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Abstract

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A DESCRIPTIVE STUDY OF NURSING HOME ORGANIZATIONAL CULTURE,
WORK ENVIRONMENT AND CULTURE CHANGE FROM THE PERSPECTIVES
OF LICENSED NURSES

Jennifer Lyn Bellot

A DISSERTATION

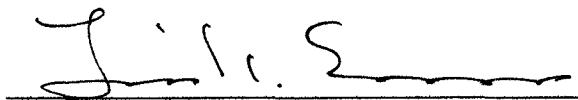
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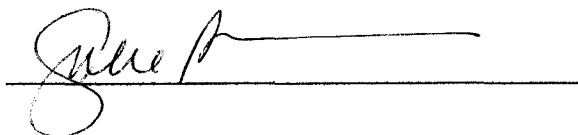
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In Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy

2007



Supervisor of Dissertation



Graduate Group Chairperson

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Jennifer Lyn Bellot

2007

A mis queridos chicos:

*Los amaré por siempre,
Mucho me gustan,
Por toda mi vida,
Mis chicos serán.*

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ABSTRACT

A DESCRIPTIVE STUDY OF NURSING HOME ORGANIZATIONAL CULTURE, WORK ENVIRONMENT AND CULTURE CHANGE FROM THE PERSPECTIVES OF LICENSED NURSES

Jennifer Lyn Bellot

Dissertation Chair: Lois K. Evans

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A Descriptive Study of Nursing Home Organizational Culture, Work Environment and
Culture Change from the Perspectives of Licensed Nurses

CHAPTER ONE

INTRODUCTION

In 2004, 1.4 million people occupied beds in more than 16,000 nursing homes in the United States. That same year, nursing home expenditures totaled over \$115 billion, with over \$70 billion financed by government funding sources (National Center for Health Statistics (NCHS), 2006). Moreover, the Institute of Medicine (IOM) projects that the aging of American baby boomers will “have a major effect on the demand for and supply of long-term care services and on the resources needed to provide these services” beginning in the year 2011 (IOM, 2001, p. 2). A combination of publicized reports of poor care and neglect, high cost of care and the aging of the population have led to heavy governmental regulation of nursing homes. Nursing home quality remains a considerable concern to administrators, advocates, payers, residents, consumers, clinicians and researchers.

Traditionally, American nursing homes have provided “total institutional living” for the elderly and disabled. Under this paradigm, there was little consideration for residents’ preferences for care. Meals and activities were not individualized; staffing was organized by shift and ward, reminiscent of a hospital acute care environment. In the mid-1980s, the institutional paradