explored on existing satisfaction surveys. These include outdoor activities, being treated as an adult by staff, caring care, appetizing preparation of food, and the location of the nursing home near to family and friends (Robinson et al., 2004). Therefore, the importance of assessing resident satisfaction from their personal perspective and not that of the facility is apparent.

It is clear that nursing homes that promote choice and control among their residents, provide for and value the QOL of their residents, and focus on providing an environment in which their residents report a good level of satisfaction are providing for

both the physical and psychological well-being of those with for whom they care. The medical model of nursing home care is not the optimum model under which to provide such care and there is a growing call for and movement towards a viable alternative to this philosophy of care.

The Changing Culture of Nursing Homes

It is clear that while resident perceptions of choice and control, satisfaction, and QOL are complex concepts dependent on the intersection of many factors, the culture of the nursing home itself plays an important role. These facilities have the power to enhance or diminish the QOL and well-being of those in their care. As a result, there is a shifting of culture within the nursing home industry. There are many factors, both internal to and external to organizations, that influence culture change and external factors are often very influential in this process (Alvesson & Sveningsson, 2008). The nursing home industry in the United States has been subject to many external pressures to reform.

Social, political, regulatory, and demographic factors have all played a part in supporting a radical change of philosophy of care. Fahey (2003) cites three forces that intersect to determine the behavior of the long-term care industry: (1) the purchaser or the demand for long-term care services, (2) the provider or the supply of long-term care services, and (3) the regulator, whom the author identifies as governmental activity, based on the assertion that it is also the primary purchaser of such services. In this context, it is often economic growth that provides a stimulus for improvements in health care systems (Giacolone, 2001).

Additionally, the demographic changes in the United States have led to often

voiced concerns about how we will provide appropriate care for the large baby boom cohort as they reach later life. The persons who are most likely to need nursing home care over the coming decades belong to the smaller cohorts that precede the baby boomers. As older adults experience decreasing rates of disability and a greater range of services develop, such as assisted living facilities and home care, the nursing home industry must adapt in order to remain competitive (Redfoot, 2003). Therefore, Redfoot concludes that the growing call for a culture change in nursing homes is driven by both demographic and socioeconomic trends and one guiding principle, that "older people – even those with disabilities – should be treated as people who should be enabled to live life as fully as possible" (p.107).The inherent differences in the philosophy, values, structure, and the resultant environment of the medical model of nursing home care and the model of care proposed as a culture change in the nursing home industry are outlined in Table 2. While the theoretical basis of the culture change movement and implementation models are described in detail in the next section, Table 2 illustrates how old and new cultures may be compared and contrasted.

It is clear that there is a paradigm cultural shift from institution-centered care and structure to a person or resident-centered based provision of care. The distinction between the two cultures represented by these models is clear. While the medical model emphasizes acute care, the priority of the medical diagnosis and the institutional needs and priorities (Misiorski, 2003; Ragsdale & McDougall, 2008; Ronch, 2004), the culture change model emphasizes a holistic, resident-centered, collaborative care and the priority of the quality of life of the resident (Mitty, 2005; Ragsdale & McDougall, 2008; Ronch, 2004).

Table 2

Comparison of the Medical Model and Culture Change Models of Nursing Home Care

Focus	Medical Model	Culture Change Model
Philosophy	Orientated to acute care (Ronch, 2004).	"A humanistic view of how people, residents, staff and family should be treated in a nursing home" (Ronch, 2004, p. 74).
Values	The acute care model of treatment based on a medical diagnosis assumes priority over the needs of older people and those with chronic illnesses. A curative approach is taken to illness (Ronch, 2004). Based upon ageist and pluralistic stereotypes (Ronch, 2004).	Orientated to the whole person (Ronch, 2004). Person-centered (Grant, 2008a). Relationship based (Ragsdale & McDougall, 2008). Encourages resident autonomy and decision making (Ragsdale & McDougall, 2008).
Organizational Structure	Hierarchical (Ronch, 2004).	Collaborative and decentralized management and values both staff empowerment (Harris, Poulsen, & Vlangas, 2006) and resident empowerment (Mitty, 2005).
	Predictable routine with little room for personal choice and decision making, dignity, and privacy (Ragsdale & McDougall, 2008).	Schedules reflecting personal needs designed by both residents and staff (Misiorski, 2003).
	Staff rotates assignments (Misiorski, 2003).	Consistent staff assignments (Misiorski, 2003)
	Decisions made on behalf of residents by staff (Misiorski, 2001).	Resident-directed care and activities (Harris et al., 2006)
	Based upon the efficient delivery of "physical care to frail and impaired individuals" (Calkins, 2002, p.42).	Based upon relationships with staff, family, resident, and community (Harris et al., 2006).
	Work is task-orientated (Misiorski, 2003).	Spontaneous and unscheduled activities occur (Misiorski, 2003).
	Departmental focus (Misiorski, 2001).	Team focus (Misiorski, 2001).
Environment	Hospital-like environment (Misiorski, 2003).	Home environment (Harris et al., 2006) "reflecting the comforts of home" (Misiorski, 2003, p.26).
Outcomes	Sense of isolation and loneliness (Misiorski, 2003).	"Sense of community and belonging" (Misiorski, 2003, p.26).

Organizational Culture Change and Nursing Homes

This examination of the philosophy, values, structure, environment, and outcomes of the traditional model and culture change models of organizational culture underscores the fact that the culture of care in nursing homes is transitioning to a resident-centered focus that emphasizes the QOL of both the residents and staff. White-Chu, Graves, Godfrey, Bonner and Sloane (2009) describe culture change in long term care as "a tremendous opportunity for us to provide the best possible quality of care and quality of life for everyone who lives in a long term care facility" (p.376). In North Carolina between the years 2000 and 2007, 66% of the state's 392 nursing homes reported that they had undertaken at least one environmental change in keeping with the philosophy of culture change (Brown & Pfeiffer, 2009).

As researchers have identified, in order to instill such change those responsible must acknowledge that this effort involves not only a change in environment or the introduction of new programs, but also a fundamental change in the philosophy of care (Calkins, 2002; Misiorski & Kahn, 2005). In order to achieve such noble goals, a re-valued, humanizing environment must be created (Ronch, 2004) and various models of culture change that embody the values outlined in Table 2 have been, and continue to be, developed.

Culture Change Models

The movement for culture change in nursing homes is a recent event and its formal conception has been identified as the collaboration of a group of long-term care providers and experts known as the Nursing Home Pioneers in 1997. This group became known as the Pioneer Network (Rahman & Schnelle, 2008). Prior to 1997, several

innovative models of care were introduced within the nursing home industry such as the Eden Alternative, developed by Dr. William Thomas, the Green House Model, and the Wellspring Model (Kehoe & Van Heesch, 2003; Ragsdale & McDougall, 2008; Thomas, 2003). Therefore, although the collective term culture change is used to refer to a philosophy of care in which the resident assumes priority over the institution (Robinson & Gallagher, 2008) several models of care exist to embody this philosophy.

The Eden Alternative. The Eden Alternative was developed by Dr. William Thomas in 1992. This model of nursing home reform recognized the importance of not only quality of care, but also quality of life among residents. A priority of this system was to produce a model that could be easily reproduced in other facilities, while also allowing for flexibility and individuality (Thomas, 2003). The premise of this model of care is to restore control to the resident, providing a homelike environment, provide a sense of security, and encourage personal relationships between staff and residents (Ragsdale & McDougall, 2008).

The Green House Project. The Eden Alternative has evolved into the Green House Project. This model is based upon three essential desired characteristics of the social and physical environments of nursing homes, that they be "warm, smart, and green" (Thomas, 2003, p.146). Green Houses are small residential units of six to eight residents, in which people can both receive the care that they need and remain involved in the community. These communities strive to be safe, to provide quality health care in a social environment, to provide connections with the outside world, and to maximize quality of life for those who live there (Thomas, 2003).

The Neighborhood Model. The Neighborhood Model provides an environment

based on the model of neighborhood living in which residents are treated as "independent, responsible and valued members of the neighborhood" (Gilbert & Bridges, 2003, p.236). Residents live in small units of eight to twenty persons that have both private living space and communal areas and residents have active input in the management of the community (Mitty, 2005). Staff are consistently assigned to the same neighborhood and so may develop relationships with the residents based on their personhood and not their medical diagnosis (Gilbert & Bridges, 2003).

Wellspring Nursing Home Alliance. This model was first developed in 1994 as a cooperative alliance of eleven skilled nursing facilities who concluded that the existing model of nursing home care is broken and came together to provide a model for nursing home reform. This model is based upon the premise that collaboration between organizations and facilities will result in shared resources, more effective clinical care, and an atmosphere of accountability. The principles of this model of care encompass cooperation and collaboration between organizations, the empowerment of staff at all levels, evidence-based decision making, accountability, and permanent resident-staff assignments. Education, shared resources, and data collection are cornerstones to this work (Kehoe & Van Heesch, 2003).

The Pioneer Network. The Pioneer Network is a coalition of organizations and individuals that advocate for change in long-term care and in the culture of aging. They emphasize person-centered care, which de-institutionalizes and promotes choice for both residents and staff. They support models of culture change that increase the opportunity for older adults to live in a caring community that is based upon relationships and the values of culture change (Pioneer Network, n.d.).

While many models of culture change exist, they share a common system of underlying values and philosophy as outlined in Table 2. Interestingly, Rahman and Schnelle (2008) point out that little research has been carried out to formally evaluate them.

Efficacy of Culture Change in Nursing Homes

The variety of methodologies and perspectives illustrated by an exploration of current research pertaining to nursing home culture change are summarized in Table 3. The facility characteristics and outcomes explored in this body of work are the culture change model, development and implementation of the process, financial, staff satisfaction, absenteeism, and retention, cost-benefit, quality of care, hospital admission rates, and organizational structure (Bond & Fiedler, 1999; Deutschman, 2005; Coleman, Looney, O'Brein, Zielgler, Pastorino, & Turber, 2002; Grant & McMahon, 2008a; Grant & McMahon, 2008b; Grant & McMahon, 2008c; Hagy, 2003; Kehoe & Van Heesch, 2003; Lopez, 2006; Rabig, Thomas, Kane, Cutler, & McAlilly, 2006; Robinson & Rosher, 2006; Tellis-Nayak, 2007b). This research illustrates the many aspects of culture change that are used to measure the outcomes of the process. From the residents' perspectives measures include quality of life, satisfaction, and choice and control (Kane et al., 1997; Kane, Lum, Cutler, Degenholtz, & Yu, 2007). Specific domains explored are loneliness, boredom, helplessness, emotional well-being, self-reported health, functional status and quality of care (Bergman-Evans, 2004; Gilbert & Bridges, 2003; Grant & McMahon, 2008a; Kane et al., 2007).

These researchers conclude that for the nursing home residents in their samples culture change decreases resident perceptions of boredom and helplessness (Bergman-

Evans, 2004), enhances resident quality of life (Grant & McMahon, 2008a; Kane et al., 2007), increases resident satisfaction and emotional well-being, and lowers functional decline (Kane et al., 2007). Therefore, while much work has been done exploring the culture change in nursing homes, there are few studies providing empirical evidence to support this change from the residents' perspective and outlining the benefits for them. Additionally, no replicated studies were found, there was no consistency in the instrumentation used or the methodology utilized, and few studies provided results that could be generalized to the nursing home population.

As identified in the review of the literature, the valued characteristics of culture change in nursing homes that pertain to the residents themselves are those of resident autonomy and choice, resident-directed care and activities, and a home-like environment and they are focused on interpersonal relationships and a sense of community (Harris et al., 2006; Misiorski, 2003; Ragsdale & McDougall, 2008; Ronch, 2004). In addition, resident satisfaction and self-reported quality of life are also central to the experience of residing in a nursing home (Degenholtz et al., 2005; Higgs, MacDonald, McDonald, & Ward, 1998; Kane, 2003a; Kane et al., 2004). Therefore, for the purposes of this study the characteristics to be explored are resident satisfaction, perceptions of choice and control, and perceived quality of life.

Table 3

The Culture Change Phenomenon in Nursing Homes

Author(s)	Purpose	Method & Design	Results/Discussion
Bergman-Evans, B. (2004).	To assess the impact of the Eden Alternative model of nursing home care on resident perceptions of loneliness, boredom, and helplessness.	Quasi-experimental design Site: State veterans nursing home (experimental) and a traditional model nursing home (control) Participants: Residents (35 baseline, 21 follow-up in Eden model; 29 baseline, 13 follow-up in the traditional model). Measurements: UCLA Loneliness Scale, Geriatric Depression Scale and a personal interview form (descriptive data).	The experimental group increased their excellent or very good self-health ratings (19.1% to 40%). A modest increase was found in the control group (15.4% to 23.1%). The experimental group did not change in the number classified as lonely. The percentage classified as both bored and helpless decreased significantly in the experimental group in comparison with the control group.
Bond, G. E. & Fiedler, F. E. (1999).	To explore the effects of social and physical interventions on nursing home resident well-being. The research question addressed hypothesized that "the goal setting and behavior modeling intervention would have a significantly greater impact in bringing about changes in staff's values than the architectural renovation intervention" (p.38).	Pre-post case study design. Site: Three nursing units within one long-term care facility. One unit was architecturally renovated; one instigated a goal setting/behavior modeling program; and one served as a control. Participants: 65 staff members of many disciplines. Measurements: Three survey scales were developed by the researchers to measure organizational culture, team relations and encouragement.	The researchers found that: Staff on the architecturally renovated and control units increased their perceptions of satisfaction, quality of care and the organization's mission, on the goal setting/behavior modeling unit there was no improvement. Staff on the architecturally renovated and control units increased their encouragement of resident independence. There was no significant improvement on the goal setting/behavior modeling unit. In the goal setting/behavior modeling unit the rated effectiveness of leadership and their ability to meet resident health and safety needs declined. These measures increased significantly for the two other groups.

Table 3 (continued)

Author(s)	Purpose	Method & Design	Results/Discussion
Coleman, M. T., Looney, S., O'Brien, J., Zielgler, C., Pastorino, C. A., & Turber, C. (2002).	To determine the effects of the implementation of the Eden Alternative.	Quasi-experimental design. Longitudinal, 12-month study. Site: Two nursing homes owned by one healthcare system. One implemented the Eden Alternative (experimental) and one provided traditional care (control). Participants: Residents. 115 at baseline with 95 available at one-year follow up. Measurements: Nursing Home Minimum Data Set (for Quality Indicators).	Findings: Residents at the Eden site had more falls than the control group, however, this was no longer significant on adjusting for functional status. Eden Alternative residents experienced more nutritional problems. Infection rates did not differ between sites. Staff turnover increased at the Eden Alternative site (leadership/administrative changes may have contributed). Hospital admission rates were lower at the Eden site despite the fact that the residents at that facility required more skilled nursing care. The authors conclude that one-year after implementation the Eden site did not "show significant improvement in functional status, infection rate, or cost of care outcomes" (p. M426).
Deutschman (2005).	"To identify the specific attributes of the nursing home organization to be used as starting points for problem solving" (p.249).	Qualitative: Ethnographic Site: Three long-term care facilities Participants: Staff/Residents Measurements: Observations and in-depth interviews.	Four areas for improvement were identified: 1. Practitioners are trying to understand the needs of their residents through a process that is influenced by other factors 2. Recruitment, training, and retention of Certified Nursing Assistants 3. Conflict between leadership needs and current leadership structure 4. Organizational and community relationships The author developed an instrument in order that leaders in long-term care may analyze their organizations regarding readiness for success.

Table 3 (continued)

Author(s)	Purpose	Method & Design	Results/Discussion
Gilbert, C. & Bridges, G. (2003).	To describe the culture change process in an urban nursing home in New York in which the neighborhood model of culture change was implemented.	Qualitative/Quantitative: descriptive with a resident quality of life survey. Site: An urban nursing home in New York Participants: 84 residents Measurements: Quality of life survey	The vast majority of resident respondents reported that they were satisfied with their care, their interactions with staff, that their needs were being met, and in their level of ability to join in with the activities of their choosing. The important features of the culture change process were the creation of neighborhood care teams headed by a department head, intentional development of a neighborhood environment, and creation and provision of opportunities for resident/family/staff interactions. The challenges of this process were the loss of discipline identity of department heads who became neighborhood directors, implementing the dining program, and continuing support and evaluation.
Grant, L. A. & McMahon, E. (2008a).	Part I of this series of articles seeks to determine to what extent culture change occurred in an organization's pilot culture change program and the effects on finances, resident quality of life and staff satisfaction.	Quantitative: longitudinal Site: Beverly Healthcare Organization Participants: Resident Centered Care Initiative (RCCI) and non-RCCI facilities within the organization. Measurements: comparison of the facilities at baseline and six and 12-month follow-up. Instruments not identified.	In comparison with the non-RCCI facilities the RCCI facilities demonstrated improvements on five measures of culture change practices: - permanent staff assignments - culture change awareness - informal leadership behavior - resident-directed behavior - leadership team behavior They also enhanced resident quality of life by improving resident choice, autonomy, and dignity. Staff at the RCCI facilities also had greater satisfaction with their job, management, work environment, and training.

Table 3 (continued)

Author(s)	Purpose	Method & Design	Results/Discussion
Grant, L. A. & McMahon, E. (2008b).	Part II of this series of articles seeks to explore the reasons why a business would pilot the RCCI and implement culture change in its facilities.	Quantitative: longitudinal Site: Beverly Healthcare Organization Participants: Resident Centered Care Initiative (RCCI) and non-RCCI facilities within the organization. Measurements: Comparison of the financial implications of the RCCI and non-RCCI facilities within the organization between 2003 (the year prior to implementation) and 2006 (the year after implementation).	The researchers found that the: - RCCI facilities showed more profits (even before implementation). However, RCCI had little effect on financial performance in this time period - Implementing the RCCI did not increase operating expenditures - The cost of RCCI implementation averaged over $78,000 per facility - Capital costs were approximately $750,000 per RCCI facility
Grant, L. A. & McMahon, E. (2008c).	Part III of this series of articles seeks to explore the process associated with the RCCI and the implementation of culture change.	Qualitative: descriptive exploration of the RCCI and a theoretical analysis of the process. Site: Beverly Healthcare Organization Participants: Resident Centered Care Initiative (RCCI) and non-RCCI facilities within the organization.	Key lessons learned from the pilot: - facilities that self-select to undergo the process are often already the highest performers - stable, strong, and effective leadership is essential to ensure progress. The implementation process: - renovations can be cost-prohibitive - a train-the-trainer model is needed - management structures must be realigned - leadership buy-in is essential to the success of this process and financial incentives may be used to encourage the development process Ways to make the process more cost-effective and faster and progress can be made without costly renovations and responsibility lies with the leadership.

Table 3 (continued)

Author(s)	Purpose	Method & Design	Results/Discussion
Hagy, A. (2003).	To describe the process of implementing culture change in a healthcare system and the lessons learned.	Qualitative, descriptive, case-study Site: 21 nursing homes in the Apple Health Care System	The essential elements of the process were identified as an evaluation of the existing model of care, communication of the vision to all staff, and implementation of the process The lessons learned and implications of the process were the importance of relationship changes, financial costs could be manageable within operational costs, organizational cultures must be flattened, the positive rewards of the response of families and staff, tailoring the process to meet state survey regulations, the positive reaction of the media, and decreased staff turnover rates.
Kane, R. A., Lum, T. Y., Cutler, L. J., Degenholtz, H. B. & Yu, T-C (2007).	To explore the effects of a small-house Green House model (GH) of nursing home care on resident outcomes and quality of care.	Two-year, longitudinal, quasi-experimental Site: Four GH units and two-comparison sites Participants: Residents, staff , and family members used as proxies if necessary Interviews & Measurements: resident quality of life, emotional well-being, satisfaction, self-reported health, functional status and quality of care. Nursing Home Minimum Data Set (for Quality Indicators).	GH residents reported better quality of life on more domains than the comparison site residents. GH residents were more satisfied than residents at both comparison sites and had better emotional well-being than the residents at one comparison site. GH residents had a lower incidence of decline in function and the GH facility had better performance on Quality Indicators.

Table 3 (continued)

Author(s)	Purpose	Method & Design	Results/Discussion
Kehoe, M. A. & Van Heesch, B. (2003).	To describe the history, philosophy, implementation and outcomes of the Wellspring model of culture change.	Descriptive study of the Wellspring model and evaluation of the charter facilities pre and post implementation of Wellspring. Sites: Eleven skilled nursing facilities "charter facilities" Measurement: OSCAR (on-line survey, certification and reporting system) and MDS (Medicaid minimum data set) datasets.	Charter facilities had: - Slightly more deficiencies than non-charter facilities during the Wellspring implementation process - No severe deficiencies post implementation (non-charter facilities had a average of 7%) - Increased staff retention Conclusions: - This is a model of nursing home care based upon best clinical practices - It may be replicated on a national basis
Lopez, S. H. (2006).	To provide a detailed ethnographic study of the nursing home.	Qualitative: ethnographic, participant-observation. Site: a nonprofit culture change nursing home Measurements: detailed field notes	Observations: - management still exercised control over community decisions - management viewed their role as nurturing the caregivers - workers had difficulty completing their daily tasks in the time available - there was a discrepancy between the rhetoric of culture change and the realities of day to day work for the staff - resource limitations such as staff, wages, attendance policy caused resentment.

Table 3 (continued)

Author(s)	Purpose	Method & Design	Results/Discussion
Rabig, J., Thomas, W., Kane, R. A., Cutler, L. J., & McAlilly, S. (2006)	To describe and discuss the implementation of the first Green House (GH) model of nursing home.	Descriptive account of the implementation of the GH Model of nursing home care.	Challenges to implementation are described such as the concerns of staff as to their loss of power and the safety of residents. Self-directed work teams also proved difficult to implement. The researchers found that staff absenteeism decreased in this model and that staff skills, teamwork, self-esteem and problems solving skills increased. The need for additional training during the implementation process was also identified.
Robinson, S. B. & Rosher, R. B. (2006).	To provide a descriptive account of the culture change process in one nursing home from the perspectives of leadership, direct care staff and a faculty researcher.	Descriptive, in-depth, two-year evaluation of the culture change process Site: One 151-bed nursing home. Participants: Facility administration, staff, residents, and family members Measurements: Family Questionnaire, Quality of Work Questionnaire, Geriatric Depression Scale, Cornell Depression in Dementia. Staff narratives were collected.	Resident depression scores significantly decreased among the cognitively intact residents between the pre and post scores. Family satisfaction showed a significant increase between the pre and post scores. Staff quality of work scores showed no significant changes. Narratives did provide evidence that reflected the value of the Eden Alternative model. The researchers concluded that while staff indicated at the two-year point that their work had more meaning and purpose than at the baseline measure, there was no change in perception of the organizational climate or of their role in decision making. Limitations of the study and challenges to the culture change process were identified. Many other structural changes occurred during the study period and their effect on the findings is unknown.

Table 3 (continued)

Author(s)	Purpose	Method & Design	Results/Discussion
Tellis-Nayak, V. (2007a).	To explore the role of leadership and work environment created by such leadership in a nursing-home facility that seeks to undergo a culture change process towards person-centered care.	Secondary analysis of existing data using a human-relations framework. Site: 156 nursing homes Participants: Certified Nursing Assistants (CNAs) and family members of nursing home residents Measurements: State inspection survey data, measures of satisfaction, loyalty, commitment, and quality.	The authors found that satisfaction increases if they feel the management is concerned about them, the quality of the work environment was found to be strongly correlated with the quality of management, pay was not the strongest motivator for CNAs, CNAs were more strongly driven by managerial practices, and the quality of the work environment affects family satisfaction and commitment, and the way families evaluate quality, and survey results.

Statement of Purpose

The overall purpose of this research study is to add to the body of literature exploring the efficacy of the culture change model in nursing homes by identifying the extent to which these valued characteristics of culture change are demonstrated by nursing home residents residing in two facilities at different stages of the culture change process. Additionally, the experience of nursing home culture change for residents is explored from the perspective of the residents, direct care staff, and family members. Therefore, this research provides an in-depth evaluation of the change process from the perspective of the long-term care resident.

Summary

Chapter Two presents a review of current literature pertaining to organizational culture, organizational culture change, the nursing home organization, and the culture change movement in nursing homes including a description of existing models of culture change. A summary of recent empirical studies is presented in tabular form. This literature review describes the changing philosophy of care and methods of care provision in the nursing home industry and the demographic, social, and health care changes that have led to the need for such changes. The need for empirical research addressing the residents' perspective of culture change is identified in this review and the statement of purpose provided addresses this need. Chapter Three outlines the research methodology employed in this study in order to provide an in-depth evaluation of the perspective of the long-term care resident.

CHAPTER 3: METHODOLOGY

Introduction

A mixed methods approach was used to provide both quantitative and qualitative data to address the research questions outlined in Chapter One. The extent to which core principles of culture change are demonstrated in the behaviors and attitudes of the residents in facilities in which such change is purported to be taking place are explored both qualitatively and quantitatively. The qualitative data further identifies the commonalities and differences in the experience of living in a nursing home for the residents in the two study sites at different stages of the culture change process.

Research Design

This research design uses a QUAN-Qual, explanatory mixed-methods approach (Gay, Mills, & Airasian, 2006), integrating both quantitative and qualitative components. As per this methodology Phase I consisted of the quantitative data collection at each nursing home. As it was not possible to utilize a true experimental design methodology, with random assignment of residents to an experimental or control group, the quantitative portion of this research was of a quasi-experimental design (Gay et al., 2006).

The qualitative portion of this research is based on an interpretivist perspective with a phenomenological approach. The phenomenological approach is well suited to addressing research questions pertaining to the essence of human experiences and has its foundations in the disciplines of psychology and education (Creswell, Hanson,

Plano, & Morales, 2007). This approach provides an understanding of research questions from the perspective of the research participants. It allows the researchers to determine essential and common structures within that perspective (Riemen, 1996).

Norlander, Gård, Lindholm and Archer (2003) describe the phenomenological approach as one which allows for the identification and exploration of aspects and qualities of phenomena, through which the researcher can gain an in-depth understanding of research participants' perceptions of the phenomena in question. Therefore, this methodological approach is appropriate and accepted for research addressing the essential elements of the subjects' experience and to allow for an exhaustive description of the phenomenon (Reimen, 1996).

The quantitative data were collected first at each nursing home and comprised of the administrator surveys and the resident surveys. The participation of the administrator at each nursing home (two in total) provided background information regarding the characteristics of the facility and the culture change process they have undergone. The resident surveys were administered in-person by the researcher.

This in-person method of survey administration was deemed to be more appropriate with the nursing home residents than self-administrated surveys as it has been found to elicit responses to both open-ended and closed-ended resident satisfaction questions in 95% of both cognitively impaired and non-cognitively impaired nursing home residents (Levy-Storms et al., 2005).

Additionally, this method of administration appears to be the most commonly used in previous studies exploring these variables within the nursing home population (Higgs et al., 1998; Kane et al., 2007; Kane et al., 1997; Levy-Storms et al., 2005). This

methodology also allowed the researcher to subjectively assess the validity of the responses. Previous researchers have postulated that long-term care residents may in fact report high levels of satisfaction with their care and these reports may be influenced by the dependency of the resident upon this care (Higgs et al., 1998). Therefore, it is important to the validity of the study that the surveys were administered by the researcher and not a member of the nursing home staff and the residents were made aware of the role of the researcher, healthcare system, and the nursing home in the research.

The qualitative portion of the study consisted of data collection from both in-depth interviews with residents and the administrators, and individual interviews with family members/friends of the residents and direct care staff charged with their care. While the survey data provided by the administrators supplied information as to the external or concrete artifacts of culture change within the nursing homes, it was also necessary to determine the administrators' perceptions of culture change and its impact on the lives of the residents.

The qualitative data obtained served to elaborate upon the quantitative data collected (Gay et al., 2006). Identified benefits of mixed-method approaches relevant to this study are the ability to provide a holistic view of the topic, the availability of qualitative findings to add more depth and understanding to the quantitative findings, and the provision of data that will be useful for critical reflection (Stewart, Makwarimba, Barnfather, Letourneau, & Neufeld, 2008). Yoshikawa, Weisner, Kalil, and Way (2008) state that the value of a qualitative approach embedded within a quantitative study is the ability to examine both data perspectives from the same participants and the ability to select the qualitative sample based upon selected characteristics of the larger sample.

The qualitative data collection consisted of both in-person, semi-structured interviews with residents and in-person, semi-structured, individual interviews with family members/friends and direct-care staff. Focus groups were the identified preferred format for the qualitative data collection from family members/friends. As Glesne (2006) states focus group interviews are particularly useful in an evaluation or action research context as policies or programs may be informed by the collection of multiple perspectives of the same experience. In this study, however, insufficient numbers of participants were recruited to use this methodology and therefore individual semi-structured interviews were utilized instead.

In conclusion, the methodology employed allows for comparison of each dependent variable pertaining to the residents residing at both nursing homes, quality of life, choice and control, and resident satisfaction, while allowing for an in-depth exploration of any differences found (Gay et al., 2006).

Research Questions

The research questions are shaped by the methodology used, i.e., the quantitative and qualitative approaches taken. For the initial, quantitative portion of the study the research questions are:

1. To what extent are different valued characteristics of culture change (quality of life, resident satisfaction, resident perceptions of choice and control) identified by long-term care residents?
2. To what extent do valued characteristics of culture change identified by long-term residents vary between facilities at different stages in the culture change process?

The research questions to be addressed in the qualitative portion of this study are:

1. What are the common elements of the experience of living in a nursing home for the residents?
2. What are the similarities in the common elements of the experience of living in a nursing home for the residents between the two facilities?
3. What are the differences in the common elements of the experience of living in a nursing home for the residents between the two facilities?

Hypotheses

The hypotheses tested in the quantitative portion of the study that relate to the quantitative research questions are:

Ho_1: $\mu_1 = \mu_2$. The self-reported quality of life of residents does not vary between residents in two facilities at different stages in the culture change process.

Ha_1: $\mu_1 \neq \mu_2$. The self-reported quality of life of residents does vary between residents in two facilities at different stages in the culture change process.

Ho_2: $\mu_1 = \mu_2$. The self-reported satisfaction of residents does not vary between residents in two facilities at different stages in the culture change process.

Ha_2: $\mu_1 \neq \mu_2$. The self-reported satisfaction of residents does vary between residents in two facilities at different stages in the culture change process.

Ho_3: $\mu_1 = \mu_2$. The self-reported perceptions of choice and control of residents does not vary between residents in two facilities at different stages in the culture change process.

Ha_3: $\mu_1 \neq \mu_2$. The self-reported perceptions of choice and control of residents does vary between residents in two facilities at different stages in the culture change process.

Procedures

Participants and Setting

This research was carried out at two nursing homes in the southeastern United States. Both nursing homes belong to a non-profit health care organization and provide skilled nursing care for adults in need of both short-term rehabilitation and long-term care. Both are committed to the philosophy of culture change and are at different stages in the process. NH-A was undergoing internal renovations at the time of the data collection, and many of the residents who participated had either recently temporarily relocated their room while the renovations took place, or were waiting to relocate. NH-B, while having been in existence for many years, had within the last two to three years moved to a new building based upon a neighborhood model of care and specifically designed to the culture change philosophy of care. Both are single story buildings; NH-A is in an urban location while NH-B is in a more suburban setting.

The participants in this study consisted of a sample of four different populations:

1. the nursing home administrator at NH-A and the nursing home administrator at NH-B
2. the long-term residents in the two nursing homes
3. direct-care staff at both nursing homes
4. persons who had family members/friends residing in either nursing home.

The primary focus of this study was the long-term residents of NH-A and NH-B. Individual demographic information is not provided for the administrators, staff, or family members/friends in order to maintain their confidentiality, due to the small sample size obtained.

All residents who met the inclusion criteria were invited to participate in the quantitative, survey portion of the research. Initially, it was estimated, based upon conversations with the administrators of the two nursing homes, that approximately 30 residents at each facility would meet the inclusion criteria for this study. However, the sample size of residents was ultimately determined by the number of residents who met the pre-determined inclusion criteria and the numbers were less than anticipated. Inclusion criteria stipulated that the residents had resided in the nursing home for a minimum of three-months, were competent to provide informed consent, or proxy consent could be requested and verbal assent from the resident obtained, and were physically and cognitively able to participate in the data collection process.

Eleven potential resident participants were identified at NH-A and 13 at NH-B. Seven residents at NH-A and six residents at NH-B completed the researcher-administered surveys. Therefore, 54% of residents that met the inclusion criteria participated at NH-A and 46% of residents that met the inclusion criteria participated at NH-B (see Table 4 for a summary of resident participant demographic characteristics).

Three residents at NH-A were male (42.9%) and four were female (57.1%). Six were Caucasian and one Black. Their average age was 75.57 years (range 67-88 years) and they had lived in the nursing home for an average of 50.57 months with a standard deviation of 25.04 (range 10 to 93 months). Six of these seven residents went on to participate in the in-person interviews.

Three residents at NH-B were male (50%) and three were female (50%), four were Caucasian (66.7%) and two African American (33.3%). Their average age was 82 years (range 65-97 years) and they had lived in the nursing home for an average of 50.17

months with a standard deviation of 40.27 (range 13 to 120 months). All of the participating residents at NH-A, except for one, lived in a shared room with one room mate. All of the residents at NH-B who participated, except for one, lived in a private room.

Table 4

Demographic Characteristics of Residents Completing the Researcher-Administered Surveys

Resident Characteristics	NH-A	NH-B
Gender	Male 42.9%	Male 50%
	Female 57.1%	Female 50%
Race/Ethnicity	6 White	4 White
	1 Black	2 Black
Mean Age (in years)	75.57	82
Age Range (in years)	67-88	65-97
Mean Length of Stay (in months)	50.57	50.17
Length of Stay Range (in months)	10-93	13-120

It was anticipated that the interview participants would be selected from the resident survey participants by the researcher and invited to further participate in the interviews on the basis of several criteria: they were able to provide an understanding of the phenomenon under investigation, they had the ability to communicate well, they were able describe their perceptions of the phenomenon well, and they were comfortable in the presence of the researcher.

Due to the smaller than anticipated sample of resident survey participants, all of the resident survey participants were identified as potential participants, having met the inclusion criteria, and were therefore invited to participate. Six of the seven residents who participated in the surveys at NH-A went on to participate in the in-person interviews and five of the six residents who participated in the surveys at NH-B went on to participate in the in-person interviews.

Variables

Independent variable. The independent variable in the quantitative portion of this study will be the nursing home site, that is, NH-A or NH-B.

Dependent (outcome) variables. The dependent variables to be explored pertain to both the level of the culture change process within the nursing homes and perceptions of three valued characteristics of culture change among the nursing home residents:

1. *The level of the culture change process.* Actual changes that have been made in the nursing home in relation to the philosophy of the culture change movement are measured using the Artifacts of Culture Change instrument; a 79-item scale measuring the level of culture change in relation to the environment, care practices, the workplace, family and community relationships (Bowman & Schoeneman, 2006).
2. *Choice and control.* Choice and control is measured using the Perceived Latitude of Control instrument (Hulicka et al., 1975) that consists of 37-items relating to activities of daily living (Hulicka et al., 1975). This instrument explores perceived choice and control as product of both the perceived level of control and the assigned importance of that control (Hulicka et al., 1975).

3. *Quality of life*. Quality of life (QOL) is a multidimensional concept (Kane et al., 2004). For the purposes of this study QOL will be measured using the identified eleven domains of QOL among nursing home residents (Kane et al., 2003). The eleven-domain QOL, 54-item instrument (Kane, 2003b; Kane et al., 2003) measures the perceived quality of life of the residents in the domains of; functional competence, security, privacy, meaningful activity, comfort, relationships, enjoyment, dignity, individuality, autonomy, and spiritual well-being (Kane, 2003a; Kane, 2003b; Kane et al., 2003, Kane, Pratt, & Schoeneman, 2004)).
4. *Resident satisfaction.* Resident satisfaction will be explored using the three satisfaction items pertaining to the resident's satisfaction with the nursing home as "a place to live, to receive care and likelihood of recommending the setting to others" (Kane et al., 2007, p.835).

Data Collection

Four groups of subjects representing the two nursing homes participated in this study and data were collected in the form of surveys and interviews.

NH-Administrators

Quantitative data collection. The two nursing home administrators were asked to complete a survey outlining the current progress in the culture change process in their facility. The researcher visited the administrators prior to and at the beginning of the data collection to ensure their cooperation and support and to provide them with the survey instrument. The administrators represent a non-random sample and a purposive sample.

The two administrators provided informed consent (see Appendix D) and completed their surveys independently and returned them to the researcher. The administrators' participation provided background information regarding the characteristics of the facility and the culture change process they have undergone. The administrator at NH-A completed the survey in November 2009 and the administrator at NH-B completed the survey in March 2010, corresponding with the data collection at each facility.

Qualitative data collection. The administrators were also asked to participate in an in-depth interview to ascertain their understanding of the culture change process and their opinion of the strengths and challenges of this model of care (see interview protocol, Appendix E). In addition, their perceptions of quality of life, resident satisfaction, and choice and control were explored to add depth to the proxy information pertaining to these concepts also provided by family members and direct care staff.

The data were collected in the form of in-depth, semi-structured, one-on-one interviews with the consenting administrators from NH-A and NH-B. In order to be of most convenience to the participants, interviews were scheduled at a time and a place of their choosing. These interviews took place in November 2009. The interviews were conducted by the researcher, were audio taped, and lasted approximately 20 minutes. Audio taping of the interviews provided a record of the interview data and allowed for verification of the information given by the participants. The semi-structured approach of the interviews provided the researcher with a specific set of questions to be addressed, but also allowed the interviewer the flexibility to probe participant responses as necessary.

Nursing Home Residents

In addition to the information provided by the administrators, the perspectives of the residents were central to the data collection process. Residents were asked to provide both quantitative and qualitative information. Both forms of data collection explored the residents' perceptions of key outcome variables under investigation.

Quantitative data collection. The sample of nursing home residents was also a non-random, purposive sample. Those identified as potential participants by the administrator (see Appendix F) who could provide informed consent were visited by the researcher and the purpose of the study, the procedures, and the consent process explained. Informed consent was then obtained (see consent form, Appendix G) and an appointment made to complete the surveys at the residents' convenience. If proxy consents were to be obtained, the nursing home administrator requested permission from the responsible party for the researcher to contact them.

The researcher then arranged to meet the responsible party at the nursing home and the purpose of the study, the procedures, and the consent process explained. Informed consent was then obtained. The researcher then visited the resident and explained the study and their verbal consent for participation was obtained. An appointment was made to complete the survey at the resident's convenience. Consent was obtained and seven residents from NH-A and six from NH-B participated in the quantitative portion of the study.

The surveys were administered by the researcher, face-to-face, in the nursing homes. They were administered in a single or a series of interviews, depending on the

level of comfort, choice, and the schedule of the resident. Each survey took approximately one-hour to complete.

The survey consisted of two previously validated instruments with established levels of reliability among this population and additional items exploring resident satisfaction (Hulicka et al., 1975; Kane et al., 2004; Kane et al., 2007). Therefore, the data collected represents resident perceptions of their perceived level and latitude of choice and control within the nursing home environment, their self-assessed quality of life, and their satisfaction with the nursing home.

Qualitative data collection. At the initial appointment to conduct the survey the researcher gained verbal permission to further approach the resident to request their participation in the interview portion of the research. Those that responded positively and were able to provide informed consent were re-visited and their continued participation in the study was again requested. The purpose of the study and procedures involved in the interview process were explained and a second informed consent was obtained from those who wished to participate (see Appendix H). An appointment was made to complete the interview at the resident's convenience.

If proxy consent was to be obtained, the researcher had previously requested permission from the responsible party to contact them for a second time if the resident wished to participate in the interview portion of the research. The researcher then contacted them and arranged to meet the responsible party at the nursing home. The purpose of the study, the procedures, and the consent process was then explained. A second informed consent was obtained (see Appendix H). The researcher then visited the resident and explained the study and interview procedures and their verbal consent for

participation was again obtained. An appointment was made to complete the interview, at the resident's convenience.

Six of the seven potential participants at NH-A and five of the six potential participants at NH-B agreed to participate and informed consent was obtained. The data were then collected in the form of in-depth, semi-structured, one-on-one interviews (see Appendix I for protocol). The interviews were audio taped and lasted approximately 15-20 minutes. Audio taping of the interviews provided record of the interview data, and allows for verification of the information given by the participants. In addition to the audio tapes, the researcher collected field notes during the interview as appropriate. Data collection was conducted by the principal researcher. The semi-structured approach of the interviews provided the researcher with a specific set of questions to be addressed, but also allowed the interviewer the flexibility to probe participant responses as appropriate.

Family Members/Friends and Direct-Care Staff

In order to ascertain a more in-depth perspective as to the experience and characteristics of culture change among the residents, two groups of additional informants were also included in this study; family members and direct-care staff. These groups were asked to participate in focus groups or one-to-one interviews. Participants were invited to attend on the basis of their relationship to the residents who completed surveys. Data were collected separately from the family members/friends and the direct care staff.

For the direct-care staff focus group, only participants identified as certified nursing assistants and as providing care for the residents who participated in the survey were invited to participate. These selection criteria were used in order to prevent staff of

different levels, that is supervisors and their staff, from attending. Including staff of different levels may have jeopardized the validity of the results because the staff may have been reluctant to express their opinions in the presence of their supervisors. There are also ethical considerations, such as the potential for a staff member to say something that their supervisor may hold against them in future interactions. Family members and friends of the residents, who completed the survey, were also invited to participate in a second focus group or one-to-one interviews. These persons were identified as visiting the residents on a regular basis, at least every two to three weeks, to ensure that they were very familiar with the facility in question (see consent forms and invitational letters, Appendices J and K).

These potential participants were identified by the nursing home administrators or their designee. Both family members and direct care staff were contacted by letter (see Appendices J and L). These letters were labeled and mailed by the facility staff and thus the researcher did not need access to the list of names and addresses. A stamped, self-addressed envelope was included in the mailing so that those contacted may indicate their willingness to participate in the focus groups or a one-to-one interview.

The administration at NH-A sent ten invitational letters to direct care staff on behalf of the researcher and the administration at NH-B sent eight. No replies were received from the NH-B requests and three replies were received from the NH-A requests and two direct care staff went on to participate. NH-A sent six letters to family members/friends on behalf of the researcher and NH-B sent seven. No replies were received from the NH-A requests and three replies were received from the NH-B requests and all went on to participate. Thus, two staff members at NH-A and three family

members/friends at NH-B participated in one-to-one interviews. The interviews at NH-A took place in January 2010 and at NH-B in May 2010.

The interviews were audio taped and lasted approximately 20-30 minutes. Audio taping of the interviews provided a record of the interview data and allowed for verification of the information given by the participants. Data collection was conducted by the principal researcher. The semi-structured approach of the interviews provided the researcher with a specific set of questions to be addressed, but also allowed the researcher the flexibility to probe participant responses as appropriate (see Appendices N and O for protocol).

Instrumentation

The instruments used to collect the quantitative data were drawn from existing instruments with established levels of reliability and validity where applicable.

Nursing Home Administrator Data Collection Instrument. The administrators were surveyed using the Artifacts of Culture Change instrument developed by the Centers for Medicare and Medicaid Services and is available for public use. This tool was developed in order to provide a uniform way of measuring the concrete changes brought about by the implementation of culture change in nursing homes (Bowman & Schoeneman, 2006). The purpose of this instrument is to provide descriptive information and a method by which nursing home administrators may gauge their progress towards culture change. Therefore, no reliability or validity information is provided.

The categories of potential areas of change were identified by Bowman and Schoeneman (2006) as being central components of the artifacts of culture change and form the basis of the tool developed, The Artifacts of Culture Change. The authors state

that these measures are not research-validated. However, this instrument is appropriate for use in this study in order to collect the descriptive data required.

The artifacts of culture change are measured by this instrument using 79-items that relate to six domains of care practice, environment, family and community, leadership, workplace practice, and outcomes (Bowman & Schoeneman, 2006). These items are scored according to a scoring system provided by the instrument developers with the maximum score being 580, with higher scores representing the presence of artifacts of culture change. The maximum scores for the individual domains are care practice (70), environment (320), family and community (30), leadership (25), workplace practice (70), and outcomes (65). Item responses consist of Likert scales with a range of three to six levels, dichotomous 'yes', 'no' responses or specific responses in which the administrator must calculate responses such as average workplace longevity of their staff and staff turnover rates. These items are then scored according to the duration or rates.

Nursing Home Administrators' Interview Protocol. The protocol was based upon prior research (Boyle, 2004; Ejaz, Straker, Fox, & Swami, 2003; Guse & Masesar, 1999; Higgs et al., 1998; Levy-Storms et al., 2005; Robinson et al., 2004) and also included questions relating to perceptions of the culture change philosophy (see Appendix E). Two questions: (i) what are three or four things you think are essential to quality of life (in the facility); and (ii) what takes away from you living a good quality of life at (the facility) were developed by Guse and Masesar (1999).

Nursing Home Resident Data Collection Instruments.

Quality of life. The eleven-domain QOL, 54-item instrument (Kane, 2003b; Kane et al., 2003) was used to measure resident self-assessed QOL. Reliability of the domain

scales ranged from a Cronbach's alpha of .77 to .53. The authors concluded that the domains are both correlated and sufficiently independent to measure the different constructs (Kane et al., 2003).

Specific findings regarding reliability and validity are provided by Kane et al. (2003). The reliability of the specific domains when used with residents with both high and low cognitive functioning are reported as comfort (.62), security (.65), meaningful activity (.53), relationships (.64), functional competence (.77), enjoyment (.71), privacy (.70), dignity (.76), autonomy (.59), and spiritual well-being (.64). Reliability was explored using confirmatory factor analysis (CFA) and reported as "(χ= 6024, *df* = 2310, *p*>.05: root mean square error of approximation = .044: comparative fit index = .973)" (p.243). As the reliability of the individuality scale was poor, the researchers excluded this domain from the CFA (Kane et al., 2003).

Responses are recorded with this instrument using either Likert or dichotomous responses. The majority of items (51) were measured using 4-point Likert scales with responses ranging from "often = 4" to "never = 1". However, if the participants had difficulty answering the question using this scale, an alternative dichotomous response format is available with the response being either "mostly yes" or "mostly no." The authors developed a re-scaled scoring system for these responses, "mostly yes = 3.8" or "mostly no = 1.5." "No response" or "don't know" are scored as 0. The authors also provide information as to the number of responses required to construct each domain scale. Lead in-statements are also provided for each set of items in the individual domains (Kane, 2003b).

This instrument was further utilized by Kane et al. (2007) to assess resident QOL in an evaluation of a Green House Program and as a measure to distinguish between nursing homes (Kane et al., 2004). Cutler, Kane, Degenholtz, Miller, & Grant (2006) also used these domains of QOL as a basis for an environmental checklist used to assess the physical environment of the nursing home resident. In addition this measure has formed the foundation for the development of resident satisfaction/QOL surveys at the state level in Minnesota (Minnesota Department of Human Services, n.d.) and a shortened version has been developed for use with the Centers for Medicare and Medicaid, Minimum Data Set collection in nursing homes (Kane, Kane, Bershandsky, Degenholtz, & Kling, 2002).

Latitude of Control. Hulicka et al. (1975) explored perceived choice and control among both community dwelling and institutionalized older adults as product of both the perceived level of control and the assigned importance of that control among daily activities and functions; the perceived latitude of choice (Hulicka et al., 1975). Hulicka et al. (1975) developed an instrument consisting of 37-items relating to activities of daily living.

Scores are given for both the amount of choice the participants feels they have in relation to each specific activity, scored on a three point Likert scale with responses of "free choice = 3", "some choice = 1" and "no choice = -3" and the importance they attach to having choice regarding each specific activity, scored on a three point Likert scale with responses of "very important = 3", "somewhat important = 2" and "unimportant = 1". Latitude of choice scores for each item are then calculated by cross-multiplying the two scores for each item. Therefore, the items with the highest

latitude of choice will be those with free choice and considered important and the lowest will be items with no choice and considered important (Hulicka et al., 1975).

Test-retest reliability for this instrument was determined using a sample of undergraduate students and was reported as .84 for latitude of choice scores, .66 for the importance scores, and .78 for choice (Hulicka et al., 1975). The authors also describe how preliminary validity checks were undertaken using a small sample of military men, whose scores were compared to those of non-enlisted men. As anticipated, latitude of choice scores were significantly lower among the enlisted men, thus suggesting the validity of latitude of choice (Hulicka et al., 1975).

The instrument developed by these researchers has also been used in several research studies (Boyle, 2004; Guse & Masesar, 1999; Hulicka, Cataldo, Morganti, & Nehrke, 1983; Jang, 1992; Morganti et al., 1980) and also with resident and staff participants to determine staff perceptions of residents' latitude of choice (Jang, 1992; Morganti et al., 1980).

Resident satisfaction. The items included to ascertain the satisfaction of the residents with the nursing home were developed and used by Kane et al. (2007) in their evaluation of a Green House Program. Reliability and validity of these items is not given. The three items measure global satisfaction with the nursing home as a "place to live and a place to receive care" (scored on a 4-pont Likert scale ranging from very satisfied to very dissatisfied) and their likelihood of recommending the nursing home to others (scored on a 4-point Likert scale ranging from very likely to very unlikely) (Kane et al., 2007).

Nursing Home Residents' Interview Protocol. The questions to be addressed in this portion of the data collection were based upon the quantitative instrument and prior work of several researchers (Boyle, 2004; Ejaz, Straker, Fox, & Swami, 2003; Guse & Masesar, 1999; Higgs et al., 1998; Levy-Storms et al., 2005; Robinson et al., 2004). As with the administrator interview protocol the two questions developed by Guse and Masesar (1999) were included. The protocol is outlined in Appendix I.

Family Member/Friends and Direct-Care Staff Interview Protocol. The interviewees were asked to expand upon the quantitative data obtained from the resident surveys. They were asked to identify whether they perceive the common characteristics of culture change to be exhibited among the nursing home residents with whom they interact and to what extent they feel these characteristics are exhibited. They were also asked to identify barriers and facilitators of choice and control and quality of life in the context of the daily lives of the residents. Therefore, the protocol addressed in this portion of the data collection was based upon the quantitative instrument and the prior work used to develop the resident interview protocol (Boyle, 2004; Ejaz et al., 2003; Guse & Masesar, 1999; Higgs et al., 1998; Levy-Storms et al., 2005; Robinson et al., 2004). As with the administrator and resident interview protocol the two questions developed by Guse and Masesar (1999) were included. The protocols are outlined in Appendices N and O.

Data Analysis

Quantitative

Initially, the quantitative data were organized and analyzed using descriptive statistics in order to simplify and summarize the data collected. A descriptive comparison

of the two nursing homes was made using the data obtained from the nursing home administrators. The instruments utilized measure the dependent variables quality of life, resident satisfaction, and choice and control; these variables are continuous. While the quality of life provides both a Likert scale with four responses and an alternative dichotomous response, used if the participant needed a simplified version of the responses, this dichotomous variable has been converted into an equivalent scale variable, continuous score (Kane, 2003b).

Inferential statistical analysis using SPSS (Version 17) was then utilized in order to compare the means and variance among means of the dependent variables by the independent variable of the nursing homes. While the use of multivariate analysis of variance (MANOVA) would have been preferable to decrease the possibility of Type I error, the assumptions of the MANOVA were not met; equal variance among the means was not demonstrated. Therefore, independent two samples, between-subjects, *t*-tests were employed.

Qualitative

After the resident, direct care staff and family member/friends interviews were completed, each audio tape was transcribed verbatim. The transcriptions were checked against the tapes to ensure accuracy and any necessary corrections made. The researcher was responsible for reading over the interview transcripts and field notes and categorizing responses into relevant themes related to the research questions. A thematic analysis involving coding and organizing the data relevant to the research questions by codes into groups for both description and analysis was carried out (Glesne, 2006).

The interview transcriptions and the observational notes of the researcher were

first grouped and labeled in order to identify initial broad categories. The data were then further divided by participants' similarities and differences into recurring themes which were labeled accordingly (Gelo et al., 2008). The aim of this analysis was to identify major common themes (codes) and connections between the experiences of the participants and then these themes were further divided into sub-codes (Glesne, 2006). The coding process for each group of participants is included in Appendices R – V. Frequencies counts of themes and sub-codes identified in the reduction of the resident data were then calculated to identify any patterns in the identified elements (Glesne, 2006).

Validity

To ensure the accuracy of the conclusions and interpretations of the qualitative data several steps were incorporated into the research methodology. First, all recorded interviews were transcribed verbatim by the researcher in their entirety and then the transcript was re-checked against the tape by the researcher. Second, member checking, whereby the transcripts, analysis and interpretation of the interviews were shared with the participants, was carried out with all available participants. This was done in order to ensure that their perspectives were adequately represented. Third, a peer review and debriefing, whereby a second researcher reviewed samples of the data, the coding procedure, and data analysis, was also completed (Glesne, 2006). The peer reviewer discussed the data coding process with the researcher and reviewed the analysis and interpretation of a sample of the interviews.

Subjectivity Statement

The researcher acknowledges that she is a proponent of culture change in long

term care and person-centered care as a philosophy of care in all aspects of health care. In addition, she has had professional experience of long-term care as a health care professional and a voluntary health agency program coordinator and personal experience as a family member of a resident in a long-term care facility. She acknowledges herself as an advocate for the important and necessary role that such facilities play in the continuum of health care services. Additionally, the researcher acknowledges that her experience working with persons with long-term health care needs may lead to assumptions about the interpretation of the statements of the nursing home residents.

While the researcher is familiar with long-term care and health care and is comfortable in long-term care settings, she had not interacted in a nursing home situation as a researcher before. However, she had participated, as a student researcher, in research studies in dementia-specific assisted living facilities. She was familiar with both nursing homes included in this study prior to commencing the research and had previously met one of the residents at one nursing home while serving in a different capacity. She is also known to several of the staff at NH-B. However, she has not been involved with the culture change process at either facility. Therefore, it is important to note that these factors are acknowledged and their possible influence on subjectivity recognized by the researcher. The reflection and awareness of the researcher and the methodology employed, that includes steps to increase the validity or truthfulness of the qualitative findings, will serve to decrease any possible researcher bias.

Summary

In conclusion, this QUAN-Qual, mixed methodology research explores the experience of nursing home culture change from the residents' perspectives. The valued

characteristics of culture change among residents are identified by three population groups, the residents themselves, direct care staff, and family members of nursing home residents. The characteristics of the two nursing homes participating in the study in relation to culture change will be ascertained. Data collection incorporates both survey and interview methods.

In Chapter Four quantitative data analysis explores the following research questions:

1. To what extent are different valued characteristics of culture change (quality of life, resident satisfaction, resident perceptions of choice and control) identified by long-term care residents?
2. To what extent do valued characteristics of culture change identified by long-term residents vary between facilities at different stages in the culture change process?

The hypotheses to be tested are:

Ho_1: $\mu_1 = \mu_2$. The self-reported quality of life of residents does not vary between residents in two facilities at different stages in the culture change process.

Ha_1: $\mu_1 \neq \mu_2$. The self-reported quality of life of residents does vary between residents in two facilities at different stages in the culture change process.

Ho_2: $\mu_1 = \mu_2$. The self-reported satisfaction of residents does not vary between residents in two facilities at different stages in the culture change process.

Ha_2: $\mu_1 \neq \mu_2$. The self-reported satisfaction of residents does vary between residents in two facilities at different stages in the culture change process.

Ho_3: $\mu_1 = \mu_2$. The self-reported perceptions of choice and control of residents does not vary between residents in two facilities at different stages in the culture change process.

Ha_3: $\mu_1 \neq \mu_2$. The self-reported perceptions of choice and control of residents does vary between residents in two facilities at different stages in the culture change process.

In Chapter Four qualitative data analysis explores the following research questions:

1. To what extent do the reports of staff and family members regarding these characteristics vary between the two different facilities at different stages in the culture change process?
2. What are the similarities in the common elements of the experience of living in a nursing home for the residents between the two facilities?
3. What are the differences in the common elements of the experience of living in a nursing home for the residents between the two facilities?

CHAPTER 4: RESEARCH FINDINGS

Quantitative Data

Artifacts of Culture Change

The nursing home administrator at NH-A and the nursing home administrator at NH-B completed the Artifacts of Culture Change Survey developed by the Centers for Medicare and Medicaid (Bowman & Schoeneman, 2006). These surveys were completed in October 2009 at NH-A and March 2010 at NH-B, corresponding with the time of the quantitative data collection.

Using the Artifacts of Culture Change instrument the maximum grand total score is 580, with the maximum scores for the individual domains being care practice 70, environment 320, family and community 30, leadership 25, workplace practice 70, and outcomes 65 (Bowman & Schoeneman, 2006). The scores for Nursing Homes A and B are outlined in Table 5.

NH-B reported higher total scores than NH-A (499 and 283 respectively). NH-B had higher scores in the artifacts of environment, family and community, and workplace practice. The leadership artifacts scores were equal between the two nursing homes and NH-A had a higher score in the care practice artifacts and outcomes artifacts. However, there were two missing items for which no response/score was entered in the care practice artifacts for NH-B.

Table 5

Artifacts of Culture Change Scores

	NH-A	NH-B
Care Practice Artifacts	53	49*
Environmental Artifacts	106	300
Family and Community Artifacts	20	25
Leadership Artifacts	18	18
Workplace Practice Artifacts	30	48
Outcome	56	50
Grand Total	283	499

*two missing scores

Nursing Home Residents

The researcher-administered surveys consisted of the Quality of Life Scale for Nursing Home Residents, the Perceived Latitude of Choice Scale, and the Resident Satisfaction items, as previously described. The survey data were analyzed in order to explore the two quantitative research questions posed in Chapter One. The first research question was: to what extent are different valued characteristics of culture change (quality of life, resident satisfaction, resident perceptions of choice and control) identified by long-term care residents? To address this question descriptive statistics were utilized to summarize the data obtained from the resident surveys.

The second research question asked: to what extent do valued characteristics of culture change identified by long-term residents vary between facilities at different stages

in the culture change process? To address this question the following hypotheses were tested:

Ho_1: $\mu_1 = \mu_2$. The self-reported quality of life of residents does not vary between residents in two facilities at different stages in the culture change process.

Ha_1: $\mu_1 \neq \mu_2$. The self-reported quality of life of residents does vary between residents in two facilities at different stages in the culture change process.

Ho_2: $\mu_1 = \mu_2$. The self-reported satisfaction of residents does not vary between residents in two facilities at different stages in the culture change process.

Ha_2: $\mu_1 \neq \mu_2$.The self-reported satisfaction of residents does vary between residents in two facilities at different stages in the culture change process.

Ho_3: $\mu_1 = \mu_2$. The self-reported perceptions of choice and control of residents does not vary between residents in two facilities at different stages in the culture change process.

Ha_3: $\mu_1 \neq \mu_2$. The self-reported perceptions of choice and control of residents does vary between residents in two facilities at different stages in the culture change process.

Quality of Life. The means and standard deviations of the items and scales of the 11-domains of the quality of life scale are provided in Table 6. The average scores were higher in NH-A than NH-B in five domains: functional competence, meaningful activities, relationships, autonomy, and individuality. The average scores were higher in NH-B than NH-A in six domains: comfort, privacy, dignity, food enjoyment, spiritual well-being, and security.

Table 6

Eleven Domain Quality of Life for Nursing Home Residents Scores

	NH-A Mean *(SD)*	NH-B Mean *(SD)*	*t*	*d*
Comfort	15.00 (1.91)	17.67 (4.32)	1.48	0.80
Functional Competence	17.86 (1.07)	17.83 (2.40)	0.24	0.02
Privacy	15.86 (3.76)	19.42 (1.02)	2.34*	1.29
Dignity	19.14 (0.90)	19.17 (1.17)	0.04	0.03
Meaningful Activities	17.50 (4.06)	17.17 (2.77)	0.17	0.09
Relationship	18.00 (3.32)	16.10 (4.24)	0.91	0.50
Autonomy	14.86 (1.35)	13.94 (2.47)	0.86	0.47
Food Enjoyment	8.00 (1.91)	9.77 (2.33)	1.50	0.84
Spiritual Well-Being	13.14 (2.27)	13.73 (2.80)	0.42	0.23
Security	16.71 (2.63)	19.47 (.82)	2.45*	1.42
Individuality	21.71 (2.87)	21.10 (2.11)	0.43	0.24

Note * $p<.05$

To test hypothesis one, a comparison of the means of the 11 domains of the Quality of Life for Nursing Home Residents were compared. While the use of multivariate analysis of variance (MANOVA) would have been preferable to decrease the possibility of Type I error, the assumptions of the MANOVA were not met. That is, homogeneity of variance in the means of the scores for the 11 domains for the two nursing homes was not found, as demonstrated using Levene's Test for Equality of

Variances. Therefore, it was necessary to conduct independent two samples, between-subjects, *t*-tests for the means of each domain.

While the means differed between the nursing homes for each domain, statistically significant differences were found in only two domains, privacy and security. Using Cohen's *d* large effect sizes were identified for both domains. In addition large effect sizes were identified for the food enjoyment and comfort and medium effect sizes for relationships and autonomy; none were statistically significant. Therefore, the null hypothesis Ho_1 that the self-reported quality of life of residents does not vary between residents in two facilities at different stages in the culture change process was rejected in the domains of privacy and security only.

Resident Satisfaction. A comparison of the means of the three resident satisfaction items is provided in Table 7. The mean resident satisfaction with the nursing home as a place to live and as a place to get care were higher at NH-B than NH-A, while the mean score for the likelihood of recommending the nursing home to others was higher at NH-A than at NH-B.

Hypothesis two was tested using two samples, between-subjects, *t*-tests. No statistically significant differences were found between the levels of resident satisfaction at NH-A and NH-B on all three items ($p > .05$). Using Cohen's *d* medium effects sizes were found for satisfaction with the nursing home as a place to live and satisfaction with the nursing home as a place to get care. Therefore, the null hypothesis that the self-reported satisfaction of residents does not vary between residents in two facilities at different stages in the culture change process was retained.

Table 7

Resident Satisfaction Scores (n=7 NH-A, n = 6 NH-B)

	NH-A Mean *(SD)*	NH-B Mean *(SD)*	*t*	*d*
Satisfied as a place to live	3.57	3.83	0.98	0.55
	(0.53)	(0.41)		
Satisfied as a place to get care	3.43	3.67	0.81	0.44
	(0.53)	(0.57)		
Recommend to others	3.86	3.83	0.11	0.08
	(0.38)	(0.41)		

Perceived Latitude of Choice. The comparative means and standard deviations for the latitude of choice, degree of choice, and the perceived importance of choice as explored on the perceived latitude of choice scale are shown in Table 8. Items for which choice was rated as very important by all residents at both facilities were: (i) who to have for friends, (ii) whether to associate with others; (iii) how much personal privacy is available; (iv) whether to participate in activities; (v) whether to go out; and (vi) what to spend money on. Items for which choice was rated as very important by all residents at NH-A only were: (i) what is served at meals; (ii) what time to go to bed; (iii) what time to get up; (iv) where to see visitors and friends; (v) when visitors and friends; (vi) what clothes to wear; and (vii) who to live with. Items for which choice was rated as very important by all residents at NH-B only were: (i) whether to attend religious services and (ii) whether to have a private room.

Items for which the degree of choice was rated as having free choice by all

residents at both facilities were: (i) what television programs to watch; (ii) who to have for friends, (ii) what clothes to wear; (iii) what type of haircut to get; (iv) who to complain to; (v) whether to attend religious services; (vi) whether to go out; and (vii) whether to participate in certain activities. Items for which the degree of choice was rated as having free choice by all residents at NH-A only were: (i) who to sit with at meals; (ii) what time to go to bed; and (iii) what books or papers to read. Items for which the degree of choice was rated as having free choice by all residents at NH-B only were: (i) where to see visitors and friends; (ii) when to watch television; (iii) where to spend free time; (iv) whether to associate with other people or not; (v) how much personal privacy is available; and (vi) color of walls, pictures etc. in living quarters.

Items that received negative mean scores for degree of choice and latitude of choice at NH-A and B were: (i) what is served at meals and (ii) what time to eat meals. What is served at meals was rated as very important by all residents at NH-A ($M = 3.00$, $SD = 0.00$) and as somewhat to very important by the residents at NH-B ($M = 2.67$, $SD = 0.52$). What time to eat meals was rated of a lower importance at both nursing homes than what is served at meals. Items that received negative mean scores for degree of choice and latitude of choice at NH-A only were: (i) when to have a bath and (ii) whether to have a private room. The choice as to whether to have a private room was rated as very important by these residents. The choice as to when to have a bath was also rated on average as somewhat to very important by these residents ($M = 2.71$, $SD = 0.49$). One item received negative scores for degree of choice and latitude of choice at NH-B only: (i) where to shop and was rated on average as somewhat to very important by these residents ($M = 2.50$, $SD = 0.84$).

Table 8

Perceived Latitude of Choice Item Scores (n = 7 NH-A, n = 6 NH-B unless stated)

Item[§]	Importance of Choice		Degree of Choice		Latitude of Choice	
	NH-A Mean (*SD*)	NH-B Mean (*SD*)	NH-A Mean (*SD*)	NH-B Mean (*SD*)	NH-A Mean (*SD*)	NH-B Mean (*SD*)
1.	3.00 (0.00)	2.33 (1.03)	3.00 (0.00)	2.00 (2.45)	9.00 (0.00)	4.00 (7.01)
2.	3.00 (0.00)	2.67 (0.52)	-.14 (2.80)	-.33 (2.07)	-.43 (8.38)	-.67 (5.39)
3.	2.29 (0.95)	1.40 (0.89)	-1.29 (2.14)	-1.40 (2.19)	-1.71 (4.86)	-1.00 (2.83)[+]
4.	2.00 (1.00)	2.80 (0.45)	2.71 (0.76)	2.00 (2.45)	5.71 (3.40)	6.00 (6.71)[+]
5.	2.71 (0.49)	2.50 (0.84)	2.71 (0.76)	2.20 (1.10)	7.57 (2.70)	6.40 (3.58)
6.	3.00 (0.00)	2.83 (0.41)	3.00 (0.00)	2.67 (0.82)	9.00 (0.00)	7.50 (2.51)
7.	3.00 (0.00)	2.83 (.41)	2.14 (2.27)	.67 (2.94)	6.43 (6.80)	2.50 (8.14)
8.	2.71 (0.49)	2.17 (0.94)	-.43 (3.21)	.00 (2.45)	-.43 (8.90)	1.83 (4.49)

Table 8 (continued)

Item[§]	Importance of Choice		Degree of Choice		Latitude of Choice	
	NH-A Mean (*SD*)	NH-B Mean (*SD*)	NH-A Mean (*SD*)	NH-B Mean (*SD*)	NH-A Mean (*SD*)	NH-B Mean (*SD*)
9.	3.00 (0.00)	2.33 (1.03)	2.71 (0.76)	3.00 (0.00)	8.14 (2.27)	7.00 (3.10)
10.	3.00 (0.00)	2.60 (0.55)	3.00 (0.00)	3.00 (0.00)	9.00 (0.00)+	7.80 (1.64)+
11.	2.71 (.76)	2.33 (1.03)	2.71 (.76)	3.00 (.00)	7.29 (2.93)	7.00 (3.10)
12.	2.71 (0.76)	2.33 (1.03)	3.00 (0.00)	3.00 (0.00)	8.14 (2.27)	7.00 (3.10)
13.	2.86 (0.38)	2.67 (0.82)	2.71 (0.76)	3.00 (0.00)	8.00 (2.65)	8.00 (2.45)
14.	2.71 (0.76)	3.00 (0.00)	2.14 (2.27)	2.67 (0.82)	7.29 (4.54)	8.00 (2.45)
15.	3.00 (0.00)	3.00 (0.00)	3.00 (0.00)	3.00 (0.00)	9.00 (0.00	9.00 (0.00)
16.	3.00 (0.00)	2.83 (0.41)	3.00 (0.00)	3.00 (0.00)	9.00 (0.00)	8.50 (1.22)
17.	3.00 (0.00)	2.67 (0.82)	3.00 (0.00)	3.00 (0.00)	9.00 (0.00)	8.00 (2.45)

Table 8 (continued)

Item[§]	Importance of Choice		Degree of Choice		Latitude of Choice	
	NH-A Mean (*SD*)	NH-B Mean (*SD*)	NH-A Mean (*SD*)	NH-B Mean (*SD*)	NH-A Mean (*SD*)	NH-B Mean (*SD*)
18.	2.71 (0.76)	2.00 (1.10)	2.71 (0.76)	1.00 (3.10)	7.29 (2.93)	2.00 (7.01)
19.	2.86 (0.38)	3.00 (0.00)	2.71 (0.57)	2.00 (2.45)	7.71 (2.36)	6.00 (7.35)
20.	3.00 (0.00)	3.00 (0.00)	2.71 (0.57)	2.00 (2.45)	8.14 (2.27)	6.00 (7.35)
21.	2.57 (0.54)	2.50 (0.84)	2.14 (1.07)	-1.33 (2.66)	5.71 (3.35)	-2.50 (7.20)
22.	3.00 (0.00)	3.00 (0.00)	2.71 (0.76)	3.00 (0.00)	8.14 (2.27)	9.00 (0.00)
23.	2.86 (0.38)	2.67 (0.52)	2.14 (1.07)	2.00 (2.45)	6.29 (3.40)	5.00 (7.01)
24.	2.86 (0.38)	2.83 (0.41)	3.00 (0.00)	3.00 (0.00)	8.57 (1.13)	8.50 (1.22)
25.	2.86 (0.38)	3.00 (0.00)	3.00 (0.00)	3.00 (0.00)	8.57 (1.13)	9.00 (0.00)
26.	2.86 (0.38)	2.33 (1.03)	3.00 (0.00)	.67 (2.94)	8.57 (1.13)	2.67 (7.63)

Table 8 (continued)

Item[§]	Importance of Choice		Degree of Choice		Latitude of Choice	
	NH-A Mean (*SD*)	NH-B Mean (*SD*)	NH-A Mean (*SD*)	NH-B Mean (*SD*)	NH-A Mean (*SD*)	NH-B Mean (*SD*)
27.	3.00 (0.00)	3.00 (0.00)	1.57 (0.98)	3.00 (0.00)	4.71 (2.93)	9.00 (0.00)
28.	2.71 (0.76)	2.33 (1.16)	2.14 (2.27)	1.00 (3.46)	7.29 (4.54)	5.00 (6.93)$^{++}$
29.	2.67 (0.82)	2.33 (1.16)	2.00 (2.45)	1.00 (3.46)	7.00 (4.90)$^{+++}$	5.00 (6.93)$^{++}$
30.	2.86 (0.38)	2.33 (1.16)	2.71 (0.76)	1.00 (3.46)	8.00 (2.65)	5.00 (6.93)$^{++}$
31.	2.83 (0.41)	2.83 (0.41)	2.33 (1.03)	2.33 (1.03)	6.83 (3.37)$^{+++}$	6.83 (3.37)
32.	3.00 (0.00)	2.67 (0.82)	1.00 (2.00)	1.67 (2.42)	3.00 (6.00)	4.00 (7.01)
33.	2.86 (0.38)	2.67 (0.82)	1.86 (2.27)	3.00 (0.00)	5.14 (6.64)	8.00 (2.45)
34.	2.43 (0.98)	3.00 (0.00)	-1.00 (2.58)	2.00 (2.45)	-1.29 (6.68)	6.00 (7.35)
35.	2.71 (0.76)	2.33 (1.03)	1.29 (2.93)	2.00 (2.45)	4.71 (7.52)	6.00 (5.02)

Table 8 (continued)

Item[§]	Importance of Choice		Degree of Choice		Latitude of Choice	
	NH-A Mean (*SD*)	NH-B Mean (*SD*)	NH-A Mean (*SD*)	NH-B Mean (*SD*)	NH-A Mean (*SD*)	NH-B Mean (*SD*)
36.	3.00 (0.00)	3.00 (0.00)	3.00 (0.00)	3.00 (0.00)	9.00 (0.00)	9.00 (0.00)
37.	3.00 (0.00)	3.00 (0.00)	3.00 (0.00)	3.00 (0.00)	9.00 (0.00)	9.00 (0.00)

Note. [§] number corresponds to item number in perceived latitude of choice instrument questions, see Appendix P
+n=5, ++n=3, +++n=6

The comparative means and standard deviations for each of the scales in the Perceived Latitude of Choice Scale for Nursing Homes A and B are provided in Table 9.

Table 9

Perceived Latitude of Choice Mean Scores

	NH-A Mean (*SD*)	NH-B Mean (*SD*)	*t*	*d*
Degree of Choice	2.18 (0.50)	2.02 (0.65)	0.48	0.28
Importance of Choice	2.82 (0.21)	2.64 (0.27)	1.31	0.74
Latitude of Choice	6.50 (1.41)	5.86 (1.76)	0.73	0.40

The means for latitude of choice, degree of choice, and importance of choice are all higher for the residents of NH-A. To address hypothesis three, comparative statistical analysis of the means was conducted using independent two samples, between-subjects, *t*-tests. While the use of multivariate analysis of variance (MANOVA) would have been preferable in order to decrease the possibility of Type I error, the assumptions of the MANOVA were not met. That is, homogeneity of variance in the means of the scores for the degree of choice, importance of choice, and latitude of choice for the two nursing homes was not found, as demonstrated using Levene's Test for Equality of Variances. Therefore, it was necessary to conduct independent two samples, between-subjects, *t*-tests for the means of each domain.

No statistically significant differences were found. Using Cohen's *d* a medium effect size was found for latitude of choice and a large effect size was found for importance of choice. Therefore, the null hypothesis that the self-reported perceptions of choice and control of residents do not vary between residents in two facilities at different stages in the culture change process was retained.

Qualitative Data

The research questions to be addressed in the qualitative portion of this study are:

1. What are the common elements of the experience of living in a nursing home for the residents?
2. What are the similarities in the common elements of the experience of living in a nursing home for the residents between the two facilities?
3. What are the differences in the common elements of the experience of living in a nursing home for the residents between the two facilities?

These questions were explored from the perspective of the resident themselves, the nursing home administrators, friends and family members of the residents, and direct care staff regularly assigned to the care of the residents.

Nursing Home Administrators

The administrators at NH-A and NH-B were interviewed separately in one-to-one interviews in November 2009. The thematic analysis is presented in Appendix Q.

Culture change. Both administrators described themselves as being very familiar with the culture change process at previous places of employment, one as an employee program, and both as continuing education with one having attended many professional meetings and conventions pertaining to culture change and the other having completed education classes that included content on culture change in graduate school.

When asked to define culture change it was described by the administrators both in terms of the residents' experience and as moving away from the institutional model of care towards a more resident controlled, home-like environment in which the residents are provided with choices in their everyday lives. One administrator, Tom (pseudonym), talked of culture change in terms of the benefits to the organization, the staff, and the residents stating, "… if you provide culture change you'll have a better experience, so better surveys, you'll have better, happier employees and less turnover." The second administrator, Susan (pseudonym), discussed the nursing home as a home-like environment that moved away from the medical model of care stating, "…having it be less of a medical model and more of a long-term care environment, more of a home-like environment for those that are here long-term."

Both administrators spoke of the benefits of culture change for the residents in terms of the relationships that can develop between the residents and the staff with Tom describing a benefit as "a better worker or helper-resident relationship." Susan focused much of her description of the benefits on this relationship stating, that staff, "… can be friends with who they're taking care of," and describing this change from the previous model of care, "…I think that when you're happy and you're relaxed you're more healthy and you enjoy a better quality of life and to me quality of life usually trumps quantity."

Tom described the need to encourage residents to have control over their health and health care decisions citing the example of one resident who successfully moved to a lower level of care and a more independent living environment:

> "Umm I think that the benefits, and we've had people who …umm… have umm been able to take ownership of their health so to speak, and even though they've lived here for several years they've …um…one person in particular decided she would lose some weight and…um…started going back to therapy and ended up umm being able to transfer and walk and she was very excited as she was able to move to an assisted living, kind of independent apartment. She was very excited about that so, I think the more you can give the decision making back to a, a resident the better everyone will be."

The challenges to implementing culture change were described by the administrators in terms of the physical environment, regulations, and the previous culture, philosophy of care and staff attitudes. Both administrators acknowledged that the physical environment could provide a challenge for the implementation of the culture change model with Susan saying, "I think that, the physical plant plays a big part of it" and Tom describing the two biggest challenges as the "physical environment and regulations." Indeed, both administrators described their need to fulfill state and federal regulatory requirements while implementing and promoting a culture change model of

care. Susan described this balance, "We still have to provide lots and lots of medical care and abide by all the regulations which in and of itself can be a fine line to walk."

Tom described the challenge of introducing more choice in terms of the dining program in the context of their recent state inspection:

> "I just had an annual survey and got cited, basically because I was doing something different with my dining program. I was trying to do buffet service and they were dinging me on food temps after we had already taken temps, and it was already at temp., and it just, it felt like being penalized for doing it differently."

Tom also saw the terminology of the regulations as being incongruent with the language and philosophy of culture change and provided an example of this in that of the resident advocacy group in the facility:

> "For instance, you know 'residents council' that word comes straight out of the regulations, you know, and to get people to use a different word for that then…you know I like, I think some of the models use 'homeowners association' but in order to get people to use that word, you know, it's hard because people are so tied in to that regulation."

The role of continuing and continuous education was identified as being important to sustaining the culture change model of care by both administrators. Tom described how the education process had to be in place so that all staff were orientated to the culture change process in order that they did not jeopardize the gains made stating the importance of, "… making sure that you have that culture change built into your orientations, so that when, people walking in the door are hitting the floor doing it the way the way the whole culture is. Otherwise you bring in people and you change that culture." Susan's statement indicates how this is very much seen as an ongoing process:

> "… this facility went through a bunch of educational training and um culture change educational seminars, things like that, with the

> staff. But we all still don't have it, yet. You know some of our staff are more well versed in it than others. And some are almost there not quite there…"

She outlined the responsibility of the organization in this process saying, "And it all comes back to the staff and umm giving them the tools and education and showing them that it's ok to make these changes."

Both administrators also described how the necessity of the change of culture from a task-orientated to a resident focused philosophy of care can provide challenges. Tom described this conflict between model and task-orientated culture saying, "people [staff] tend to want to get into a task orientated break up of their day," and Susan acknowledged that, "teaching the staff to think differently is the hardest part and we still face those challenges."

Quality of Life. When asked to identify factors important to the quality of life of their residents both administrators described the important role they felt that quality of care plays in quality of life. Susan stated, "… quality care has to, has to fall in there somewhere. We can't, you know, not talk about quality of care just because it's culture change" and " Just knowing there are people there to care for you when you need it is huge." Tom described quality of care in terms of specific tasks or programs, "I think a great toileting or incontinence program. I think that impacts skin and independence, and dignity, so I think that a really good toileting program " and "You know pressure areas can happen in a matter of hours. So if you're not communicating with each other, I to nurse, to supervisor, to doctors, to families. I think if you don't have that really good underlying communication system built in you have the potential for, for harm."

Thus, communication between staff and family members was also seen as an important part of quality of life by this administrator as was the communication between residents and staff.

> "I would say some sort of customer service initiative so that staff are interacting with your residents in a manner that they feel special rather than a task. So, so an overlaying customer service model so that you're very much hospitality orientated and not medical model orientated."

Susan discussed the importance of resident relationships within the facility and involvement with the local community to quality of life, "…having friends and outlets and community resources available to you so that you're not secluded in quote the nursing home".

Choice was another common factor identified by both administrators in the context of quality of life. Susan specifically cited choice as the most important component of resident quality of life.

> "I think choice is the, the number one, is the number one thing. Having a choice, whether it be about what time you get up, what you eat, what time you want to go to bed, what you want to wear, when you want to take a shower, you know morning versus evening. I think that if you still can make your choices, that's huge. As opposed to being on a schedule that somebody handed you."

Tom cited the dining program at the facility as an important part of quality of life in terms of introduction of choice stating,

> "…there's so much that they can't control, they can't control their health, they can't control that their family doesn't have somewhere for them at their home or have time to take care of them, so what they can control are, you know, probably one of the biggest quality of life I think is what they can control, which is dining."

In discussion of the factors that detract from the quality of life of the residents many of the factors identified, such as communal living, the physical environment,

adaptation to communal living, and the balance between regulations and resident autonomy, related to the theme of institutional living. Tom discussed how the physical environment of the facility could present challenges for the residents:

> "other than may be some of the physical barriers, you know, their rooms could be a little bigger. Storage areas. You know you could, if people wanted to park their wheelchairs and their walkers outside the dining room and go and be seated in the chair. You know those kind of just general storage areas. Umm, it seems like you never have enough room."

This administrator discussed how the attitude of the residents and their adaptation to life in the facility could also affect their quality of life, "…I would say the only other thing holding them back would be themselves, you know if they, if they don't see it or they can't work with us…"

Additionally, Susan discussed how the adjustment of the resident to communal, facility living could be a barrier to quality of life, "Nobody wants to come to a nursing home… that's out of any of our control. It could be the nicest place in the world and still not home" and in acknowledging the process stated, "…we have great social workers and umm, medical staff that help them along but it is very difficult to watch that process."

Choice and Control. Both administrators acknowledged that while they try to provide choice and control in the lives of their residents the logistics of communal living and state and federal regulation require for some scheduling of tasks and activities, with Tom stating, "We have to have some schedules you know because we take care of multiple people but if you don't like your schedule just tell us, we can adapt to that" and Susan acknowledging that, "We still have some regimen. You know we still have to serve our meals within a certain time frame per the state regulations..." Susan also discussed the dining program in terms of choice, "…we try and serve our meals for at least an hour

so that and we, we're always willing to, we have food available all day long so if they want to just have cereal or eat their breakfast later that's an option" and "We have a whole menu of alternates."

The importance of resident self-advocacy was evident in this discussion. Susan acknowledged that living in a nursing home can be a threat to the level of control available, "…we try and do our best but it's not, it'll never be the same as being independent and at home." Both administrators described the active role played by staff in empowering residents to make choices where able with Tom stating, "I think the staff do a great job of making little decisions in, within their control" and Susan stating, "I've always felt that if people can make choices for themselves, it's giving them back, you know, some of their independence and it can be the smallest choice in the world," and "…letting them determine you know when they want to shower, or you know when they want to go play cards in the dining room with their friends here. Umm, I think when you take that away from somebody, you umm, almost just take their personality with it."

Tom also discussed the residents' level of dependency as a factor in the amount of choice and control they can maintain saying, "I think it's harder for individuals who are totally dependent, obviously" and the active residents council in the facility. Tom also discussed how they will work with family members to serve as resident advocates if necessary. Susan discussed the fact that while the residents do not always have a choice as to whether they have a shared room or not the staff try and accommodate the resident's choice as able, "private versus semi-private, just depending on our availability. Umm, we try to accommodate with wait lists and moving people around, we do that on a daily basis to accommodate …"

Resident Satisfaction. When asked to name the factor they would identify as the worst thing about living in their particular facility Tom named the behavior of other residents. This was discussed in the context of those residents with cognitive losses.

> "…we have someone here now that has, progressed in their disease process and their illness, and they're like yelling out all the time. So if I were living here and someone down the hall were yelling out like that all night to me that would be bad."

Bathing was also mentioned by Tom as one of the worst things although it was acknowledged that this had been a recent focus for improvement, "maybe the shower/bathing process but we've done some really nice work in making that environment nicer, more appealing." In discussion of the best things about living in their particular facility Tom named the dining program and the activities program stating, "We have a really good activities program with a lot of different creative outings" and "I think the dining room. I think the choices that we offer…"

Susan primarily discussed the actual need for relocation to a facility setting as one of the worst things about living in a nursing home and also the adaptation to communal living, stating "I mean you're in a, you're in a community living, you know you can't always make it dark and quiet when you want it dark and quiet. And that just comes along with living in a, a community setting. That's very difficult for anybody I think." Thus, the need for and process of institutionalization again factored into this discussion.

This administrator also identified choice, in the context of dining and activities of daily living, and the quality of care and a caring staff as the best things about living in their facility stating:

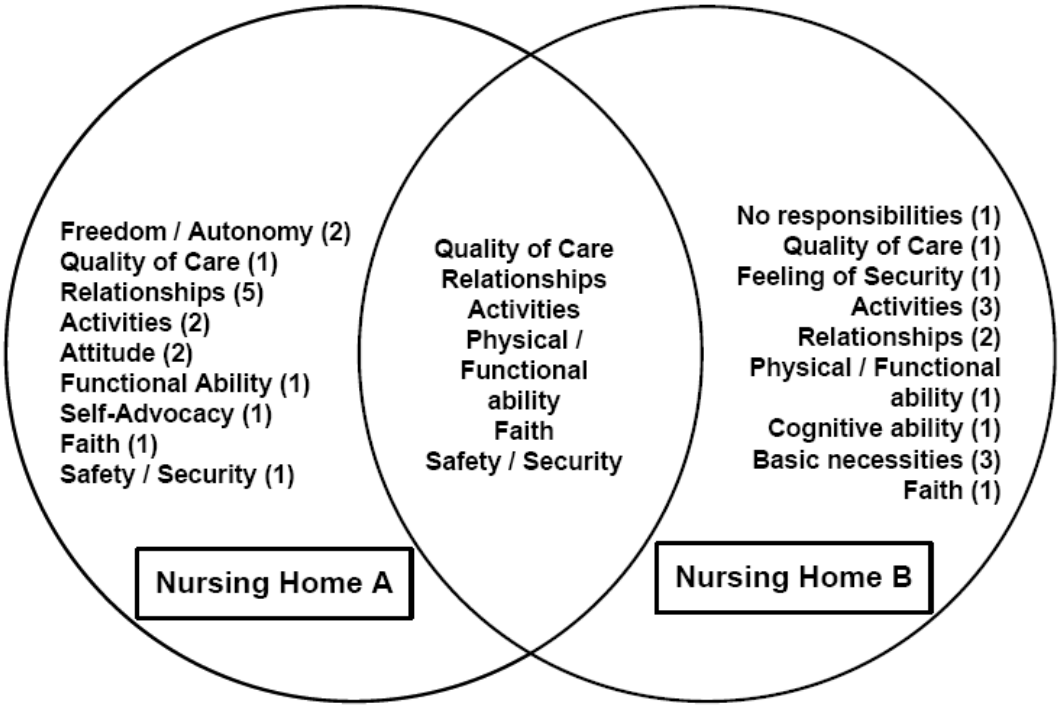
> "So I think that we do a good job here of providing choice and um I think we do a great job of providing quality care. So, um, when you have those things that go hand-in-hand it does wonders for quality of life. Umm, very home-like. The staff is very involved; they really care for our residents. Genuinely care for them."

Nursing Home Residents

The residents at NH-A and NH-B who participated in the survey portion of this study were asked to participate in a follow up one-to-one interview. The interviews took place in NH-A in December 2009 and in NH-B in March 2010.

Quality of Life. The factors identified as essential to QOL by the residents of NH-A and NH-B are outlined in Figure 1. Themes common to residents at both nursing homes and their frequencies are given.

Figure 1. Quality of Life: Frequencies, Categories, and Themes



Quality of care, relationships, activities, physical/functional ability, faith, and safety/security were the themes identified by residents at both NH-A and NH-B. Using the Chi Square test for independence no significant differences in the frequencies of these common factors were found between NH-A and NH-B, $\chi^2 = 6.00$, $df = 5$, $p = .11$.

Relationships were the most commonly occurring theme with seven of the eleven respondents discussing relationships as essential to quality of life. This was addressed in terms of both relationships with other residents, relationships with staff, and relationships with family and friends and the outside community; one resident discussed relationships twice both in terms of relationships with staff and with other residents.

The importance of peer support and peer relationships were very much reflected in statements such as, "Well, one thing you must have is a decent friend to talk to, okay?" and "Be a friend for everyone as best as you can. I'm always a people person so that's not hard for me," and "Well, just meeting people. Does that make sense?" One resident, Charles (pseudonym) stated: "Well, to a good quality of life here, well with me I think it's try to get acquainted with some of the other residents and not, not be a recluse." In the context of relationships with staff Charles also stated:

> "… when we first came here I tried to get acquainted with the other residents. And, err, you know tried to, tried to build up a good relationship with the staff that work here, that look after us."

The importance of the strength of relationships with those outside the facility was acknowledged by another resident Shirley (pseudonym) saying, "Having good friends and family. Family is fortune. I think that's pretty important."

Quality of care was spoken of in terms of care for specific medical conditions and in the general care and services provided in the nursing home with Derek (pseudonym) summarizing this as:

> "You got three hot meals a day and you got a bed to sleep in and all you medications and all that taken care of. If you get sick or don't feel good, they got nurses on duty 24 hours a day."

While functional ability or physical condition was only mentioned by two residents as being essential to QOL it was the only common detractor mentioned by residents of both nursing homes. Thus, the importance of functional/physical ability to quality of life is highlighted by their responses. Shirley stated:

> "Well, I, I pretty much can function on my own as far as, you know the things I have to do daily …… And you know, I think that's good you know, you need to do things for yourself. Then you don't have to depend on somebody for everything. But I know there are a lot of people that have to. Cos they can't help themselves. So I'm just lucky enough so far I haven't had to do that."

And Henry said:

> "And that's the reason I came here because they have a good rehab facility, and I went through all the exercises and everything to learn to speak good and to talk good because when I first came here I really couldn't eat … but those would be the two essential components."

The importance of activities was also cited as being important to QOL with the activities both inside and outside the buildings being discussed. These quotes illustrate the multiple roles that these activities play in the lives of the residents. Tom described the connections that are maintained with the world outside the nursing home:

> "And you must have something to do, like activities like I get to do every afternoon. And when you're talking about participants you must have some kind of religious outlet you know… And being

> able to go somewhere. Like, I'm able to go to Wal-Mart or other excursions out. So patients see things and not get closed in and can't get out."

And Derek described the importance of the relationships with others as a component of these activities:

> "Activities you can participate in, they take you out shopping once a month and you go out to eat once a month and most of it, that's about it. And they have like outings that you can go on. So, it's about the same thing as you home, but it's better cos you go out as a group."

Faith was discussed by three respondents as being an important component of QOL. One respondent, Rita (pseudonym) stated, "I think [pause] having faith in God. You know you've got to trust, you've got to trust somebody. And if you can't trust Him who can you trust…" Feelings of safety and security were also stated as essential components of QOL with Derek stating, "So, it's a, one way for matters, err, that you been protected when you ain't got nobody to take care of you."

Themes mentioned by residents at one nursing home only but by more than one respondent were freedom/choice and attitude. These factors were each mentioned by two different residents at NH-A. The residents at NH-A discussed freedom in the context of the level of both functional ability and autonomy with the residents making such statements as, " Cos I can pretty much come, do as I please, do what I want," and "Well, freedom to do what I want to do and am capable of doing."

Several other factors were mentioned by single participants such as some of their individual basic and personal needs in life: sleep, food, and cigarettes, and having no day to day responsibilities. Cognitive abilities and being able to read were very important to

the quality of life of one resident, Henry, who loved books and keeping abreast of current issues by reading several newspapers.

> "Well, [pause] basically that's it because if your brain isn't working, and there are some people here for example, who don't read or they've been so traumatized that they don't think straight. And if I didn't read I think I'd be grieving."

Factors cited as detracting from QOL in their current circumstances were functional/physical ability, as previously discussed, and this was cited by two residents (one from NH-B and one from NH-A). Additionally, the responsiveness of the staff when they needed help was mentioned by two residents at NH-A. Single residents at NH-A also mentioned logistical constraints such as the availability of the mechanical hoist when needed, the geographic location of the facility away from family and friends, and the occurrence of personal possessions going missing from a resident's room as detractors to QOL.

In the context of detractors of QOL two residents at NH-B mentioned the need to comply with the rules and regulations involved with communal living. While neither directly stated that they felt this contributed to a loss of quality of life they did both describe how they had to adapt to the constraints of the facility with Charles stating:

> "No, not really because anywhere you go there's rules and regulations. And if you're home there's still rules that you have to abide by. You know, whether you with somebody or by yourself. See what I'm saying. You're going to have rules even with the people that you rent from…So they have rules and regulations and if you learn to abide by the rules and regulations you'll get along fine."

Derek also discussed rules and regulations:

> "Well, I mean if you compare it with your life in your own home, the independence as to living, there's bound to be some changes because when you get into a, a fraternal place like this they, they

> have rules and regulations that .. … that I have to lend, lend myself to if I'm going to enjoy living here."

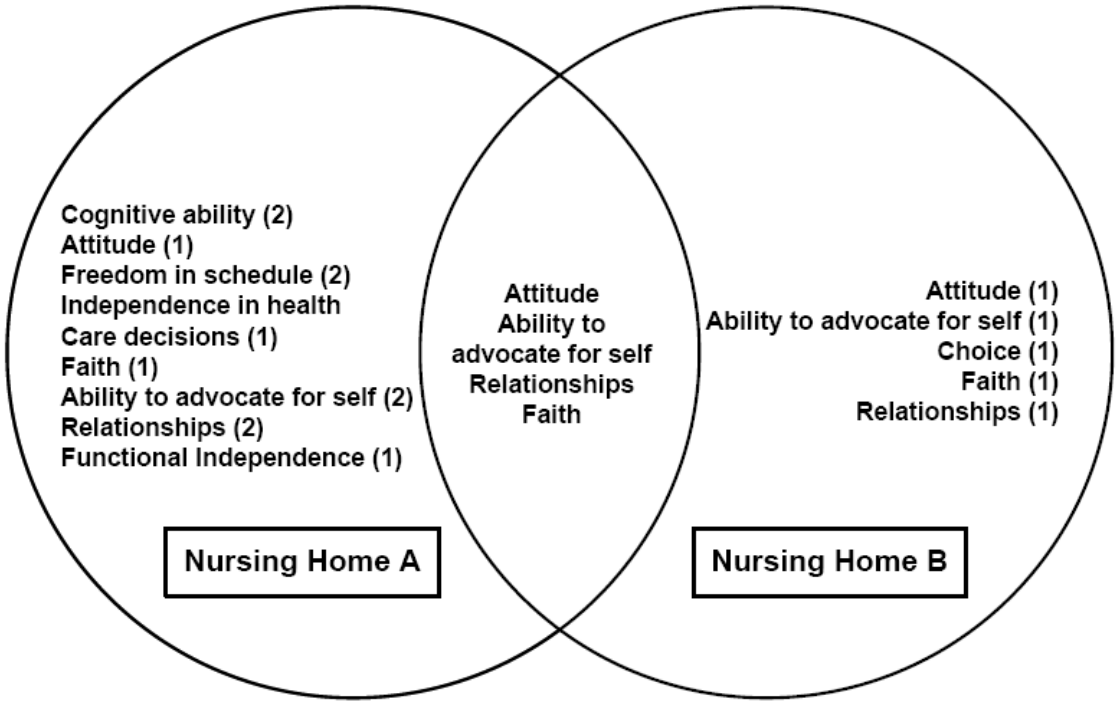
Choice and Control. The majority of residents (four) at NH-A stated that they felt they had control over their day to day lives. Two residents at NH-A felt that they had control but only to a certain extent. Physical limitations and the need for assistance with activities of daily living were discussed by both these residents as perceived reasons for the limited control they have over their day. The majority of residents (three) at NH-B felt that they had control but only to a certain extent, while two stated that they felt they had control over their day to day lives. As with the residents at NH-A, physical limitations and the need for assistance with activities of daily living were discussed as perceived reasons for the limited control as was the limitation on privacy of living in a communal living environment.

The factors identified as essential to the maintenance of choice and control by the residents of NH-A and NH-B are outlined in Figure 2. Themes common to residents at both nursing homes and their frequencies are also given. Using the Chi Square test for independence no significant differences in the frequencies of these common factors were found between NH-A and NH-B, $\chi^2 = 2.67$, $df = 3$, $p = .10$.

The commonalities identified in the responses of the residents at NH-A and NH-B were attitude, the ability to advocate for oneself, faith and relationships. Maintaining a positive attitude and faith were discussed in the context of attitude and discussing problems and preferences with staff in a friendly manner and being aware of residents' rights were discussed in the context of self-advocacy. Relationships with staff were also cited as being important to maintaining control in everyday life with Cynthia

(pseudonym) simply stating, "…they treat me nice," and Betty saying, "…as a patient here you are encouraged to go and do the things you want to do."

Figure 2. Factors Important to Maintenance of Control: Frequencies, Categories and Themes



Two residents at NH-A discussed cognitive ability as an important factor with one resident, Sylvia (pseudonym) stating, "I think the fact that I have my faculties…But also I know people who don't have their faculties who aren't forced into anything that I see." The philosophy of the facility in providing choice and freedom were also discussed by two residents, Sylvia and Shirley, at NH-A discussing this freedom in terms of, "they allow me a lot of freedom. Nobody ever tells me what time to go to bed and when to get up," and "because there ain't nobody who says you can't do this, you can't do that, you

know, err, as long as you're able you can get up and go anywhere in the building you want to go and do pretty much what you want to do."

Thus, it appears that functional/physical ability and cognitive ability again feature heavily in these statements. The ability to make health care decisions was also mentioned by a single resident at NH-A as a factor that helped them to maintain control over their everyday life.

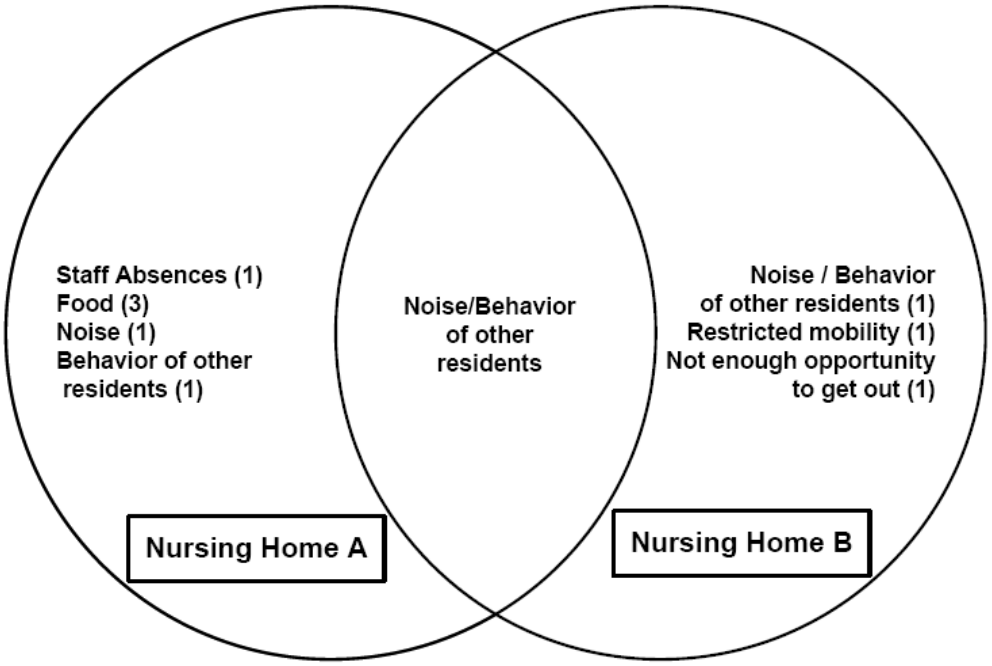
Resident Satisfaction. All of the residents at NH-A and NH-B stated that they were satisfied with the care they receive at their particular facility and that they would recommend it to others as a place to live. When asked to identify the best thing and the worst things about living in their facility several factors were identified with noise being a common worst factor between NH-A and NH-B and relationships being a common best factor between NH-A and NH-B as outlined. Themes common to residents at both nursing homes and their frequencies are provided in Figures 3 and 4.

Noise was discussed by Sylvia who lives in NH-A in terms of general noise within the facility, "You know I don't know if that is true in most facilities or not. But err, a lot of times it's very noisy. Umm, particularly at shift change" and by Derek at NH-B in terms of noise made by other residents. Therefore, noise was discussed here in congruence with the behavior of the other residents as identified by one resident at NH-A.

Three residents, all living in NH-A mentioned food as being the worst aspect and all discussed this in the context of the variety of the menu rather than the quality of the food. Statements by Sylvia such as, "I'd like to change him [catering administrator] so that we get some new ideas on menus instead of the same thing over and over," and Tom

"In a one month period I counted chicken on the menu out of 30 days 24 times. That's a lot of chicken. Too much chicken! [laughs]," reflect the request for more variety in the menu planning. Other factors identified as the worst aspect of nursing home life were the effects of staff absences and the effects that has on the staff's ability to assist with personal chores like bathing the residents, the personal physical limitations of one resident, and the need for the residents to be able to go on more organized trips outside the facility.

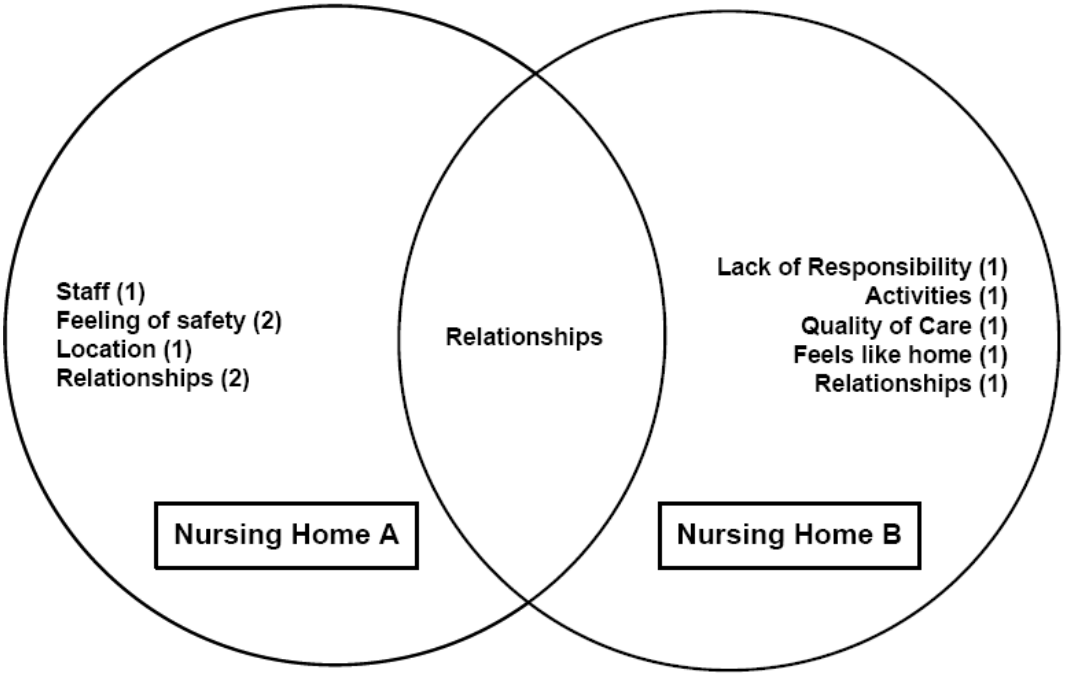
Figure 3. Worst Factors: Frequencies, Categories and Themes



Relationships again formed part of the discussion of resident satisfaction with two residents at NH-A and one resident at NH-B identifying relationships as the best thing about living in their facility. Belinda (pseudonym) stated, "Well, I've met a lot of people and I enjoy people and I like talking to them, the other residents. I like people." Tom explained further:

> "I'd say the friendship of the people that I've met here. I've met some real good people….Residents and some staff. Yeah I've met some real good staff members here. And a lot of patients here, that er, that, we all have our faculties with us and we have something to talk about and we can relate to one another. And I, so that helps out a lot. And some of the staff I get along with really well and some not so good [laughs]. But er, that makes it easier to stay here."

Figure 4. Best Factors: Frequencies, Categories and Themes



The staff were also cited by Keith (pseudonym) as the best thing about living in the facility, "The administration and workers, and the nurses here are first rate they are awesome. The best that you could find of any, any workers. They are great. They are fully dedicated." A feeling of safety and security was also discussed by two residents at NH-A who both discussed safety in the context of their medical conditions and how they could not live alone or at home because of their conditions and now feel safe under the care of the staff at the nursing home. The statement of Shirley illustrates this, "There's no going back, I'm safe living here."

The medical care was also discussed as the best thing by Henry, a resident at NH-B, who felt that by living in the nursing home he had access to more medical care and more preventative health care than he would have living at home. Other factors cited were a lack of responsibility for day-to-day issues such as medications and grocery shopping while still being able to be independent within the facility, and the communal activities available to the residents. Charles, who had a long-standing relationship with the facility in which he lived also stated that, "Well, the best thing, I, the fact that I have the feeling of coming back home here..."

When asked if they would change anything about their everyday routine or the way in which staff provide care, very few residents wished for anything to be different. At NH-B Henry identified the menu choices and Belinda suggested more activities in the form of trips outside the facility. A comment was also made regarding activities by Sylvia at NH-A who also wished for more availability of activities at the weekend stating:

> "I know the activities people whom I adore, they're thrilled to death to be home and we love them to have their time but it seems to me something could be worked out with volunteers or something to do in the afternoons [referring to Sunday afternoons], if it's just to sit and listen to good music."

Residents at NH-A also suggested that the staff be more responsive especially when they need them in a hurry, that staff should be given more time to work with their patients, that complaints be addressed, and that there should be more distinction between resident areas and therapy areas so that the residents have more quiet areas.

Additionally, when asked these questions several residents stated that they would like their physical/functional ability to be different with such statements as:

> Put my legs back on! [laughter] Cos you know that ain't gonna happen but still. I don't know! That's hard to say because I'm very content.
>
> Changes I would make they would depend on changes in my ability [coughs]. But it's not the fault of the staff [coughs].

During the course of the interviews two residents at NH-A, Betty and Rita (pseudonyms), and two residents at NH-B, Charles and Derek, made the point that they felt fortunate to have been able to secure a home in their current facility and that others may not have been so lucky stating:

> "Yeah. See before my daughter found [name of nursing home] she checked in to several different nursing homes in [name of city] and she said this was the best one that she found."
>
> "One time when I was in the hospital and I was ready to leave and I'm going to the nursing home and the girl said, 'Oh my!' Then she asked what one, and I said [name of nursing home] and she said, 'Oh, you're ok.' So I've met so many other people you wouldn't believe."
>
> "And think people who have been in a nursing home came here and they said they wished they'd been here a long time ago."
>
> "Because I think a lot, many people maybe get turned down. Don't get in here. So, I feel so fortunate that we, we got in a place and we like it. Where people look after us."

Direct Care Staff

Three CNAs employed at NH-A responded by mail to the request for their participation. Two participated in individual interviews; one respondent did not further respond to the follow-up request for an interview. The interviews took place in January 2010. Both the CNAs had worked in NH-A for two years or more. No CNAs from NH-B

responded to the request to participate in this study. Therefore, these results relate to perceptions of NH-A only.

When asked to describe the nursing home as a place to live the staff members discussed the nursing home environment, relationships, and the role of the facility in the provision of both long term care and short term rehabilitation. One respondent, Sophie (pseudonym), focused primarily on the role of the nursing home in the care of the residents and also the relationships between the residents and staff. The manner in which these relationships promote choice among the residents and the role of the staff in empowering this choice was evident in this discussion:

> "They [residents] become really close to people that work here so we kinda learn what they like and what they don't like," and "If they want to lay in bed all day they can lay in bed. Now we'd go in there and try and encourage to get up, but whatever …."

Another focus was the physical environment and layout of the nursing home with concern voiced as to how this environment afforded little privacy for the residents with the second interviewee Teresa (pseudonym) saying, "There's not a lot of privacy for these residents you know" and "…they don't have all the, umm, privacy that they would have if they was at their own house."

Quality of Life. When asked to identify the factors they saw as essential for resident quality of life both CNAs discussed the important role that the caregivers play in this with Sophie stating, "…their caregivers need to show compassion towards them and understanding" and, "I think the number one thing would be care and compassion." The importance of providing choice and respect for those for whom they care was emphasized by Teresa saying:

> "A good quality of life is giving them the right to choose what they want to eat, what they want to wear, when they want to get up, what you know making them feel like they are still independent. To be able to do much for themselves as they did when they were, before they ever came here. Giving them those options, you know. Give them their respect; give them the options to what they want to do."

Factors related to quality of care, safety and nutrition were also discussed by Sophie, "To make sure that their safety is taken care of," and "Make sure that they're getting a lot of nutrients." Sophie also cited the need to provide a home-like environment as important to quality of life, "…a lot of the long term patients have things from their home inside their room. So it kind of makes it feel like an at home place even though you may have a room mate your section is, you can make it whatever you want to make it. Put whatever you want in it."

In discussion of factors that may detract from quality of life for the residents the main factors discussed were the time staff have available to interact with the residents, the functional ability of the resident, and issues with other residents or their room mates. Both respondents identified the functional level of the resident as a threat to quality of life for the residents saying, "… a lot of them aren't in rehab, if they need it then they're put in it and then we try to keep them up and moving as much as possible," and "Because you know whether they're incontinent or not incontinent they need some kind of assistance either to pull up their clothes or take off their clothes. They lose all their dignity, all their pride."

Behaviors of other residents and the ability to adapt to living with a room mate were deemed as important by Sophie who stated, "I think if there's a case where two people are in one room and one patient may be one that hollers or sleeps during the day

and stays up at night. And the other patients can't adapt, then I think that would affect the quality" and, "I would say if anything it's just the trying to adapt to being able to live with a different person." The amount of time that direct care staff have available to interact with the residents was also seen by Teresa as a barrier to quality of life and to the level of choice available to the residents as reflected by the statement, "This is what you [resident] have to do because we only have such a short time to do it and we have to move on to the next person."

Choice and Control. Both CNAs expressed the opinion that the residents for whom they provide care had a great deal of choice and control in their everyday lives and one described how even though the staff may encourage a resident to participate in certain activities that the decision was the resident's alone. Sophie stated that, "…if they just absolutely don't want to then they don't have to. We're not going to force them to do anything."

When asked what factors may provide a barrier to resident choice and control both respondents identified the cognitive ability of the resident as an important factor. Sophie discussed the role the staff play in interpreting non verbal communication if the resident were to be unable to verbally communicate their wishes:

> "But those are kind of situations where say it's something they don't like to eat you kind of read their facial expressions. And you read if they're backing away from you or coming towards you."

When asked about the factors that assist residents in maintaining a level of control in their lives Sophie discussed the importance of peer support and both respondents identified the relationships and levels of trust between staff members and the residents as important saying, "I would say let them know that they can express what they want. You

know, I don't want any of my patients to think they can't tell me, hey, I don't feel like doing this today" and Teresa discussed a staff-resident group communication session stating "…especially staff, going in a spending that time with the residents and talking to them, that makes them feel so much better."

Areas in which these staff members felt the residents may like more choice and control were in the areas of activities, with Sophie stating that a more active resident had expressed the need for more activities, and in the day to day things that may occur between room mates, with Teresa giving the example of the temperature control in the shared rooms:

> "He's over there and he's hot but I'm cold and I want the heat you know. So it's a give and take situation. They don't have their own bedroom they have to share the commode; they have to share the faucet, you know."

Resident Satisfaction. When asked to identify the worst and best things about living in their facility the best things were described as the decreased responsibility for day to day financial matters such as bill paying and the relationships that can develop that provide a sense of support for the residents. In discussing the best thing about the nursing home for the very dependent residents Sophie stated, "I think it gives them [pause] a sense of like family, a friendship, a bond with someone …." Isolation from the outside world and the food were the two factors identified as the worst things about living in the facility by the respondents. Sophie acknowledged that activities were available to provide the residents with the opportunity to leave the facility; this was not always a possibility for those with higher levels of dependency, "because some of them are so totally dependent that they can't go on those trips." The difficulty in meeting the food preferences of all the residents was acknowledged in Teresa's discussion of food, "…

before these folks came here I'm pretty sure they had their own way of eating and things that they liked and disliked but they don't have those choices" even though, "They have a lot of options, if it's not a hot food it could be a salad or a sandwich or something like that you know."

In conclusion, both respondents reacted very positively when asked if they would recommend their facility to others as a place to work. However, Teresa had one caveat reflecting her perception of the culture and philosophy of the facility, "as long as they fit with this facility. If you don't have that heart to care for people this is not the place to be. You really do need it."

Family Members/Friends of Nursing Home Residents

Three family members or friends of residents at NH-B responded to the request for their participation in this study. No family members or friends of residents at NH-A responded. Therefore, these results relate to perceptions of NH-B only. The respondents were interviewed individually and in a group of two, as per their request.

Those interviewed described the nursing home as a place to live in terms of the quality of care, the physical environment and the atmosphere, and the staff. The quality of care was expressed in terms of comparison to other long term care facilities, "this is certainly one that offers a lot in terms of, um, quality compared to other facilities that we looked at over the years" and in terms of specific services such as the rehabilitative services, "…you actually have a full time rehab department that if you need to take advantage of you can." The care was also equated to the psychological well-being of the residents as indicated by a statement made by Michelle (pseudonym), "…to me the

residents get very good care and there's a chance, it allows them to interact with each other."

The quality of the staff was acknowledged along with an appreciation of the stability of the staff with Angela (pseudonym), saying, "I believe they have very caring staff that surprisingly doesn't turnover that much." Fran (pseudonym), described the role of the CNAs saying, "I don't know if they are, are aware of how important they are," and "They are incredibly important and their attitude and their feeling about being here is huge." However, this was mentioned in reference to the different atmosphere encountered in different units of the nursing home:

> "We've noticed on this wing they love what they do and we've noticed other wings, maybe they've been here a long time and maybe they might, might need to try something else for a while, they are frustrated…"

Quality of Life. When asked to name the factors essential for the residents to live a good quality of life the responses centered on the staff, the activities, the environment, and the food. The staff were discussed in the context of their relationships with the residents with Fran stating, "I think the number one thing is the CNAs and the interaction they [*the residents*] have with the people that work here," and in respect to the care received and the lack of turnover Angela described, "… a competent, compassionate, caring staff with little turnover … on a daily basis is very important as they rely on these folks to meet their needs 24 hours a day and anytime there's a substitute, umm it's very disruptive."

However, it was also acknowledged that while the attitudes of the staff can enhance quality of life there is also a risk that these attitudes can detract from quality of life as Fran said, "It would be the negativity of the staff, if they encounter that."

The philosophy of care was also discussed by Angela in the context of staff attitudes and in the empowerment of the staff to meet the individual needs of the resident.

> "…the mindset that we're here for them [*the residents*], this is their home and everyone's an extension of that family, an extension of their home is a very important mindset to have when you address anything. And that's umm, it, it sounds good but sometimes it's very hard to pull off."
>
> "The empowerment to do what it takes to make a resident feel like, that their needs are being addressed and met and you can be responsive."

The theme of empowerment was also addressed, in the context of staff empowerment, in the discussion of detractors from quality of life with Angela stating, "I believe, lack of empowerment, lack of flexibility, and lack of funding sometimes, umm, prevents staff from getting creative, from taking that extra step that they could take to make somebody's quality of life better."

Angela also cited the availability and variety of activities as essential to quality of life in terms of the diverse needs of the residents.

> "…and a diverse level of activity because there's so many different levels of cognitive ability here and a lot of the umm, activities are sometimes gauged towards folks that sometimes don't have as much mental capacity as opposed to some of the residents that do have a lot of mental wherewithal. So I think that the level of activity is umm, umm important."

The level and variety of activities were also cited by Fran who said, "…they bring in outside entertainment. And I have never seen any people love anything so much as these people love the outside entertainment," and "we're both impressed at … when we see the monthly calendars and see how filled up it is, with events and things going on…"

The environment was also discussed comparatively to the previous building in which the facility was housed, with which all the respondents were also familiar, as the words of Michelle reflect:

> "…like I said I think the layout of the new facility because it's on one floor I think it gives them more dignity back because I think they are less dependent on getting where they need to go and I think they do have a little, a little bit more. It's easier, it's just easier because it's all on one floor. They can get wherever on their own, it's not that far away… I think it's given them, I would describe it as a look of dignity."

Food was also identified by Fran as being important to resident quality of life, "And I think the food is important. The meals are important." However, a lack of flexibility in the dining menu planning was also discussed by Angela in the context of possible detractors in that, "The other thing is that lack of flexibility at whatever level, for example would be let's say we've been telling the kitchen folks for two years that the residents don't like pasta." This respondent suggested a possible solution in the provision of a daily menu, as they do in hospitals.

In discussing factors that may detract from quality of life Angela discussed structural limitations that may be beyond the control of the staff in the context of the availability of the mechanical lift to assist with toileting, "[name of family member/friend] has to use a standing lift, it's a special piece of equipment, if someone else in this unit is using it then they cannot get to him," and "You have a staff that could be using the lift but there's just only one per unit. Those kinds of things will sometimes get in the way." Angela attributed this need for additional resources to a lack of funding.

Choice and Control. Choices were discussed in the context of the residents' everyday lives in terms of the choices made available to them within the dining program

and in the involvement and empowerment of residents to make decisions regarding the personalization of their rooms and the planning of the new facility with Michelle stating, "…when they moved they did have input on the types of furniture they had, umm, some of the choices, I mean they did have options of things to weigh in on." An example of how one resident had chosen to personalize her living space was given by Fran:

> "I've noticed that [name of resident], one of the residents loves hats, and they allow her to hang hats on her wall. And so that means that they've got to have someone come in and put a nail on the wall. But that's an option and it makes it home."

The dining and the activities programs were mentioned as both areas in which choice and control are provided and areas where potential for increased resident choice and control exist. All the respondents cited the dining program as an area in which increased choice and control could be provided while also acknowledging the challenge of providing for all tastes and preferences in a communal setting.

> "They have options and they ask them what to eat and drink and you know obviously they can't order what they want but err I think that's, it's not like they just give you whatever you're going to get."

> "But they do give them a lot of options. They can go church; they can not go to church. They can go to bingo; they can not go to bingo. They can come to dinner; they can not come to dinner."

In addition, Angela felt that the residents could have more input into the types of activities provided:

> "…the two activities that the whole time I've been here are pretty much the two activities to leave campus and that's to go to [name of local restaurant] and eat fish or to go to [name of local store] to shop. Now in ten years there could be some more creativity and other options in doing things, so. Those are the kinds of things that I think that if people are given a forum for speaking up they might be able to vocalize themselves."

Michelle also talked of the activities program in terms of the individualization of opportunities to meet the personal interests and needs of the residents. She described how one resident who loved to garden had been provided with and assisted in creating a vegetable garden. The respondent stated that although it was not easy for the staff to provide this garden it enhanced his quality of life. The provision of such an outlet was described as being provided out of generosity and love.

When asked to identify the factors that may assist the residents to maintain control in their lives and the factors that may provide barriers to the maintenance of such control, the opportunity and the ability for the residents to voice their opinions was discussed by Angela saying, "I think that if they are able to articulate those choices then they do." Angela also cited the need for the caregivers to have an understanding and knowledge of the residents' preferences if they cannot articulate them. The need for a forum for residents to express opinions and to input into the day to day decision making process was also discussed with Angela stating that although a residents council exists that all residents may not be able to feel comfortable in expressing their opinions in such a setting, "if you're an individual that doesn't want to speak up one on one you're not going to speak up in a room of 25 people."

Resident Satisfaction. When asked to identify the worst and best things about living in their facility the best things were described in the context of the staff with one respondent citing consistency, low-turnover, and the quality of the care provided. In terms of the environment, the basic philosophy of care, to provide a more home-like environment, and the layout and aesthetics of the facility being attractive to both visitors

and volunteers were discussed. The variety and number of activities were also mentioned as one of the best things about the facility by all three respondents:

> "Well I, I think in our case, at least in our neighborhood that we do have a consistent staff with very little turnover, we're very lucky in that. I think that's the most important thing and I think it's very, I think their quality of medical care is very good. The nurses, the doctors, the rehab staff they're very good."

> "There are a lot of activities and the fact that they take the residents places I think is so nice."

> "I think because it is a beautiful facility as well, it probably attracts a lot of volunteers and churches and things that…"

Loss of independence was identified as the worst thing about living in the facility. This was discussed in terms of the losses that had led to the residents seeking nursing home placement with Angela saying, "Lack of independence. No one ever overcomes that. It's never ok to be here," and "They know that they have to be here, on some level understand that but they always, even [name of family member/friend] longs for the day when he can walk out of here. That's something, that's human nature I don't think that's going to change."

Michelle talked about how the level of care has to be sufficient enough to provide for the level of dependency of the residents, thus acknowledging the need for quality of care:

> "When, I mean, a lot of the people here are 100% dependent on the care that they get. Just to get around in their day to day. Such as to get out of bed. Get dressed and undressed. Get bathed and to the bathroom, whatever they need to do. So when you have that 100% dependency…You could have the Taj Mahal here, and if someone's not going to help you get out of bed and if you've soiled yourself and certain things like that. Nothings going to make that better so I believe that if it, if those things are not adequately dealt, not just adequately but if you know …"

All respondents stated without reservation that they would recommend this facility to others with Fran stating, “I just think the facilities are fantastic and I know I keep coming back, and I know it’s aesthetic but that has so much to do with…,” and Michele also saying, “it just seems to me impressive about the level of care that is available.” All the respondents talked of the variety and availability of medical care and rehabilitative services and Angela addressed this in terms of the ability to age in place by saying, “And one of the greatest things about this facility is that you can walk through that door and end your life here and not have to go to other facilities.”

Summary

Chapter Four presents the findings of the quantitative and qualitative data collection. The level of the culture change process was measured using the Artifacts of Culture Change instrument and NH-B was shown to have a greater total score than NH-A. A comparative inferential analysis of the quantitative data as to the resident quality of life, perceptions of choice and control, and level of satisfaction at NH-A and NH-B showed significant differences only in the domains of privacy and security on the 11-domain Nursing Home Resident Quality of Life Instrument.

While NH-B scored higher on the Artifacts of Culture Change Survey than NH-A, NH-A demonstrated higher mean scores than NH-B on the 11-domain Nursing Home Resident Quality of Life Instrument domains of functional competence, meaningful activities, relationships, autonomy, and individuality and on the resident satisfaction items of the likelihood of residents recommending the nursing home to others. NH-A also demonstrated higher mean scores than NH-B for the total scores of degree of control,

importance of control, and latitude of control on the Perceived Latitude of Control scale. However, as previously stated, these mean differences were not statistically significant.

In addition to the statistically significant mean differences in the 11-domain Nursing Home Resident Quality of Life Instrument domains of privacy and security NH-B demonstrated higher mean scores than NH-A in the domains of comfort, dignity, food enjoyment, and spiritual well-being. NH-B also demonstrated higher mean scores than NH-A on the resident satisfaction items of satisfaction with the nursing home as a place to receive care and a place to live. These mean differences were not statistically significant.

While not statistically significant, large effect sizes were identified for food enjoyment and comfort on the 11-domain Nursing Home Resident Quality of Life Instrument and for importance of choice on the Perceived Latitude of Control scale. Additionally, medium effect sizes were identified for relationships and autonomy on the 11-domain Nursing Home Resident Quality of Life Instrument; satisfaction with the nursing home as a place to live and satisfaction with the nursing home as a place to receive care; and for latitude of choice on the Perceived Latitude of Control scale.

The analysis of the qualitative data from the four groups of participants identified the major themes in the categories of resident quality of life, perceptions of choice and control, and level of satisfaction. Excerpts from the interviews were provided in order to support these findings. Common themes in the discussion of factors reported as essential to quality of life by the residents at both NH-A and NH-B were quality of care, relationships, activities, physical/functional ability, faith, and safety/security. Relationships and faith were again identified as common themes in the factors reported as

essential to maintaining control in their lives by the residents at both NH-A and NH-B. Attitude and the ability to advocate for oneself were also identified as themes common to residents at NH-A and NH-B in this category. Only one theme common to both residents at NH-A and NH-B was identified as the worst thing about living in a nursing home and as the best thing about living in a nursing home, the noise/behavior of other residents and relationships respectively.

Based upon the results described Chapter Five will present an interpretation and discussion of the findings. The findings will be discussed in the context of the existing body of literature and prior research. Additionally, implications of the findings to practitioners in the field of long-term care will be presented as will recommendations for further research.

CHAPTER 5: DISCUSSION, IMPLICATIONS FOR PRACTICE, AND RECOMMENDATIONS FOR FUTURE RESEARCH

This study was conducted to explore nursing home residents' perceptions of quality of life, choice and control, and satisfaction in two nursing homes that have undertaken and are continuing the process of culture change. Using a survey and interviews nursing home residents were asked to provide their perceptions of these three outcome variables. Interviews with nursing home administrators, direct care staff, and family members or friends of residents provided additional insight. The quantitative and qualitative data obtained via this research process provides evidence as to the numerous, individual, and complex factors influencing these three variables. Commonalities and differences were found between the two nursing homes. The two nursing homes included in this study were at different places in the culture change process and provided different structural living environments as evidenced by the Artifacts of Culture Change data.

Discussion

The Perceived Latitude of Choice instrument utilized in this study (Hulicka et al., 1975) has been used in its original or modified form to compare perceived levels of control in the lives of older adults in both institutional and community settings (Boyle, 2004; Hulicka et al., 1975; Hulika et al., 1983.), to compare resident and staff perceptions of control in institutional environments (Jang, 1992; Morganti et al., 1980), and to compare perceptions of control between different levels of institutional environments (Hulicka et al., 1983). This study differs in that perceptions of resident control, at two

facilities offering the same level of care, were the focus of the comparison. As evidenced by the results of this study no significant differences as to the importance, degree, or latitude of control were found between the residents at the two facilities.

However, a large effect size was demonstrated when comparing the importance of choice and a medium effect size was found when comparing the latitude of choice between the residents at the two facilities. These findings indicate that the size of the sample used may have been too small to detect the statistical significance of these differences. Therefore, it may be postulated that if the sample size had been large enough these findings may indeed have been statistically significant. This adds to the findings of Hulicka et al. (1983) who compared institutionalized older adults in a community setting and a domiciliary facility and a health related facility. The researchers found that those in the health related facility had lower total scores of perceived level of choice than those residing in a domiciliary facility, while there were no significant differences in the assigned importance of choice. Thus, it may be that the differences are influenced by the level of dependency of the residents or the level of care needed by the residents.

As Kane et al. (2003) state, long-term care needs to provide for both quality of care and quality of life and assessment of such needs must include elements of everyday living; not just address measures of the care received. Statistically significant differences were found when comparing resident reports of their quality of life at the two nursing homes in the domains of privacy and security only, with NH-B having higher mean scores in both domains. However, a large effect size was found for the domains of food enjoyment and comfort with NH-B again having higher mean scores in both domains.

Additionally, a medium effect size was found for the domains of relationships and

autonomy with NH-A having higher mean scores in both domains. These effect sizes indicate that the size of the sample used may have been too small to detect the statistical significance of these differences. Indeed, in discussing the development of the quality of life tools for nursing home residents, Kane (2003a) speculates that a sample of at least 20 residents should be used for a nursing home with 100 beds. As a sample of this size was not obtained in this research and large and medium effect sizes were obtained, it may be suggested that a larger sample size would have revealed more statistically significant differences.

No statistically significant differences between NH-A and NH-B were found on comparison of the three items pertaining to resident satisfaction with the nursing home. However, a medium effect size was found for the items related to satisfaction with the nursing home as a place to live and place to get care both medium effect size. The mean score was greater for NH-B than NH-A on both items. Therefore, again a larger sample size may well have resulted in significant differences.

In the context of the QOL survey instrument used in this research, privacy is described as the residents' control of information about themselves and in the ability to be alone or with others as wished (Kane, 2001; Kane et al., 2003). Security is defined as an "overall sense of security, safety, and order" (Kane et al., 2003, p. 241) and a trust the living environment as a place where people are well-intentioned and there is a mutual understanding of the basic rules of life (Kane, 2001). In this study it is unknown if the responses of the resident participants at NH-A were influenced by ongoing renovations and physical disruptions within the facility. From these definitions of the specific domains of privacy and security it may be speculated that these domains may be the ones

to be most affected if any influence was indeed found.

In addition, the fact that the majority of residents interviewed at NH-A shared rooms while the majority of residents who participated at NH-B had single rooms may well have influenced feelings of privacy and security. Prior research has identified the importance of privacy and having a private room to quality of life in nursing homes (Guse & Masesar, 1999). Kane et al. (2004) demonstrated that facility level factors account for a portion of the effects on QOL scores, using 10 domains of the QOL instrument utilized in this study. The researchers found that facilities with a higher percentage of private rooms had higher average scores in the domains of comfort and privacy.

In this study all but one of participants in NH-A shared room with an unrelated person. None of the residents cited sharing a room as detracting from their QOL in the open-ended questions. However, whether to have a private room was rated as 'very important' by all the residents at NH-B and received a negative mean score for degree of choice at NH-A. Thus, it may be that the perceived lack of choice in a decision that may be largely determined by the physical layout of the facility and financial ability leads to an acceptance of the situation as inevitable.

In their review of environmental enhancements by nursing homes in North Carolina, Brown and Pfeiffer (2009) state that resident choice and control is best ensured when there is a match between the environment and the culture of care. Additionally, Kane (2003a) describes that while the personalities of the residents are not under the control of the nursing home, the openness of the environment to welcoming visitors and the philosophy of care are. Discussion of the ability of the nursing home environment to

welcome community members and volunteers was made in this study by family members/friends.

In discussing their perceptions of life at their particular nursing home several of the residents at both nursing homes indicated their gratitude at securing a home in their particular facility. This may well be reflected in their assessment of their current situation. This expression of gratitude may be an indicator of their current satisfaction with the nursing home, their physical and medical needs, limited choices or options available to them when they needed to find a long-term care facility, and/or the difficulty of their situation and struggles endured prior to their nursing home admission. In addition, several residents discussed their feelings of safety/security in the nursing home environment.

Some residents appeared reluctant to express negative perceptions of their abode and indeed one resident even approached the researcher to caution against the negativity of another resident whom they thought may be included in the study. The loyalty and pride many had in their establishment was clear, although none gave the impression of perfection. Studies exploring older adult resident satisfaction with nursing homes and long-stay hospital wards in the United Kingdom have suggested that the constraints of the situation, that is physical dependency, influence the residents' appreciation of the care on which they are dependent (Higgs et al., 1998).

Relationships between residents and between staff and residents repeatedly emerged as a factor effecting QOL in conversations with residents, staff, and family members or friends. Relationships were discussed in terms of quality of care, quality of life, and resident empowerment. They were also cited as one of the best things about

living in the facility. Guse & Masesar (1999) explored the factors important to QOL as identified by residents in a long-term care facility in Canada and found spending time with family and who to have for friends, rated as 'very important' by the majority of respondents (66% and 63% respectively).

Relationships with staff were also identified as being essential to QOL in the nursing home (Guse & Masesar, 1999). Degenholtz et al. (2006) found resident QOL to be negatively associated with conflict in relationships and positively associated with social engagement. Previous research has also explored relationships between nursing home residents and their caregivers in the context of their contribution to thriving among residents (Bergland & Kirkevold, 2005). Both nursing home administrators identified relationships between residents and staff as a benefit of culture change and one discussed these relationships in the context of resident QOL. While the researcher was collecting the data she witnessed or was told by the residents of many acts of kindness on the part of the staff and family members of other residents. It was clear that, although not part of the formal data collection process, such acts may well contribute towards residents' perceptions of QOL and positively contribute to relationships within the nursing home community.

While the importance of relationships with staff were also recognized by the residents in this current study, the administrators, staff, and family members/friends also appeared very aware of the power of these relationships to influence both resident quality of life and level of choice and control. Kane et al. (2006) explored nursing home staff's self-assessment of their ability to influence of the quality of life of residents. Their results demonstrated that CNAs (who work closest with residents) saw themselves as having a

higher level of impact on resident QOL in comparison with physicians, nursing staff, social workers, and activity therapists. The authors concluded that these results demonstrate the importance of involving CNAs in the decision making process regarding resident care. The role of the staff in empowering the residents to make decisions for themselves was a factor identified in many of the interviews with all participant groups.

Relationships were also cited as important to the maintenance of choice and control in their lives by residents at both NH-A and NH-B in the individual interviews. Thus, the importance of relationships to residents in both their sense of control and perceived importance of control is clear. The residents at NH-A discussed this in terms of the freedom they were given by staff. The importance of their own role in these relationships was also acknowledged as residents recognized their need to communicate their wishes and needs with staff and their need to work with staff to solve issues that arise. At NH-B the residents talked about the need to develop relationships with staff, with one resident talking about his intentionality in developing such relationships. Their dependence on the assistance of the staff was acknowledged as was the need to adapt to the constraints of institutional living. Residents also commented on how well they were treated by staff and one resident stated that they felt 'part of the family.'

Items for which choice was rated as very important by all residents at both facilities primarily relate to both relationships and personal privacy such as who to have for friends, whether to associate with others, and how much personal privacy is available. The importance of the activity program, especially the trips outside the facility also became evident in the discussions with residents. In fact, it was often difficult to schedule interviews with the residents at both facilities due to the activities they were planning on

participating in during the day. These activities appeared to fulfill many functions; they allowed for social interactions with other residents, staff, and community members; they allowed for a sense of independence; they also allowed for a sense of autonomy and control; they met spiritual needs; and they provided a routine to the day.

Staff communicated their perceptions of how their relationships with the residents helped to encourage self-advocacy and control. Staff also recognized their role in developing relationships with residents that promote the residents' ability to advocate for themselves. They acknowledged that their knowledge of the residents' preferences was important to resident choice and control in their everyday lives. The importance of being able to speak up and to advocate for themselves was also a theme of residents' discussions of choice and control. Prior research has explored staff attitudes towards residents in the context of culture change. An evaluation of culture change within ten nursing facilities belonging to one long-term care provider demonstrated increased numbers of staff who responded positively to resident requests (Grant & McMahon, 2008a).

Interestingly, some residents talked of control in their lives as something bestowed upon them by the institution using terms like "they allow me" when discussing their level of control. This passive attitude to their control of their everyday decisions may have been a function of their physical needs or of their attitude towards institutional living. Boyle (2004) demonstrated that older adults may often reassess and diminish the importance of choice, if choice becomes decreased in their lives. However, this researcher also found the institutionalized older adults in her study to perceive themselves as having a greater degree of choice in their lives than the comparison sample of older

adults, receiving care in private homes. Thus, the importance of adjustment to the living situation is clear.

Indeed, two residents discussed the need for adaptation to the institutional rules and regulations of the facility perhaps indicating the task of maintaining their independence while residing in a communal living environment. Attitude towards living in a nursing home was also discussed by several residents as a factor contributing to QOL and maintenance of control. One resident discussed the conscious decision made to make the best of his new circumstances and the difference that becoming an advocate for others in the nursing home had made in his life. Several discussed the importance of a positive attitude and of trust in a higher power in their lives.

Additionally, meals formed a large part of the discussions with participants groups. The choice of what is served at meals and what time meals are served were rated as a low degree choice by residents at both facilities. While no discussion of food quality was made during the interviews, discussion as to the amount of choice in the menu was discussed by residents, administrators, direct care staff and family members. However, the perceptions of the different participant groups differed.

In this respect, residents rated their degree of choice negatively at both facilities and this was reflected in qualitative descriptions of lack of menu choice or ability to influence meal planning at NH-A. Thus, while staff, administrators, and family members/friends acknowledged the choice afforded at individual meals, the residents and family members/friends were also concerned with the variety and menu choices over a long period of time. Dining programs following the culture change model of care, such as buffet style dining, have been shown to allow choice for residents and to decrease weight

loss and promote weight gain (Andreoli, Breuer, Marbury, Williams, & Rosenblut, 2007). Dining programs appear to be an area in which nursing homes are beginning to introduce an increased level of resident choice with Doty, Koren, and Sturia (2008) reporting that approximately one third of nursing homes in the United States have made steps towards a resident centered dining program.

The balance between meeting regulatory requirements and meeting the philosophy of culture change was also discussed by the nursing home administrators. This potential for conflict has been documented in the literature regarding culture change in nursing homes (Moles, 2006) and the need for regulators to be open to environmental or programming changes has been identified (Keane & Shoesmith, 2005). Indeed, regulatory agencies such as the Centers for Medicare and Medicaid Services have promoted culture change in nursing homes and have provided training and technical assistance to both to surveyors and nursing homes (Doty et al. 2008; Mitty, 2005). The importance of quality of care to quality of life was repeatedly emphasized in the interviews with the different participant groups.

All participant groups acknowledged the importance of quality of care in their environment and all residents stated that they were satisfied with the care provided and would recommend their facility to others. However, constraints on direct care staff time were also mentioned by both residents and direct care staff at NH-A. In addition logistical considerations, such as the availability of mechanized lifts to assist with resident transfers, were also discussed by a resident at NH-A and by a family member at NH-B. The work of Lopez (2006), who conducted an ethnographic study while working as a nursing assistant in an Eden facility, clearly shows that even culture change facilities

with good reputations are not immune to such issues. In this instance the researcher found that lack of time to complete tasks put undue strain on the direct care staff and affected quality of care (Lopez, 2006).

While physical and functional status are only addressed broadly in this research (in terms of the functional competence domain of the QOL instrument), prior research has shown that health problems, limited mobility, and limitations in physical function detract from individual QOL (Degenholtz et al., 2006; Guse & Masesar, 1999). Indeed, Degenholtz et al. (2006) reported that QOL is influenced by both resident and facility level factors and much individual variance identified in their study was explained by resident demographic factors and resident health status. Residents at both NH-A and NH-B cited physical and functional ability as contributing to QOL.

Cognitive ability was also discussed in terms of QOL and ability to maintain choice and control in everyday life. Cognitive status was not assessed in this study; all participants were assessed as being cognitively and physically able to participate in the study by the nursing home administration. However, differences between the two nursing homes were noted. It was necessary to obtain proxy consent for the majority of residents at NH-B while all the residents at NH-A could provide informed consent; perhaps indicating an increased level of dependency of the residents at NH-B who were also older, on average, than the residents of NH-A.

Implications for Practice

Based on the findings of this study several recommendations for practice arise:

1. The importance of relationships to the residents in this study is clear. As Kane (2003a) states there are often low expectations as to the influence providers can have

on resident quality of life. The reports of all participants in this study indicate the importance of these relationships to residents. Resident relationships with staff, other residents, and with family/friends and the community, were identified as common themes to all three variables explored: quality of life, choice and control, and resident satisfaction. Therefore, an environment that allows these relationships to develop, nurtures and values them will be of worth to residents and staff alike.

2. The importance of the ability of residents to voice their opinions and express their needs was also highlighted by this research. From the findings it appears that such needs are being met in both informal and formal settings, such as resident advocacy groups. However, one family member/friend of a resident cautioned that it may be difficult for all residents to voice their opinions in a group setting and opportunity should be provided for their views to be ascertained on a one-to-one basis. While this may occur for some residents, if such relationships develop with staff, it may be that staff members need to intentionally and regularly solicit such opinions or initiate conversations with residents.
3. From the discussions with both residents and family members/friends it appears that adjustment to institutional living for both groups can be a difficult and complex task. One family member recommended a formal orientation process for family members in order that they form realistic expectations of the path ahead. Residents talked of their need to accept their new situation and make the most of it and the importance of attitude to their current situation. As peer-relationships were also identified as important, a peer-mentoring or resident led peer-support program may be of value to residents either when they enter the nursing home as long-term residents or if their

circumstances change and they move to long-term resident status from a short-stay arrangement.

4. The importance of privacy and security were also highlighted by the findings of this study. Kane (2001) supports the provision of private rooms and bathrooms in nursing facilities and states that the importance of such measures is underestimated. Thus, in planning of new facilities it should be ensured that this is taken into consideration.
5. It appears from these findings that quality of care is not neglected when culture change is introduced into a facility. While it may be possible to have good quality of care without a good quality of life for the residents, it would be incorrect to assume that a good quality of life can exist without good quality of care. Logistics such as the availability of the mechanical lifts and staff time were highlighted in this study and influenced quality of life and residents' perceptions of control. Practical considerations such as these must be considered and addressed in implementing culture change.
6. The personal goals of the residents must also be in line with the goals and philosophy of culture change. While empowering residents to have more control over their health, care must be taken to also consider personal goals, fears and concerns, or preferences. For instance, while one administrator spoke of an example of the success of their culture change process as one resident improving their function and health status enough to relocate to an assisted living facility; conversely, one resident spoke of their fear of being encouraged to consider a less supportive environment. Thus, while these are two separate scenarios the possibility that incongruence of goals may exist should be explored and addressed when determining resident goals and long and

short term objectives.

7. The importance of the activity program to the residents and family members/friends was clearly indicated in this study. Recommendations were made by the residents for more activity options to be offered at weekends and for more activities outside the facility to be included.
8. The value of the dining program and the menu planning was reflected in this study in the residents' qualitative descriptions of the lack of menu choice and their lack of ability to influence meal planning. Thus, the importance of involving residents in this process is highlighted by these findings.

Recommendations for Future Research

Research that explores culture change from the residents' perspective is limited and as the focus of such changes is purported to be the residents themselves, this is an important area for exploration. In response to such gaps in the literature the following recommendations for future research priorities are made:

1. More research as to resident perceptions of culture change should be undertaken; ideally a longitudinal study documenting resident perceptions of nursing home life before the culture change process is implemented and during the process of culture change. More needs to be known about both the experience of nursing home life for residents and residents' perceptions of the culture change process. A lack of qualitative research addressing these issues is evident.
2. This study indicated the importance of relationships in the nursing home environment. However, an increased understanding of mechanism by which relationships are formed between residents and staff in the long-term care

environment is needed.

   i. An exploration of the effects of such relationships on resident quality of life, resident perceptions of choice and control, and resident satisfaction is needed to add to the knowledge of culture change.

   ii. In order to build upon the findings from this study, additional research exploring the perceptions of staff of their relationships with residents and the benefits and challenges of such relationships for the direct care staff should be undertaken.

   iii. Qualitative research exploring 'random acts of kindness' in the nursing home and their relationship to perceived quality of life among residents and workplace satisfaction among nursing home staff would also contribute to the understanding of the mechanism and importance of relationship development.

3. While several residents identified the importance of personal attitudes towards and adaptation to institutional life this was not a concept explored in depth in this study. Therefore, additional research in this area would be valuable to both administrators and staff. It would allow staff to be more aware of the issues that individual residents may face when making the adjustment to institutional living.

4. Also in relation to resident attitudes towards institutional life, qualitative research exploring the relationship of resident satisfaction with the nursing home as a place to live and to receive care and other factors such as the circumstances and experiences that led to their nursing home placement, the level of social and health care support received prior to admission, and their level of fear or anxiety regarding remaining in

their own home would add to the body of literature pertaining to resident satisfaction in the long-term care environment.

Conclusion

The findings of this study contribute to the growing body of knowledge pertaining to culture change in nursing homes and the implications for residents, staff, family members/friends of residents and administrators. An in-depth evaluation of the culture change process from the perspective of the resident is provided that offers additional insight into the factors that contribute to resident quality of life, perceptions of choice and control in everyday life, and satisfaction with the nursing home as a place to live and to receive care. Implications for practice have been drawn by the researcher that highlight the importance of privacy and security, relationships, adjustment and attitude towards institutionalization, and the effects of the circumstances leading to institutionalization on the process itself. These implications will be of interest to those working in all long-term care facilities as well as to those in nursing homes undergoing or embarking on the culture change process. From the findings of this study it is clear that many avenues for further research exist and need to be addressed in order to provide additional insight into the experience of culture change for nursing home residents.

REFERENCES

Alvesson, M. & Sveningsson, S. (2008). *Changing organizational culture: Cultural change work in progress.* New York, NY: Routledge.

Andreoli, N. A., Breuer, L., Marbury, D., Williams, S., & Rosenblut, M. M. (2007). Serving culture change at mealtimes: Positive psychological and medical outcomes through a better dining service. *Nursing Home Magazine, September*, 48-50.

Appel Doll, G. (2004). Pioneering change in Kansas: The PEAK project. Nursing Homes: *Long Term Care Management, 53*(4), 55-59.

Bergland, A. & Kirkevold, M. (2005). Resident-caregiver relationships and thriving among nursing home residents. *Research in Nursing and Health, 28*, 365-375. doi: 10.1002.nur.20097

Bergman-Evans, B. (2004). Beyond the basics: Effects of the Eden Alternative Model on quality of life issues. *Journal of Gerontological Nursing, 30*(6), 27-34.

Bharucha, A. J., Pandav, R., Shen, C., Dodge, H. H., & Ganguli, M. (2004). Predictors of nursing facility admission: A 12-year epidemiological study in the United States. *Journal of the American Geriatrics Society, 52*, 434-439. Retrieved October 5, 2008, from CinAHL database.

Bond, G. E. & Fielder, F. E. (1999). A comparison of leadership vs. renovation in changing staff values. *Nursing Economic$, 17*(1), 37-43. Retrieved October 25, 2008, from Academic Search Premier database.

Bowman, C. S. & Schoeneman, K. C. (2006). *Development of the artifacts of culture change tool.* Centers for Medicare and Medicaid Services. Report of contract HHSM-500-2005-00076P. Retrieved November 5, 2008, from www.actionpact.com/pdf/artifacts.pdf

Boyle, G. (2004). Facilitating choice and control for older people in long-term care. *Health and Social Care in the Community, 12*(3), 212-220.

Brown, K. & Pfeiffer, N. (2009). Tracking environmental enhancements. *Long-Term Living: For the Continuing Care Professional, 58*(5) 16-19. Retrieved May 22, 2010, from CinAHL database.

Calkins, M. P. (2002). The nursing home of the future: Are you ready? *Nursing Home: Long Term Care Management, 51*(6), 42-47.

Carboni, J. T. (1990). Homelessness among the instutionalized elderly. *Journal of Gerontological Nursing, 16*(7), 32-37.

Castle, N. G. (2007). A review of satisfaction instruments used in long-term care settings. *Journal of Aging and Social Policy, 19*(2), 9-41.

Castle, N. G., Lowe, T. J., Lucas, J. A., Robinson, J. P., & Crystal, S. (2004). Use of resident satisfaction surveys in New Jersey nursing homes and assisted living facilities. *Journal of Applied Gerontology, 23*(2), 156-171. doi: 10.1177/0733464804265584.

Centers for Disease Control. (2008). *National Nursing Home Survey.* Retrieved October 28, 2008, from www.cdc.gov/nchs/nnhs.htm

Centers for Medicare and Medicaid Services (2006). *Artifacts of Culture Change.* Retrieved September 30, 2008 from http://search.cms.hhs.gov/search?q=culture+change&site=cms_collection&output=xml_no_dtd&client=cms_frontend&proxystylesheet=cms_frontend&oe=UTF-8

Connors, R. & Smith, T. (1999). *Journey to the Emerald City: Achieve a competitive edge by creating a culture of accountability.* Paramus, NJ: Prentice Hall.

Creswell, J. W., Hanson, W. E., Clark Plano, V. L., & Morales, A. (2007). Qualitative research designs: Selection and implementation. *The Counseling Psychologist, 35*, 236-264. doi: 10.1177/0011000006287390.

Coleman, M. T., Looney, S., O'Brien, J., Zielgler, C., Pastorino, C. A., & Turber, C. (2002). The Eden Alternative: Findings after 1 year of implementation. *Journal of Gerontology MEDICAL SCIENCES, 57A,* 7, M422-M427.

Cutler, L. J., Kane, R. A., Degenholtz, H. B., Miller, M. J. & Grant, L. (2006). Assessing and comparing physical environments for nursing home residents: Using new tools for greater research specificity. *The Gerontologist, 46*(1), 42-51.

Decker, F. H. (2005). *Nursing homes, 1977-1999: What has changed, what has not?* Hyattsville, MA: National Center for Health Statistics.

Degenholtz, H. B., Kane, R. A., Kane, R. L., Bershadsky, B., & Kling, K. C. (2005). Predicting nursing facility residents' quality of life using external indicators. *Health Services Research, 41*(2), 335-356. doi: 10.1111/j.475-6673.2005.00494.x

Deutschman, M. T. (2005). An ethnographic study of nursing home culture to define organizational realities of culture change. *Journal of Health and Human Services Administration, 28*(2), 246-281.

Doty, M. M., Koren, M. J., & Sturia, E. L. (2008). *Culture change in nursing homes: How far have we come? Findings from the Commonwealth Fund 2007 National*

Survey of Nursing Homes. The Commonwealth Fund, Publication no. 1131. Retrieved June 15, 2009, from http://www.commonwealthfund.org/Content/Surveys/2007/The-Commonwealth-Fund-2007-National-Survey-of-Nursing-Homes.aspx

Ejaz, F. K., Straker, J. K., Fox, K., & Swami, S. (2003). Developing a satisfaction survey for families of Ohio's nursing home residents. *The Gerontologist, 43*(4), 447-458.

Fahey, C. J. (2003). Culture change in long-term care facilities: Changing the facility or changing the system. *Journal of Social Work in Long-Term Care, 2*(1/2), 35-51.

Federal Interagency Forum on Aging-Related Statistics (2008). *Older Americans 2008: Key Indicators of Well-Being.* Washington, DC: U.S. Government Printing Office. March 2008.

Forbes-Thompson, S., & Gessert, C. E. (2006). Nursing homes and suffering: Part of the problem or part of the solution? *The Journal of Applied Gerontology, 25*(3), 234-251. doi: 10.1177/0733464806288561

Gaugler, J. E., Leach, C. R., & Anderson, K. A. (2004). Correlates of resident psychosocial status in long-term care. *International Journal of Geriatric Psychiatry, 19*, 773-780. doi: 10.1002/gps.1157

Gay, L.R., Mills, G.E., & Airasian, P. (2006). *Educational research: Competencies for analysis and applications* (8th ed.). Upper Saddle River, NJ: Pearson Prentice Hall.

Gelo, O., Braakman, D., & Benetka, G. (2008). Quantitative and qualitative research: Beyond the debate. *Integrative Psychological and Behavioral Science, 42*, 266-290. doi: 10.1007/s12124-008-9078-3.

Giacalone, J. A. (2001). *The U.S. nursing home industry.* Armonk, NY: M.E. Sharpe, Inc.

Gilbert, C. & Bridges, G. (2003). Center for Nursing and Rehabilitation – Culture change in an urban environment. *Journal of Social Work in Long-Term Care, 2*(1/2), 233-243.

Glesne, C. (2006). *Becoming qualitative researchers: An introduction* (3rd ed.). Boston, MA: Pearson Education Inc.

Grant, L. A. & McMahon, E. (2008a). The cultural evolution part one: Testing new strategies to drive performance. *Provider, Jan*, 35-39.

Grant, L. A. & McMahon, E. (2008b). The cultural evolution part two: Culture change or perish: The business case. *Provider, Feb,* 31-36.

Grant, L. A. & McMahon, E. (2008c). The cultural evolution part three: Strategic investments in person-centered care. *Provider, March*, 53-56.

Guse, L. W. & Masesar, M. A. (1999). Quality of life and successful aging in long-term care: Perceptions of residents. *Issues in Mental Health Nursing, 20*, 527-539.

Hagy, A. (2003). Apple Health CARE: Culture change in a privately owned nursing home chain. *Journal of Social Work in Long-Term Care, 2*(3/4), 295-299.

Harper Ice, G. (2002). Daily Life in a nursing home: Has it changed in 25 years? *Journal of Aging Studies, 16*, 345-359. Retrieved November 20, 2008, from Elsevier Science database.

Harris, Y., Poulsen, R., & Vlangas, G. (2006). *Measuring culture change: A literature review. Colorado Foundation for Medical Care.* Publication Number: PM-411-114 CO 2006. Retrieved November 20, 2008 from www.cfmc.org/files/nh/MCC%20Lit%20Review.pdf

Higgs, P. F. D., MacDonald, L. D., MacDonald, J. S., & Ward, M. C. (1998). Home from home: Residents' opinions of nursing homes and long-stay wards. *Age and Ageing, 27,* 199-205. Retrieved November 30, 2008, from CinAHL database.

Hulicka, I. M., Cataldo, J. F., Morganti, J. B., & Nehrke, M. F. (1983). Perceptions of choice and importance by the elderly: Implications for intervention. *Interdisciplinary Topics in Gerontology, 17*, 25-39.

Hulicka, I. M., Morganti, J. B., & Cataldo, J. F. (1975). Perceived latitude of choice of institutionalized and noninstitutionalized elderly women. *Experimental Aging Research, 1*(1), 27-39.

Institute of Medicine. (March, 2001). *Brief Report. Crossing the Quality Chasm: A New Health System for the 21st Century.* Retrieved November 5, 2007, from http://www.iom.edu/CMS/8089/5432/27184.aspx

Institute of Medicine). 2001. *Improving the Quality of Long-Term Care. Washington, D.C.: National Academy Press.* Retrieved June 30, 2010, from http://www.iom.edu/Reports/2000/Improving-the-Quality-of-Long-Term-Care.aspx

Jang, G. (1992). Autonomy of institutionalized elderly: Resident and staff perceptions. *Canadian Journal on Aging, 11*(3), 249-261.

Jones, K. R., DeBaca, V. & Yarbrough, M. (1997). Organizational culture assessment before and after implementing patient-focused care. *Nursing Economics, 15*(2), 72-80. Retrieved October 7, 2008, from CinAHL database.

Kane, R. A. (2001). Long-term care and a good quality of life: Bringing them closer together. *The Gerontologist, 41*(3), 293-304.

Kane, R. A. (2003a). Definition, measurement, and correlates of quality of life in nursing homes: Toward a reasonable practice, research, and policy agenda. *The Gerontologist, 43,* Special Issue II, 28-36. Retrieved September 30, 2008 from CinAHL database.

Kane, R.A. (2003b). Quality if Life Scales for Nursing Home Residents. Report of CMS Project: Measures, Indicators, and Improvement of Quality of Life in Nursing Homes. Master Contract #500-96-0008 between CMS and the University of Minnesota. Retrieved February 3, 2009, from http://www.hpm.umn.edu/ltcresourcecenter/research/quality_of_life_nh.htm

Kane, R. A., Pratt, M., & Schoeneman, K. (2004). *Measures, Indicators, and Improvement of Quality of Life in Nursing Homes: Final Report.* Report submitted to Centers for Medicare and Medicaid Services by Division for Health Service Research and Policy, School of Public Health, University of Minnesota.

Kane, R. A., Caplan, A. L., Urv-Wong, E. K., Freeman, I. C., Aroskar, M. A., & Finch, M. (1997). Everyday matters in the lives of nursing home residents: The wish for and perception of choice and control. *Journal of the American Geriatrics Society, 45*(9), 1086-1093.

Kane, R. A., Kane, R. L., Berhadsky, B., Degenholtz, H. & Kling, K. C. (2002). *Recommendations on Short Quality of Life Measures for Potential Incorporation into the Nursing Home Minimum Data set.* Report submitted to the Centers for Medicare and Medicaid, September 2, 2002. Retrieved February 3, 2009 from http://www.hpm.umn.edu/ltcresourcecenter/research/quality_of_life_nh_measures.htm

Kane, R.A., Kling, K. C., Bershadsky, B., Kane, R.L., Giles, K., Degenholtz, H. B. et al. (2003). Quality of life measures for nursing home residents. *Journal of Gerontology: MEDICAL SCIENCES, 58A*(3), 240-248. Retrieved November 29, 2008, from CinAHL database.

Kane, R. A., Lum, T. Y., Cutler, L. J., Degenholtz, H. H., & Yu, T-C. (2007). Resident outcomes in small-house nursing homes: A longitudinal evaluation of the initial green house program. *Journal of the American Geriatric Society, 55,* 832-839. Retrieved October 8, 2008, from CinAHL database.

Kane, R. L., Bershadsky, B., Kane, R. A., Degenholtz, H. H., Liu, J., Giles, K. & Kling, K. C. (2004). Using resident reports of quality of life to distinguish among nursing homes. *The Gerontologist, 44*(5), 624-632.

Keane, W. L. & Shoesmith, J. (2005). Creating the ideal person-centered program and environment for residential dementia care: 10 steps and 10 challenges towards a new culture. *Alzheimer's Care Quarterly, 6*(4), 316-324. Retrieved May 16, 2008, from CinAHL database.

Kehoe, M. A. & Van Heesch, B. (2003). Culture change in long-term care: The Wellspring model. *Journal of Social Work in Long-Term Care, 2*(1/2), 159-173.

Keyton, J. (2005). *Communication and organizational culture.* Thousand Oaks, CA: Sage Publications, Inc.

Kotter, J. P. (2007). Leading Change: Why transformation efforts fail. *Harvard Business Review, January*, 96-103. Retrieved October 29, 2008, from Business Source Premier database.

Kotter, J. P. & Schlesinger, L. A. (2008). Choosing Strategies for change. *Harvard Business Review, July-August*, 130-139. Retrieved October 29, 2008, from Business Source Premier database.

Langer, E. J. & Rodin, J. (1976). The effects of choice and enhanced personal responsibility for the aged: A field experiment in an institutional setting. *Journal of Personality and Social Psychology, 34*(2), 191-198.

Levy-Storms, L., Simmons, S. F., Guitierrez, V. F., Miller-Martinez, D., Hickey, K., & Schnelle, J. F. (2005). A refined protocol fro coding nursing home residents' comments during satisfaction interviews. *Journal of Gerontology: SOCIAL SCIENCES, 60B*(6), S326-S330. Retrieved November 29, 2008, from Highwire Press.

Lopez, S. H. (2006). Culture change management in long-term care: A shop-floor view. *Politics and Society, 34*(1), 55-79. doi: 10.1177/0032329205284756

Lowe, T. J., Lucas, J. A., Castle, N. G., Robinson, J. P., & Crystal, S. (2003).Consumer satisfaction in long-term care: State initiatives in nursing homes and assisted living facilities. *The Gerontologist, 43*(6), 883-896.

Martin, J. (2002). *Organizational culture: Mapping the terrain.* Thousand Oaks, CA: Sage Publications.

Meyerson, D. & Martin, J. (1987). Cultural change: An integration of three different views. *Journal of Management Studies, 24*(6), 623-647. Retrieved June 12, 2008, from Business Source Premier database.

Minnesota Department of Human Services (n.d.). *Minnesota Department of Human Services Resident Survey 2009.* Retrieved March 10, 2009 from http://www.vitalresearch.com/MNSurvey2009/

Misiorski, S. (2001). Building a better life: Transforming institutional culture. *Alzheimer's Care Quarterly, 2*(3), 5-9. Retrieved May 16, 2008, from CinAHL database.

Misiorski, S. (2003).Pioneering culture change. *Nursing Homes: Long Term Care Management, 52*(10), 24-31. Retrieved May 16, 2008, from CinAHL database.

Misiorski, S. & Kahn, K. (2005). Changing the culture of long-term care: Moving beyond programmatic change. *Journal of Social Work in Long-Term Care, 3*(3/4), 137-146. doi; 10.1300/J181v03n03_10

Mitty, E. L. (2005). Culture change in nursing homes: An ethical perspective. *Annals of Long-Term Care, 13*(3), 47-51. Retrieved May 16, 2008, from Freely Accessible Science Journals database.

Moles, D. (2006). Bringing culture into better focus: What are the real ingredients of culture change in nursing facilities? *Nursing Homes: Long-Term Care Management, 55*(11), 18-20. Retrieved May 16, 2008, from CinAHL database.

Moody, H. R. (2006). *Aging concepts and controversies* (3rd ed.). Thousand Oaks, CA: Pine Forge Press.

Morganti, J. B., Nehrke, M. F., & Hulicka, I. M. (1980). Resident and staff perceptions of latitude of choice in elderly institutionalized men. *Experimental Aging Research, 6*(4), 367-384.

Morganti, J. B., Nehrke, M. F., Hulicka, I. M., Cataldo, J. F. (1988). Life-span differences in life satisfaction, self-concept, and locus of control. *International Journal of Aging and Human Development, 26*(1), 45-56.

National Center for Health Care Statistics (n.d.) *National Nursing Home Survey (2004).* Retrieved October 6, 2008, from http://www.cdc.gov/nchs/nnhs.htm

Norlander, T., Gård, L., Lindholm, L. & Archer, T. (2003). New age: Exploration of outlook-on-life frameworks from a phenomenological perspective. *Mental Health, Religion, and Culture, 6*(1), 1-20. Retrieved July 18, 2008 from PsychINFO database.

Pioneer Network (n.d.). Toward a new culture of aging. Retrieved November 1, 2008 from www.pioneernetwork.net

Pruncho, R. A. & Rose, M. S. (2002). Time use by frail older people in different care settings. *Journal of Applied Gerontology, 21*(5), 5-23. doi: 10.1177/073346802021001001

Rabig, J., Thomas, W., Kane, R. A., Cutler, L. J., & McAlilly, S. (2006). Radical redesign of nursing homes: Applying the Green House concept in Tupelo, Mississippi. *The Gerontologist, 46*(4), 533-539. Retrieved October, 25, 2008, from Highwire Press database.

Ragsdale, V. & McDougall, G. J. (2008). The changing face of long-term care: Looking at the past decade. *Issues in Mental Health Nursing, 29*(9), 992-1001. doi: 10.1080/01612840802274818

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. Retrieved September 30, 2008, from CinAHL database.

Redfoot, D. L. (2003). The changing consumer: The social context of culture change in long-term care. *Journal of Social Work in Long-Term Care, 2*(1/2), 95-110.

Riemen, D. J. (1996). Appendix C: A Phenomenology: The essential structure of a caring institution. In Creswell, J. W. (Ed.), *Qualitative inquiry and research design: Choosing among five traditions* (pp. 271-295). Thousand Oaks, CA: Sage.

Reynolds, W. E. (2003). Policy values and culture change in long term care – The role of state government in catalyzing change. *The Journal of Social work in Long Term Care, 2*(3/4), 397-410.

Robinson, G. E. & Gallagher, A. (2008). Culture change impacts quality of life for nursing home residents. *Topics in Clinical Nutrition, 23*(2), 120-130.

Robinson, J. P., Lucas, J. A., Castle, N. G., Lowe, T. J., & Crystal, S. (2004). Consumer satisfaction in nursing homes: Current practices and resident priorities. *Research on Aging, 26,* 454-480. doi: 10.1177/0164027504264435.

Robinson, S. B. & Rosher, R. B. (2006). Tangling with the barriers to culture change: Creating a resident-centered nursing home environment. *Journal of Gerontological Nursing, 32*(10), 19-27. Retrieved May 16, 2008, from CinAHL database.

Rodin, J. & Langer, E. J. (1977). Long-term effects of a control-relevant intervention with institutionalized aged. *Journal of Personality and Social Psychology, 35*(12), 897-902.

Ronch (2004).Changing institutional culture: Can we re-value the nursing home. *Journal of Gerontological Social Work, 43*(1), 61-82. Retrieved October 25, 2008, from Academic Search Premier database.

Ryvicker, M. (2008). Preservation of self in the nursing home: Contradictory practices within two models of care [Electronic version]. *Journal of Aging Studies,* In Press, Corrected Proof, Available online 7 October, 2008, doi:10.1016/j.jaging.2007.09.004

Sathe, V. & Davidson, E. J. (2000). Toward a new conceptualization of culture change. In Ashkanasy, N. M., Wilderom, C. P. M., & Peterson, M. F. (Eds), *Handbook of organizational culture and climate.* Thousand Oaks, CA: Sage Publications, Inc.

Schein, E. H. (1990). Organizational culture. *American Psychologist, 45*(2), 109-119. Retrieved October 23, 2008, from PsychINFO database.

Schein, E. H. (1996). What you need to know about organizational culture. *Training and Development Journal, 40*(1), 30-33. Retrieved October 23, 2008, from PsychINFO database.

Schein, E. H. (2004). *Organizational culture and change 3rd Ed*. San Francisco, CA: Jossey-Bass.

Schein, E. H. (2005). Defining organizational culture. In Shafritz, J. M., Ott, J. S., & Jang, Y. S. (Eds), *Classics of organizational theory*, 6th Ed. (pp. 360-367). Belmont, CA: Thomson Wadsworth. (Reprinted from Organizational culture and leadership, pp. 3-15, 1993, San Francisco: Jossey-Bass).

Scocco, P., Rapattoni, M. & Fantoni, G. (2006). Nursing home institutionalization: A source of eustress or distress for the elderly? *International Journal of Geriatric Psychiatry, 21,* 281-287. doi: 10.1002/gps.1453

Scott-Cawiezell, J., Jones, K.,Moore, L. & Vojir, C. (2005). Nursing home culture: A critical component in sustained improvement. *Journal of Nursing Care Quality, 20*(4), 341-348. Retrieved October 7, 2008, from CinAHL database.

Stanley, D. J., Meyer, J. P., & Topolnytsky, L. (2005). Employee cynicism and resistance to organizational change. *Journal of Business and Psychology, 19*(4), 429-458. doi: 10.1001/s10869-005-4518-2

Stewart, M., Makwarimba, E., Barnfather, A., Letourneau, N., & Neufeld, A. (2008). Researching reducing health disparities: Mixed-methods approaches. *Social Science and Medicine, 66*, 1406-1417. doi: 10.1016/j.socscimed.2007.11.021.

Straker, Ejaz, McCarthy & Jones (2007). Developing and testing a satisfaction survey for nursing home residents: The Ohio experience. *Journal of Aging and Social Policy, 19*(2), 85-105.

Tellis-Nayak, V. (2007a). Culture change: Its lapses, anomalies – and achievements. *Nursing Homes: Long Term Care Management, 56*(5), 22-23. Retrieved May 16, 2008, from CinAHL database.

Tellis-Nayak, V. (2007b). A person-centered workplace: The foundation for person-centered caregiving in long-term care. *Journal of the American Medical Directors Association, 8*(1), 46-54. Retrieved October 22, 2008, from www.jamda.com

Thomas, W. H. (2003). The evolution of Eden. *Journal of Social Work in Long-Term Care, 2*(1/2), 141-157.

Trice, H. & Beyer, J. (2005). Changing organizational cultures. In Shafritz, J. M., Ott, J. S., & Jang, Y. S. (Eds), *Classics of organizational theory*, 6th Ed. (pp.383-392). Belmont, CA: Thomson Wadsworth. (Reprinted from The cultures of work organizations, pp. 393-428, 1993, Upper Saddle River, NJ: Prentice-Hall).

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,* 370-378. doi: 10.1016/j.jamda.2009.04.004

Wilkins, A. L. & Gibb Dyer, W. (1988). Toward culturally sensitive theories of culture change. *Academy of Management Review, 13*(4), 522-533.

Yoshikawa, H., Weisner, T. S., Kalil, A., & Way, N. (2008). Mixing qualitative and quantitative research in developmental science: Uses and methodological choices. *Developmental Psychology, 44*(2), 344-354. doi: 10.1037/0012-1649.44.2.344.

APPENDIX A: IRB APPROVAL LETTER HEALTH CARE ORGANIZATION

September 2, 2009

Louise Murray, MA

RE: A Comparative Exploration Of Culture Change In Nursing Homes: The Residents' Perspective
IRB File # 09-09-04E

Dear Ms. Murray

I have reviewed your original protocol. On behalf of the Institutional Review Board, I hereby grant expedited approval of the above research proposal dated June 1, 2009, Appendices A through R, and Informed Consents dated September 2, 2009 (expiration September 1, 2010) for use within the facilities of [redacted] The HIPAA Authorization included within the consent form has also been approved. If you plan to use the application in institutions outside the Authority, you must submit it to the IRB at that institution for approval. Any changes to the research study must be presented to the IRB for approval prior to implementation.

Approval is for one year. In approximately 10 months, we will contact you for an annual review. *If you should complete the study prior to that time, notify the IRB office of the study's completion and provide us with follow-up regarding the results.* Please keep the committee informed of your progress and report promptly any adverse events to the IRB office. If we can be of further assistance, feel free to contact the IRB Office at [redacted]

Please refer to the IRB file number in communication regarding this study.

Sincerely,

[redacted]

Chairman, IRB

Note: The IRB complies with the requirements found in Part 50 and Part 56 of the 21 Code of Federal Regulations and Part 46 of the 45 Code of Federal Regulations. Federal-Wide Assurance # 00000387. The Registration Number is IORG 0000740. The [redacted] utional Review Board follows the ICH GCP guidelines with regard to the rights of human subjects.

APPENDIX B: IRB APPROVAL LETTER UNC CHARLOTTE

UNC CHARLOTTE

Compliance Office / Office of Research Services

9201 University City Blvd, Charlotte, NC 28223-0001
t/ 704.687.3311 f/ 704.687.2292 www.research.uncc.edu/comp/complian.cfm

Institutional Review Board (IRB) for Research with Human Subjects
Approval of IRB Authorization

Protocol #:	**09-08-10**	
Title:	**A Comparative Exploration of Culture Change in Nursing Homes: The Residents' Perspective**	
Designated IRB:	[redacted]	
FWA #:	**00000387**	
Date:	**8/17/2009**	
Investigator:	**Ms. Louise Murray**	**Gerontology**
Co-investigator:	**Dr. John Gretes**	**Educational Leadership**
Co-investigator:	[redacted]	[redacted]
Co-investigator:	[redacted]	[redacted]

UNC Charlotte's has obtained sufficient supporting documentation regarding this study to rely on the review and continuing oversight performed by the Designated IRB. UNC Charlotte is assured that the review provided by the Designated IRB meets the human subjects protection requirements of an OHRP-approved FWA.

The Designated IRB will follow OHRP-required procedures for reporting its findings and actions to appropriate officials at UNC Charlotte. The Designated IRB remains responsible for ensuring compliance with its determinations and with the terms of its OHRP-approved Assurance for activities under its purview.

This document must be kept on file at both institutions and provided to OHRP upon request.

Please note that it is the investigator's responsibility to promptly inform the IRB committees of any changes in the proposed research, as well as any unanticipated problems that may arise involving risks to subjects. UNC Charlotte's Amendment and Event Reporting guidelines and forms are available on our web site: http://www.research.uncc.edu/comp/human.cfm

[redacted] 9-11-09

Dr. M. Lyn Exum, IRB Chair Date

APPENDIX C: IRB AUTHORIZATION AGREEMENT

Version Date: 01/06

Institutional Review Board (IRB) Authorization Agreement

Name of Institution or Organization Providing IRB Review (Institution A):

[redacted]
OHRP Federalwide Assurance (FWA) #: 00000387

Name of Institution Relying on the Designated IRB (Institution B):

UNC Charlotte
Federalwide Assurance (FWA)#: 00000649 IRB Registration #: 00001466

The Officials signing below agree that **UNC Charlotte** may rely on [redacted] designated IRB for review and continuing oversight of its human subject research described below: (*check one*)

(_____) This agreement applies to all human subjects research covered by Institution B's FWA:

(X) This agreement is limited to the following specific protocol(s):

Name of Research Project: **A Comparative Exploration of Culture Change in Nursing Homes: The Residents' Perspective**

[redacted] IRB File #: 9-9-04E

UNC Charlotte Protocol #: 09-08-10

Name of Principal Investigator: **Louise Murray**
University of North Carolina at Charlotte

Name of Co-Investigator:

Sponsor or Funding Agency: Award Number, if any:

The review and continuing oversight performed by the Designated IRB will meet the human subjects protection requirements of UNC Charlotte's OHRP-approved FWA. The Designated IRB (Institution A) will follow written procedures for reporting its findings and actions to appropriate officials at UNC Charlotte. UNC Charlotte remains responsible for ensuring compliance with the IRB's determinations and with the terms of its OHRP-approved Assurance for activities on its campus. This document must be kept on file at both institutions and provided to OHRP upon request.

Signature of Signatory Official Providing IRB Review: [redacted] Date: 8/20/09

Signature of Signatory Official Relying on Designated IRB: [redacted] Date: 8/17/09

Dr. Stephen R. Mosier
Vice Chancellor for Research & Federal Relations, UNC Charlotte 9201 University City Blvd., Charlotte, NC 28223-0001; PH: 704-687-2291

APPENDIX D: Nursing Home Administrator Consent to Participate in Survey and Interviews

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

A COMPARATIVE EXPLORATION OF CULTURE CHANGE IN NURSING HOMES: THE RESIDENTS' PERSPECTIVE

INTRODUCTION

Ms. Louise Murray is asking you to participate in this research study of culture change at *(name of nursing home)* and (*name of health care organization*). Louise Murray is a doctoral candidate in the Department of Educational Leadership at the University of North Carolina at Charlotte. She will conducting this study as her dissertation research, under the supervision of [redacted] at [redacted] and her dissertation committee at UNC Charlotte headed by Dr. John Gretes.

You are being asked to take part because you are over 18 years of age and are the Administrator at *(name of nursing home).* The purpose of this study is to look at quality of life, resident satisfaction, and residents' perceptions of choice and control in everyday life in different nursing homes undertaking the culture change process. You will be one of approximately 130 people involved in this research project at (*name of health care organization*).

HOW THE STUDY WORKS

If you consent to take part in this study you will be asked to take part in a one-to-one interview to answer questions about your perceptions and experience of the culture change process in nursing homes, resident quality of life, resident satisfaction with the nursing home, and your perceptions of resident choice and control in everyday life. Louise Murray will contact you to make an appointment to conduct the interview at your convenience.

The interview will be audio-taped. The interview should take approximately 30-45 minutes to complete. If there is anything we need to follow up on from the first interview we will contact you to request a second interview within two weeks of the first one. This second interview will also be audio-taped and will only take 15-20 minutes.

In addition, if you consent to take part in this study you will be asked to answer survey questions. Louise Murray will leave the survey with you after your interview to complete at your convenience. You may then return it to her in the stamped, addressed envelope provided. The questions relate to the culture change process in your nursing home. The survey should take approximately 60 minutes to complete.

Participant initials _____

RISKS
There are no known risks to participating in this project. The only drawback to participation is the time it will take – about 1hr 45 min – 2 hrs. At this time we do not know of any risks, but unforeseen risks are always possible. You are a volunteer. The decision whether or not to participate is completely up to you. You may choose not to answer any of the questions or to stop the survey at any time.

EXCLUSION CRITERIA
You may not participate in this study if you are under 18 years of age and are not the Administrator at (name of nursing home).

BENEFITS
There are no known benefits to individual participants. The only benefit to you, if you choose to participate, is the knowledge that you have helped us to add to the knowledge of the worth of the culture change process in nursing homes.

ADDITIONAL COST
There are no costs associated with participating in this research.

COMPENSATION
There will be no compensation for participating in this study. In the event that you are harmed as a result of your participation in this study, we will provide or arrange for treatment as necessary. This treatment, as well as other medical expenses, will be billed to you or your insurance company in the usual manner.

WITHDRAWAL
Your participation in this study is completely voluntary. You should feel under no pressure to be in the study. If you decide not to be in the study, that will not in any way harm your relations with (*name of health care organization*). You are free to stop being in the study if you change your mind after entering it. This would not harm your relations with (*name of health care organization*).

CONFIDENTIALITY:
To ensure your confidentiality your real name and any identifying material will be removed from the survey and you will be assigned an identifying number. All reports of the data will not contain your name or the name of the nursing home at which you are the Administrator.

Participant initials _____

To maintain your confidentiality, the recordings of the interview(s) will be transcribed by Louise Murray. To further ensure confidentiality your real name and any identifying material will be removed from the transcript by Louise Murray and the written report will not contain your real name. After transcription the recording will be destroyed and only the researchers will have access to the transcript.

The records of this study will be kept private. In any sort of report we might publish, we will not include any information that will make it possible to identify you or your nursing home. Your record for this study may, however, be reviewed and/or photocopied by (*name of health care organization*), or by representatives of the Food and Drug Administration or other government agencies. To that extent, confidentiality is not absolute.

AUTHORIZATION:
If you wish to take part in this study, you will be asked to sign this consent form. You have been told that the data collected in the survey will be reviewed, collected on a computer database, stored in electronic or manual files, audited, and/or otherwise processed by Louise Murray.

This Authorization does not have an expiration date. You have been told that according to the guidelines for good clinical practice, the study investigator and sponsor will keep your personal information for at least 6 years. If you do not withdraw this Authorization in writing, it will remain in effect indefinitely. If you wish to revoke authorization to use your personal information, you will notify the study coordinator, [Louise Murray, [redacted], in writing. Some of the data obtained prior to your revocation may still be used if considered necessary for the study.

QUESTIONS
The researchers doing the study at *(name of health care organization)* are Louise Murray under the supervision [redacted] at [redacted] and her dissertation committee at UNC Charlotte headed by Dr. John Gretes. You may ask Louise Murray any questions you have now. If you have questions later, you may contact Louise Murray at [redacted], [redacted] and Dr. John Gretes at [redacted]

The Institutional Review Board is a group of people who review the research to protect your rights. If you have questions about the conduct of this study or about your rights as a research subject, you may call the chairperson of the Institutional Review Board of (*name of health care organization*) for information regarding patients' rights in a research study. You can obtain the name and number of this person by calling _____.

Participant initials _____

CONSENT

I have read the above information. I have asked any questions I had, and those questions have been answered. I agree to be in this study. Louise Murray will give me a copy of this form.

Participant Print Name	**Date**	**Time**
Participant Signature	**Date**	**Time**
Signature of Person Obtaining Consent	**Date**	**Time**
Investigator Signature	**Date**	**Time**

APPENDIX E: Nursing Home Administrators Interview Protocol

Demographic Information

Age: _____ Gender: M ____ F _____

Ethnicity/Race: _____

Length of time you have worked at *(name of nursing home):* _____(in months)

Warm-up Questions

1. Before taking this post at (name of nursing home) were you familiar with the philosophy and model of culture change? If so, please elaborate.

Culture Change

2. Please tell me how you would define culture change within nursing homes?
3. What do you think are the benefits for the residents of a nursing home adopting this model of care?
4. What do you think are the biggest challenges to implementing such change?
5. What do you think are the biggest challenges to sustaining such changes?

Quality of Life

6. What are three or four things that you feel are absolutely essential for the residents living a good quality of life here at (name of nursing home)?*
7. What takes away from the residents living a good quality of life here at (name of nursing home*

Choice and Control

8. Do you feel that the residents have control over their everyday life here at (name of nursing home)?
    - If no:
        - what stops them making their own choices/decisions?
        - what areas of life here at (name of nursing home) do you think that the residents would like more control over?
    - If yes:
        - what things do you think help the residents to maintain control over their everyday lives?

Satisfaction

9. What do you think is the best thing about living here for the residents?
10. What do you think is the worst thing about living here for the residents?

Concluding Question

Would you recommend (name of nursing home) as a place to work to others?

*Questions developed by Guse and Masesar (1999).

APPENDIX F: Potential Participants for Inclusion in the study:

A COMPARATIVE EXPLORATION OF CULTURE CHANGE IN NURSING HOMES: THE RESIDENTS' PERSPECTIVE

Principle Investigator: Louise M. Murray

Please identify the residents who meet the following criteria for inclusion in this study:

☐ Are aged 18 years old or over

☐ Are physically and psychologically able to participate in survey research and interview sessions lasting approximately 45 minutes

☐ Can give informed consent to participate

☐ Have lived in (name of nursing home) for three months or more

Name of Resident	Date of Birth	Room #

Date: _____

Signature: _____ Print Name: _____

Designation: ☐ NH-Administrator ☐ Medical Director

APPENDIX G: Resident Consent to Participate in Survey

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

A COMPARATIVE EXPLORATION OF CULTURE CHANGE IN NURSING HOMES: THE RESIDENTS' PERSPECTIVE

INTRODUCTION

Ms. Louise Murray is asking you to participate in this research study of culture change at *(name of nursing home)* and (*name of health care organization*). Louise Murray is a doctoral candidate in the Department of Educational Leadership at the University of North Carolina at Charlotte. She will conducting this study as her dissertation research, under the supervision of [redacted] at [redacted] and her dissertation committee at UNC Charlotte headed by Dr. John Gretes.

Please note: when we say "you" in this consent, we are referring to the resident at *(name of nursing home*) but the form may also be signed by a relative/proxy.

You are being asked to take part because you are over 18 years of age and have lived in *(name of nursing home)* for three months or more. The purpose of this study is to look at quality of life, resident satisfaction, and residents' perceptions of choice and control in everyday life in different nursing homes undertaking the culture change process. You will be one of approximately 70 people involved in this research project at (*name of health care organization*).

HOW THE STUDY WORKS

If you consent to take part in this study you will be asked to answer survey questions. Louise Murray will contact you to make an appointment to conduct the survey at your convenience. She will then sit down with you and ask you the survey questions. The questions relate to your assessment of your quality of life, satisfaction with the nursing home, and perceptions of choice and control in your everyday life. The survey should take approximately 30-45 minutes to complete and you may choose to complete it in one or two visits.

Patient initials _____
MRN/History # _____
(JCAHO Requirement)

RISKS

There are no known risks to participating in this project. The only drawback to participation is the time it will take – about forty-five minutes. At this time we do not know of any risks, but unforeseen risks are always possible. You are a volunteer. The decision whether or not to participate is completely up to you. You may choose not to answer any of the questions or to stop the survey at any time.

EXCLUSION CRITERIA

You may not participate in this study if you are under 18 years of age, have not lived in *(name of nursing home)* for three months or more, or are unable to provide informed consent to participate.

BENEFITS

There are no known benefits to individual participants. The only benefit to you, if you choose to participate, is the knowledge that you have helped us to add to the knowledge of the worth of the culture change process in nursing homes.

ADDITIONAL COST

There are no costs associated with participating in this research.

COMPENSATION

There will be no compensation for participating in this study. In the event that you are harmed as a result of your participation in this study, we will provide or arrange for treatment as necessary. This treatment, as well as other medical expenses, will be billed to you or your insurance company in the usual manner.

WITHDRAWAL

Your participation in this study is completely voluntary. You should feel under no pressure to be in the study. If you decide not to be in the study, that will not in any way harm your relations with your doctors or with (*name of health care organization*). You are free to stop being in the study if you change your mind after entering it. This would not harm your relations with your doctors or (*name of health care organization*).

Patient initials _____
MRN/History # _____
(JCAHO Requirement)

CONFIDENTIALITY:

Louise Murray will not have access to your medical records or medical information. To ensure your confidentiality your real name and any identifying material will be removed from the survey and you will be assigned an identifying number. All reports of the data or published materials will contain combined results only.

The records of this study will be kept private. In any sort of report we might publish, we will not include any information that will make it possible to identify a patient. Your record for this study may, however, be reviewed and/or photocopied by (*name of health care organization*), or by representatives of the Food and Drug Administration or other government agencies. To that extent, confidentiality is not absolute.

AUTHORIZATION:

If you wish to take part in this study, you will be asked to sign this consent form. You have been told that personal information about you (including sensitive personal information, such as your racial/ethnic origin) and the data collected in the survey will be reviewed, collected on a computer database, stored in electronic or manual files, audited, and/or otherwise processed by Louise Murray.

This Authorization does not have an expiration date. You have been told that according to the guidelines for good clinical practice, the study investigator and sponsor will keep your personal information for at least 6 years. If you do not withdraw this Authorization in writing, it will remain in effect indefinitely. If you wish to revoke authorization to use your personal information, you will notify the study coordinator, [Louise Murray, [redacted]], in writing. Some of the data obtained prior to your revocation may still be used if considered necessary for the study.

QUESTIONS

The researchers doing the study at *(name of health care organization)* are Louise Murray under the supervision [redacted] at [redacted] and her dissertation committee at UNC Charlotte headed by Dr. John Gretes. You may ask Louise Murray any questions you have now. If you have questions later, you may contact Louise Murray at [redacted] and Dr. John Gretes at [redacted]

Patient initials _____
MRN/History # _____
(JCAHO Requirement)

The Institutional Review Board is a group of people who review the research to protect your rights. If you have questions about the conduct of this study or about your rights as a research subject, you may call the chairperson of the Institutional Review Board of (*name of health care organization*) for information regarding patients' rights in a research study. You can obtain the name and number of this person by calling _____.

This space intentionally left blank.

Patient initials _____
MRN/History # _____
(JCAHO Requirement)

CONSENT

I have read the above information. I have asked any questions I had, and those questions have been answered. I agree to be in this study. Louise Murray will give me a copy of this form.

_____	_____	_____
Resident Print Name	**Date**	**Time**
_____	_____	_____
Resident [guardian] Print Name	**Date**	**Time**
_____	_____	_____
Resident [guardian] Signature	**Date**	**Time**
_____	_____	_____
Resident Legal Representative or Next of Kin Signature	**Date**	**Time**
_____	_____	_____
Signature of Person Obtaining Consent	**Date**	**Time**
_____	_____	_____
Investigator Signature	**Date**	**Time**

Identity of representative:
___Next of Kin
___Parent/Guardian
___Healthcare Power of Attorney

MRN/History # _____
(JCAHO Requirement)

APPENDIX H: Resident Consent to Participate in the Interviews

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

A COMPARATIVE EXPLORATION OF CULTURE CHANGE IN NURSING HOMES: THE RESIDENTS' PERSPECTIVE

INTRODUCTION

Ms. Louise Murray is asking you to participate in this research study of culture change at (*name of nursing home*) and (*name of health care organization*). Louise Murray is a doctoral candidate in the Department of Educational Leadership at the University of North Carolina at Charlotte. She will conducting this study as her dissertation research, under the supervision of [redacted] at [redacted] and her dissertation committee at UNC Charlotte headed by Dr. John Gretes.

Please note: when we say "you" in this consent, we are referring to the resident at (*name of nursing home*) but the form may also be signed by a relative/proxy.

You are being asked to take part because you are over 18 years of age and have lived in (*name of nursing home*) for three months or more, and recently completed a survey pertaining to this research study. The purpose of this study is to look at quality of life, resident satisfaction, and residents' perceptions of choice and control in everyday life in different nursing homes undertaking the culture change process. You will be one of approximately 70 people involved in this research project at (*name of health care organization*).

HOW THE STUDY WORKS

If you consent to take part in this study you will be asked to take part in a one-to-one interview to answer questions about your assessment of your quality of life, satisfaction with the nursing home, and perceptions of choice and control in your everyday life. Louise Murray will contact you to make an appointment to conduct the interview at your convenience.

The interview will be audio-taped. The interview should take approximately 20-30 minutes to complete. If there is anything we need to follow up on from the first interview we will contact you to request a second interview within two weeks of the first one. This second interview will also be audio-taped and will only take 15-20 minutes.

Patient initials _____
MRN/History # _____
(JCAHO Requirement)

RISKS

There are no known risks to participating in this project. The only drawback to participation is the time it will take – about thirty minutes. At this time we do not know of any risks, but unforeseen risks are always possible. You are a volunteer. The decision whether or not to participate is completely up to you. You may choose not to answer any of the questions or to stop the interview at any time.

EXCLUSION CRITERIA

You may not participate in this study if you are under 18 years of age, have not lived in (*name of nursing home*) for three months or more, did not recently participate in the survey portion of this research study, or are unable to provide informed consent to participate.

BENEFITS

There are no known benefits to individual participants. The only benefit to you, if you choose to participate, is the knowledge that you have helped us to add to the knowledge of the worth of the culture change process in nursing homes.

ADDITIONAL COST

There are no costs associated with participating in this research.

COMPENSATION

There will be no compensation for participating in this study. In the event that you are harmed as a result of your participation in this study, we will provide or arrange for treatment as necessary. This treatment, as well as other medical expenses, will be billed to you or your insurance company in the usual manner.

WITHDRAWAL

Your participation in this study is completely voluntary. You should feel under no pressure to be in the study. If you decide not to be in the study, that will not in any way harm your relations with your doctors or with (*name of health care organization*). You are free to stop being in the study if you change your mind after entering it. This would not harm your relations with your doctors or (*name of health care organization*).

Patient initials _____
MRN/History # _____
(JCAHO Requirement)

CONFIDENTIALITY:
Louise Murray will not have access to your medical records or medical information. To ensure your confidentiality your real name and any identifying material will be removed from the interview and you will be assigned an identifying number. All reports of the data or published materials will contain combined results only.

To maintain your confidentiality, the recordings will be transcribed and analyzed by Louise Murray. After transcription the recording will be destroyed and only the researchers will have access to the transcript. To further ensure confidentiality your real name and any identifying material will be removed from the transcript by Louise Murray and the written report will not contain your real name.

The records of this study will be kept private. In any sort of report we might publish, we will not include any information that will make it possible to identify a patient. Your record for this study may, however, be reviewed and/or photocopied by (*name of health care organization*), or by representatives of the Food and Drug Administration or other government agencies. To that extent, confidentiality is not absolute.

AUTHORIZATION:
If you wish to take part in this study, you will be asked to sign this consent form. You have been told that personal information about you (including sensitive personal information, such as your racial/ethnic origin) and the data collected in the survey will be reviewed, collected on a computer database, stored in electronic or manual files, audited, and/or otherwise processed by: Louise Murray.

This Authorization does not have an expiration date. You have been told that according to the guidelines for good clinical practice, the study investigator and sponsor will keep your personal information for at least 6 years. If you do not withdraw this Authorization in writing, it will remain in effect indefinitely. If you wish to revoke authorization to use your personal information, you will notify the study coordinator, [Louise Murray, [redacted]], in writing. Some of the data obtained prior to your revocation may still be used if considered necessary for the study.

QUESTIONS
The researchers doing the study at *(name of health care organization)* are Louise Murray under the supervision [redacted] at [redacted] and her dissertation committee at UNC Charlotte headed by Dr. John Gretes. You may ask Louise Murray any questions you have now. If you have questions later, you may contact Louise Murray at [redacted], and Dr. John Gretes at [redacted]

Patient initials _____
MRN/History # _____
(JCAHO Requirement)

The Institutional Review Board is a group of people who review the research to protect your rights. If you have questions about the conduct of this study or about your rights as a research subject, you may call the chairperson of the Institutional Review Board of (*name of health care organization*) for information regarding patients' rights in a research study. You can obtain the name and number of this person by calling _____.

This space intentionally left blank.

Patient initials _____
MRN/History # _____
(JCAHO Requirement)

CONSENT

I have read the above information. I have asked any questions I had, and those questions have been answered. I agree to be in this study. Louise Murray will give me a copy of this form.

Resident [guardian] Print Name	**Date**	**Time**
Resident [guardian] Signature	**Date**	**Time**
Resident Legal Representative or Next of Kin Signature	**Date**	**Time**
Signature of Person Obtaining Consent	**Date**	**Time**
Investigator Signature	**Date**	**Time**

Identity of representative:
___Next of Kin
___Parent/Guardian
___Healthcare Power of Attorney

MRN/History # _____
(JCAHO Requirement)

APPENDIX I: Resident Interview Protocol

***Additional probing questions based on the survey data will be added as appropriate*

Warm-up Questions

1. How long have you lived here at (name of nursing home)?
2. Can you tell me a little bit about yourself?

Quality of Life

3. What are three or four things that you feel are absolutely essential for your living a good quality of life here at (name of nursing home)?*
4. What takes away from your living a good quality of life here at (name of nursing home)?*

Choice and Control

5. Do you feel as though you have control over your everyday life here at (name of nursing home)?
    - If no:
        - what stops you from making your own choices/decisions?
        - what areas of your life here at (name of nursing home) would you like more control?
    - If yes:
        - what things help you maintain control over your everyday life?

Satisfaction

6. Overall, are you satisfied with the care at this facility?
7. What is the best thing about living here?
8. What is the worst thing about living here?
9. Would you recommend (name of nursing home) to others?

Concluding Question

10. If there was anything you could change about your day to day life in this nursing home what would it be?
11. If you could change something about how the staff help you what would it be?

*Questions developed by Guse and Masesar (1999).

APPENDIX J: Letter to Family Members Inviting Participation in the Focus Group/Interview

Dear Sir or Madam,

My name is Louise Murray and I am a doctoral candidate in the Department of Educational Leadership at the University of North Carolina at Charlotte. I am conducting a study of culture change in nursing homes. I will be conducting this study as my dissertation research, under the guidance of [redacted] and my dissertation committee at UNC Charlotte headed by Dr. John Gretes.

I am writing to you as a family member/friend of a resident at (*name of nursing home*). I wish to conduct a focus group, a group of six-ten family member/friends, or individual one-to-one interviews, in order to ask questions about how you feel about the residents' quality of life, satisfaction, and the amount of choice and control you feel they have in their everyday lives at (*name of nursing home*). This focus group or interview will be audio-taped and should take approximately 30-45 minutes to complete. The focus group or interviews will be held in private room at (*name of nursing home*). A $50 store gift card will be available to ONE participant and will be randomly drawn by the researcher, Louise Murray.

If you wish to volunteer to participate in this study (the study will be further explained and your consent will be obtained at the beginning of the focus group or one-to-one interview) please fill in the form on the next page and return it to Louise Murray in the stamped-addressed envelope provided. Please respond by _____.

Please keep this letter for your records. Your decision whether or not to participate is completely voluntary and will not in any way harm your relations with the doctors or with the staff at (*name of nursing home*) and (*name of health care organization*).

If you have any questions or need further information, please contact Louise Murray at [redacted] or lmmurray@uncc.edu.

Sincerely,

Louise Murray
Doctoral Candidate
Department of Educational Leadership
College of Education
UNC Charlotte
Charlotte, NC 28223
lmmurray@uncc.edu

I _____ wish to participate in the focus group/individual interviews to be held at (*name of nursing home*). I am over 18 years of age and have a family member or friend who has lived in (*name of nursing home*) for three months or more.

If you have another family member/friend who also visits your family member/friend at (*name of nursing home*) and is over 18 years of age please feel free to invite them to participate in the study with you.

I am/We are available during the following times (please check all that are suitable):

Weekday AM _____ Weekday PM _____ Weekday Evening _____

Saturday AM _____ Saturday PM _____.

Number of persons who will attend _____

Please contact me at:

Phone #: _____

Email: _____

Name (PRINT): _____

APPENDIX K: Family Members/Friends Consent to Participate in the Focus Group/Interview

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

A COMPARATIVE EXPLORATION OF CULTURE CHANGE IN NURSING HOMES: THE RESIDENTS' PERSPECTIVE

INTRODUCTION

Ms. Louise Murray is asking you to participate in this research study of culture change at *(name of nursing home)* and (*name of health care organization*). Louise Murray is a doctoral candidate in the Department of Educational Leadership at the University of North Carolina at Charlotte. She will conducting this study as her dissertation research, under the supervision of [redacted] and her dissertation committee at UNC Charlotte headed by Dr. John Gretes.

You are being asked to take part because you are over 18 years of age and have a family member or friend who has lived in (*name of nursing home*) for three months or more. The purpose of this study is to look at quality of life, resident satisfaction, and residents' perceptions of choice and control in everyday life in different nursing homes undertaking the culture change process. You will be one of approximately 70 people involved in this research project at CHS.

HOW THE STUDY WORKS

If you consent to take part in this study you will be asked to answer questions in a focus group or a one-to-one interview setting. Louise Murray will ask you the interview questions and invite you to talk about how you feel about the residents 'quality of life, satisfaction, and the amount of choice and control you feel they have in their everyday lives here at (*name of nursing home*). This focus group/interview will be audio-taped and should take approximately 30-45 minutes to complete.

RISKS

There are no known risks to participating in this project. The only drawback to participation is the time it will take – about forty-five minutes. At this time we do not know of any risks, but unforeseen risks are always possible. You are a volunteer. The decision whether or not to participate is completely up to you. You may choose not to answer any of the questions or to stop your participation in the focus group/interview at any time.

Participant initials _____

EXCLUSION CRITERIA
You may not participate in this study if you are under 18 years of age, do not have a family member/friend who has lived in (*name of nursing home*) for three months or more, or are unable to provide informed consent to participate.

BENEFITS
There are no known benefits to individual participants. The only benefit to you, if you choose to participate, is the knowledge that you have helped us to add to the knowledge of the worth of the culture change process in nursing homes.

ADDITIONAL COST
There are no costs associated with participating in this research.

COMPENSATION
There will be no compensation for participating in this study. However, a $50 store card (Target/Walmart) will be awarded to ONE participant and the recipient will be determined by random drawing of a name by the researcher, Louise Murray. The card will be presented in-person at the end of the focus group or when all the interviews are completed the recipient will be contacted by phone or email to arrange delivery.

In the event that you are harmed as a result of your participation in this study, we will provide or arrange for treatment as necessary. This treatment, as well as other medical expenses, will be billed to you or your insurance company in the usual manner.

WITHDRAWAL
Your participation in this study is completely voluntary. You should feel under no pressure to be in the study. If you decide not to be in the study, that will not in any way harm your relations with the doctors or with the staff at (*name of nursing home*) and (*name of health care organization*). You are free to stop being in the study if you change your mind after entering it. This would not harm your relations with the doctors or staff at (*name of nursing home*) and (*name of health care organization*).

CONFIDENTIALITY:
To ensure your confidentiality your real name and any identifying material will be removed from the tape. All reports of the data or published materials will contain combined results only. To maintain your confidentiality, the recordings will be transcribed and analyzed by Louise Murray. After transcription the recording will be destroyed and only the researchers will have access to the transcript. To further ensure confidentiality your real name and any identifying material will be removed from the transcript by Louise Murray and any written report will not contain your real name.

Participant initials _____

The records of this study will be kept private. In any sort of report we might publish, we will not include any information that will make it possible to identify you. Your record for this study may, however, be reviewed and/or photocopied by (*name of health care organization*) or by representatives of the Food and Drug Administration or other government agencies. To that extent, confidentiality is not absolute. Additionally, although other focus group participants will be asked not to divulge the information disclosed by their fellow participants, this can only be requested and not guaranteed.

AUTHORIZATION:

If you wish to take part in this study, you will be asked to sign this consent form. You have been told that personal information about you (including sensitive personal information, such as your racial/ethnic origin) and the data collected in the survey will be reviewed, collected on a computer database, stored in electronic or manual files, audited, and/or otherwise processed by: Louise Murray.

QUESTIONS

The researchers doing the study at (*name of health care organization)* Louise Murray under the supervision[redacted]at [redacted] and her dissertation committee at UNC Charlotte headed by Dr. John Gretes. You may ask Louise Murray any questions you have now. If you have questions later, you may contact Louise Murray at [redacted] nd Dr. John Gretes at [redacted]

The Institutional Review Board is a group of people who review the research to protect your rights. If you have questions about the conduct of this study or about your rights as a research subject, you may call the chairperson of the Institutional Review Board of *name of health care organization*) for information regarding patients' rights in a research study. You can obtain the name and number of this person by calling _____.

This space left intentionally blank.

Participant initials _____

CONSENT

I have read the above information. I have asked any questions I had, and those questions have been answered. I agree to be in this study. Louise Murray will give me a copy of this form.

_____	_____	_____
Participant Print Name	**Date**	**Time**
_____	_____	_____
Participant Signature	**Date**	**Time**
_____	_____	_____
Signature of Person Obtaining Consent	**Date**	**Time**
_____	_____	_____
Investigator Signature	**Date**	**Time**

APPENDIX L: Letter to Direct Care Staff Inviting Participation in the Focus Group/Interview

Dear Sir or Madam,

My name is Louise Murray and I am a doctoral candidate in the Department of Educational Leadership at the University of North Carolina at Charlotte. I am conducting a study of culture change in nursing homes. I will be conducting this study as my dissertation research, under the guidance of [redacted] and my dissertation committee at UNC Charlotte headed by Dr. John Gretes.

I am writing to you as a certified nursing assistant (CNA) at (*name of nursing home*). I wish to conduct a focus group, a group of six-ten CNAs, or individual one-to-one interviews, in order to ask questions about how you feel about the residents 'quality of life, satisfaction, and the amount of choice and control you feel they have in their everyday lives at (*name of nursing home*). This focus group or interview will be audio-taped and should take approximately 30-45 minutes to complete. The focus group, or interviews, will be held in private room at (*name of nursing home*).

If you wish to volunteer to participate (the study will be further explained and your consent will be obtained at the beginning of the focus group or one-to-one interview) please fill in the form on the next page and return it to Louise Murray in the stamped-addressed envelope provided.

Please keep this letter for your records. Your decision whether or not to participate is completely voluntary and will not in any way harm your relations with the doctors or with the staff at (*name of nursing home*) and (*name of health care organization*).

Please respond by_____.

If you have any questions or need further information, please contact Louise Murray at [redacted] or lmmurray@uncc.edu.

Sincerely,

Louise Murray
Doctoral Candidate
Department of Educational Leadership
College of Education
UNC Charlotte
Charlotte, NC 28223
lmmurray@uncc.edu

I _____ wish to participate in the focus group/individual interviews to be held at (*name of nursing home*). I am over 18 years of age and my main role is as a certified nursing assistant at (*name of nursing home*). I primarily work with residents who have lived at (*name of nursing home*) for three months or more.

I am available during the following times (PLEASE CHECK ALL THAT ARE SUITABLE):

Weekday AM _____ Weekday PM _____ Weekday Evening _____

Saturday AM _____ Saturday PM _____

Please contact me at:

Phone #: _____

Email: _____

Name (PRINT): _____

APPENDIX M: Direct Care Staff Consent to Participate in the Focus Group/Interview

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

A COMPARATIVE EXPLORATION OF CULTURE CHANGE IN NURSING HOMES: THE RESIDENTS' PERSPECTIVE

INTRODUCTION

Ms. Louise Murray is asking you to participate in this research study of culture change at *(name of nursing home)* and (*name of health care organization*). Louise Murray is a doctoral candidate in the Department of Educational Leadership at the University of North Carolina at Charlotte. She will conducting this study as her dissertation research, under the supervision of [redacted] and her dissertation committee at UNC Charlotte headed by Dr. John Gretes.

You are being asked to take part because you are over 18 years of age and are a certified nursing assistant at (*name of nursing home*) who is regularly scheduled to work with residents who have lived at (*name of nursing home*) for three months or more. The purpose of this study is to look at quality of life, resident satisfaction, and residents' perceptions of choice and control in everyday life in different nursing homes undertaking the culture change process. You will be one of approximately 70 people involved in this research project at (*name of health care organization*).

HOW THE STUDY WORKS

If you consent to take part in this study you will be asked to answer questions in a focus group or a one-to-one interview setting. Louise Murray will ask you the interview questions and invite you to talk about how you feel about the residents 'quality of life, satisfaction, and the amount of choice and control you feel they have in their everyday lives here at (*name of nursing home*). This focus group/interview will be audio-taped and should take approximately 30-45 minutes to complete.

RISKS

There are no known risks to participating in this project. The only drawback to participation is the time it will take – about forty-five minutes. At this time we do not know of any risks, but unforeseen risks are always possible. You are a volunteer. The decision whether or not to participate is completely up to you. You may choose not to answer any of the questions or to stop your participation in the focus group/interview at any time.

Participant initials _____

EXCLUSION CRITERIA

You may not participate in this study if you are under 18 years of age and are not a certified nursing assistant at (*name of nursing home*) who is regularly scheduled to work with residents who have lived at (*name of nursing home*) for three months or more

BENEFITS

There are no known benefits to individual participants. The only benefit to you, if you choose to participate, is the knowledge that you have helped us to add to the knowledge of the worth of the culture change process in nursing homes.

ADDITIONAL COST

There are no costs associated with participating in this research.

COMPENSATION

There will be no compensation for participating in this study. In the event that you are harmed as a result of your participation in this study, we will provide or arrange for treatment as necessary. This treatment, as well as other medical expenses, will be billed to you or your insurance company in the usual manner.

WITHDRAWAL

Your participation in this study is completely voluntary. You should feel under no pressure to be in the study. If you decide not to be in the study, that will not in any way harm your relations with your supervisors or the staff at (*name of nursing home*) and (*name of health care organization*). You are free to stop being in the study if you change your mind after entering it. This would not harm your relations with your supervisors or the staff at (*name of nursing home*) and (*name of health care organization*).

CONFIDENTIALITY:

To ensure your confidentiality your real name and any identifying material will be removed from the tape. All reports of the data or published materials will contain combined results only.

To maintain your confidentiality, the recordings will be transcribed and analyzed by Louise Murray. After transcription the recording will be destroyed and only the researchers will have access to the transcript. To further ensure confidentiality your real name and any identifying material will be removed from the transcript by Louise Murray and any written report will not contain your real name.

Participant initials _____

The records of this study will be kept private. In any sort of report we might publish, we will not include any information that will make it possible to identify you. Your record for this study may, however, be reviewed and/or photocopied by (*name of health care organization*), or by representatives of the Food and Drug Administration or other government agencies. To that extent, confidentiality is not absolute. Additionally, although other focus group participants will be asked not to divulge the information disclosed by their fellow participants, this can only be requested and not guaranteed.

AUTHORIZATION:
If you wish to take part in this study, you will be asked to sign this consent form. You have been told that personal information about you (including sensitive personal information, such as your racial/ethnic origin) and the data collected in the survey will be reviewed, collected on a computer database, stored in electronic or manual files, audited, and/or otherwise processed by: Louise Murray.

QUESTIONS
The researchers doing the study at [redacted] are Louise Murray under the supervision [redacted] at [redacted] and her dissertation committee at UNC Charlotte headed by Dr. John Gretes. You may ask Louise Murray any questions you have now. If you have questions later, you may contact Louise Murray at [redacted] and Dr. John Gretes at [redacted]

The Institutional Review Board is a group of people who review the research to protect your rights. If you have questions about the conduct of this study or about your rights as a research subject, you may call the chairperson of the Institutional Review Board of [redacted] for information regarding patients' rights in a research study. You can obtain the name and number of this person by calling _____.

This space left intentionally blank.

Participant initials _____

CONSENT

I have read the above information. I have asked any questions I had, and those questions have been answered. I agree to be in this study. Louise Murray will give me a copy of this form.

Participant Print Name	**Date**	**Time**
Participant Signature	**Date**	**Time**
Signature of Person Obtaining Consent	**Date**	**Time**
Investigator Signature	**Date**	**Time**

APPENDIX N: Family Members/Friends Interview Protocol

Age: _____

Gender: M ____ F _____

Ethnicity/Race: _____

Length of time your family member /friend has resided at (name of nursing home): _____(in months)

***Additional probing questions based on the survey data will be added as appropriate*

Warm-up Questions

1. How would you describe (name of nursing home) as a place to live?

Quality of Life

2. What are three or four things that you feel are absolutely essential for the residents living a good quality of life here at (name of nursing home)?*
3. What takes away from the residents living a good quality of life here at (name of nursing home)?*

Choice and Control

4. Do you feel that the residents have control over their everyday life here at (name of nursing home)?
    - If no:
        - what stops them making their own choices/decisions?
        - what areas of life here at (name of nursing home) do you think that the residents would like more control over?
    - If yes:
        - what things do you think help the residents to maintain control over their everyday lives?

Satisfaction

5. Overall, are you satisfied with the care at this facility?
6. What do you think is the best thing about living here for the residents?
7. What do you think is the worst thing about living here for the residents?

Concluding Question

8. Would you recommend (name of nursing home) to others?

*Questions developed by Guse and Masesar (1999).

APPENDIX O: Direct Care Staff Interview Protocol

Demographic Information

Age: _____ Gender: M ____ F _____

Ethnicity/Race: _____

Length of time you have worked at (name of nursing home): _____(in months)

***Additional probing questions based on the survey data will be added as appropriate*

Warm-up Questions

1. How would you describe (name of nursing home) as a place to live?

Quality of Life

2. What are three or four things that you feel are absolutely essential for the residents living a good quality of life here at (name of nursing home)?*

3. What takes away from the residents living a good quality of life here at (name of nursing home)?*

Choice and Control

4. Do you feel that the residents have control over their everyday life here at (name of nursing home)?
    a. If no:
        i. what stops them making their own choices/decisions?
        ii. what areas of life here at (name of nursing home) do you think that the residents would like more control over?
    b. If yes:
        i. what things do you think help the residents to maintain control over their everyday lives?

Satisfaction

5. What do you think is the best thing about living here for the residents?

6. What do you think is the worst thing about living here for the residents?

Concluding Question

7. Would you recommend (name of nursing home) as a place to work to others?

*Questions developed by Guse and Masesar (1999).

APPENDIX P: **Perceived Latitude of Choice Scale Questions.**

Hulicka, I. M., Morganti, J. B., & Cataldo, J. F. (1975). Perceived latitude of choice of institutionalized and noninstitutionalized elderly women. Experimental Aging Research, 1(1), 27-39.

1. Who to sit with at meals
2. What is served at meals
3. What time to eat meals
4. Who to have a snack or coffee with
5. Where to have a snack or coffee
6. What time to go to bed
7. What time to get up
8. When to have a bath
9. Where to see visitors or friends
10. When to see visitors or friends
11. When to watch TV
12. What TV programs to watch
13. Where to spend free time
14. With whom to spend free time
15. Who to have for friends
16. What clothes to wear
17. What type haircut to get
18. What to be called (first name, last name, nickname)
19. What hobbies to have
20. What to spend money on
21. Where to shop
22. Whether to associate with other people or not
23. Whether to offer suggestions to other people about how things are done
24. Who to complain to
25. Whether to attend religious services
26. What papers or books to read
27. How much personal privacy is available

28. Whether to work
29. Where to work
30. What type work to do
31. What personal possessions to have
32. Who to live with
33. Color of walls, pictures etc. in living quarters
34. Whether to have a private room
35. Whether to live at the same place or go elsewhere
36. Whether to go out (leave living quarters for a few hours)
37. Whether to participate in certain activities (games, sports, educational meetings, etc.)

APPENDIX Q: Nursing Home Administrators Qualitative Data Analysis

Category	Sub-Theme	Theme
Previous experience	Classes/seminars	Continuing Education
	Previous places of employment	Workplace
	Meetings/conventions	Continuing Education
Define culture change	Resident/staff experience	Resident/staff benefits
	Benefits for residents/staff	Resident/staff benefits
	Accommodate Choice	Resident benefits
	Move away from medical model	Resident/staff benefits
Benefits for residents	Quality of life	Quality of life
	Relationships between staff & residents	Relationships
	Holistic approach	Holistic approach
Challenges/implementation	Physical environment	Environment
	Need to fulfill regulatory requirements within the philosophy of care	Regulations and Philosophy
	Staff education	Education
	Staff Attitudes	Philosophy
	Move from task orientation to person orientation	Philosophy

Category	Sub-Theme	Theme
Challenges to sustaining	Providing constant, continuing education	Education
	Need to fulfill regulatory requirements within the philosophy of care	Regulations and Philosophy
	Provision of tools & education for staff	Education
	Staff turnover	Education
QOL	Choice	Choice
	Quality care	Quality care
	Relationships/community interaction	Relationships
	Dining	Choice
	Customer service	Relationships
	Good communication between staff	Quality care
Detracts QOL	Not home	Institutional living
	Communal living	Institutional living
	Regulations vs. autonomy	Institutional living
	Meals/dining	Meals/dining
	Physical environment	Environment
	Resident attitudes/adaptation	Institutional living
Choice and Control	Can be constrained by level of dependency	Functional/Physical Ability
	Resident council involvement	Resident Advocacy
	Staff empowerment of residents	Resident Advocacy

Category	Sub-Theme	Theme
	Balance between schedules and individuality	Institutional living
	Choice offered - meals/dining	Choice
Best	Choice/autonomy	Choice
	Quality of care	Quality of care
	Dining Program/choices	Choice
	Activities program	Choice
	Privacy	Choice
Worst	Behavior of other residents	Behavior of other residents
	Bathing	Bathing
	Not being at home	Institutional living
	Adaptation to communal living	Institutional living

APPENDIX R: Resident Qualitative Data Analysis Nursing Home A

Category	Sub-Theme	Theme	Frequency
Quality of Life	Freedom/Choice to do what wants	Freedom/Choice	(1)
	Care received	Quality of care	(1)
	Relationships with other residents	Relationships	(1)
	Activities	Faith	(1)
	Religious activities	Activities	(2)
	Activities outside the facility	Activities	(2)
	Freedom to come and go as I please	Freedom/Choice	(2)
	Attitude/acceptance	Attitude	(1)
	Functional ability/independence	Functional ability	(1)
	Relationships with family and friends	Relationships	(2)
	Faith	Faith	(2)
	People	Relationships	(3)
	Positive attitude	Attitude	(2)
	Friends with others	Relationships	(4)
	Able to speak up	Self-advocacy	(1)
	Being able to confide in people	Relationships	(5)
	Feeling of safety	Safety	(1)
Detracts Quality of Life	Food	Food	(1)
	Location away from family and friends	Location	(1)
	Behavior of other residents	Behavior other	(1)

Category	Sub-Theme	Theme	Frequency
		residents	
	Things going missing	Security	(1)
	Logistics of care	Logistics	(1)
	Physical condition	Physical ability	
Choice and Control	Yes		(4)
	To a certain extent		(2)
Helps to maintain	Have my faculties	Cognitive Ability	(1)
	They allow me freedom	Freedom in schedule	(1)
	Independence to make health care decisions	Independence to make health care decisions	(1)
	Faculties	Cognitive ability	(2)
	Advocate for self and others	Self-advocacy	(1)
	No one tells me you can't	Freedom in schedule	(2)
	Functional independence	Functional ability	(1)
	Attitude	Attitude	(1)
	Faith	Faith	(1)
	Staff encouragement	Relationships	(2)
	Advocate for self	Self-advocacy	(2)
Satisfied with care	Yes		(5)

Category	Sub-Theme	Theme	Frequency
	Mostly		(1)
Best	Safe because of medical needs	Safety	(1)
	Relationships with staff	Relationships	(1)
	Relationships with residents	Relationships	(2)
	Feeling of safety	Safety	(2)
	Staff	Staff	(1)
	Location	Location	(1)
Worst	Food	Food	(1)
	Noise in facility	Noise	(1)
	Food - menu variability	Food	(2)
	Food	Food	(3)
	Staff not turning up for work	Staff absences	(1)
	Behavior of other residents	Behavior of other residents	(1)
Recommend to others	Yes		(6)

APPENDIX S: Resident Qualitative Data Analysis Nursing Home B

Category	Sub-Theme	Theme	Frequency
Quality of Life	No responsibilities	Freedom from responsibilities	(1)
	Care/Security	Quality of care	(1)
		Security	(1)
	Activities	Activities	(1)
	Company on activities	Relationships	(1)
	Physical/functional ability	Physical/ functional ability	(1)
	Cognitive ability	Cognitive ability	(1)
	Make friends with other residents	Relationships	(2)
	Relationships with staff	Relationships	(3)
	Activities	Activities	(2)
	Food	Basic necessities	(1)
	Sleep	Basic necessities	(2)
	Going out	Activities	(3)
	Religion	Faith	(1)
	Able to smoke when wants	Basic necessities	(3)
Detracts QOL	Need to adapt to rules & regulations	Rules & regulations	(1)
	Loss of independence of home - Rules & regulations	Rules & regulations	(2)
	Physical/functional ability	Physical/ functional ability	(1)
Choice and Control	Yes		(3)
	Yes but limited by ability	Limited	(1)

Category	Sub-Theme	Theme	Frequency
	Yes but limited by privacy – communal living	Limited	(2)
Helps to maintain	Speaks up when necessary	Resident self-advocacy	(1)
	Activities/time alone	Choice	(1)
	Staff	Relationships	(1)
	Outlook on life in general	Attitude	(1)
	Faith	Faith	(1)
Satisfied with care	Yes		(5)
Best	Lack of Responsibilities	Freedom from responsibilities	(1)
	Activities – independence with care	Activities	(1)
	Medical/preventative care	Quality of care	(1)
	Feeling of coming back home	Feels like home	(1)
	Relationships with other residents	Relationships	(1)
Worst	Noise – other residents	Noise/Behavior other residents	(1)
	Restricted mobility	Restricted mobility	(1)
	Not enough opportunity to get out	Not enough opportunity to get out	(1)

Category	Sub-Theme	Theme	Frequency
Recommend to others	Yes		(4)
	Care		(1)
	Food		(1)
	Activities		(1)

APPENDIX T: Direct Care Staff Qualitative Data Analysis

Category	Sub-Theme	Theme
NH Place to live	Lack of privacy	Environment
	Empowering relationships between staff and residents	Relationships
	Relationships promote control/choice	Relationships
	Dual role – rehab and long-term care	Role
Quality of Life	Choices/autonomy	Choice
	Choice = respect given by caregivers	Caregivers
	Compassion of caregivers	Caregivers
	Empathy for their situation	Caregivers
	Safety	Safety
	Nutrition	Nutrition
	Home-like environment	Environment
Detracts QOL	Time with staff	Caregivers
	Loss of functional ability	Functional ability
	Behavior of other residents	Other residents
	Compatibility of room mates/Adaptation to	Other residents
	Physical ability/care	Functional ability
Choice and Control	Encouragement but resident choice	Resident self-advocacy
Prevents Choice and Control	Cognitive ability	Cognitive ability
	Ability to voice opinions	Self-advocacy

Category	Sub-Theme	Theme
Helps to maintain	Cognitive ability/attitude	Cognitive ability
	Peer support – relationships – staff support	Relationships
	Ability/comfort to express wishes	Self-advocacy
More Choice and Control	Shared space	Environment
	Activities	Activities
Best	Decreased responsibility	Decreased responsibility
	Relationships	Relationships
Worst	Food – accommodating all preferences	Food
	Isolation for those with high levels of dependency	Isolation

APPENDIX U: Family Members/Friends Qualitative Data Analysis

Category	Sub-Theme	Theme
NH Place to live	Quality of care – rehab - staff	Quality of care
	Caring staff	Staff
	Atmosphere	Atmosphere
	Good care	Quality of care
	Resident interaction	Atmosphere
	Independence	Environment
	Residents feel as if it is their home	Environment
	Differences between neighborhoods	Atmosphere
	Well laid out for residents needs	Environment
	CNAs	Staff
Quality of Life	Staff	Staff
	Diverse activities	Activities
	Resident empowerment	Empowerment
	Staff-resident interactions	Staff
	Community interaction	Community
	Foods	Food
	Outside activities	Activities
	Activities	Activities
	Environment	Environment
Detracts QOL	Logistical constraints - lifts	Logistics
	Menu choices	Menu
	Staff	Staff
	Staff empowerment	Empowerment

Category	Sub-Theme	Theme
Choice and Control	Cognitive ability - able to voice opinions – staff understanding	Staff support
	Involved in culture change process – environmental decisions	Empowerment
	Individual choices e.g. meals	Choices - meals
	Able to make rooms their own	Choices - rooms
Prevents Choice and Control	Unable to voice opinions	Unable
Helps to maintain	Forum for residents to voice opinions	Forums
	Activities - options	Activities - options
	Rooms - personalization	Personalization
More Choice and Control	Activities outside the facility	Activities
	Food.	Food
Best	Consistent staff	Staff
	Low turnover	Staff
	Quality of care	Care
	Beautiful facility	Facility
	Variety and # of activities	Activities
	Philosophy of making facility home-like	Philosophy
	Attracts visitors/volunteers	Environment
Worst	Lack of independence leading to admission	Lack independence

Category	Sub-Theme	Theme
	Care has to be there	Care
Recommend to others	Rehab services	Rehab
	Versatility	Care
	Facilities/lay out of the facility	Environment
	Staff willingness to accommodate individual interests/needs	Staff/care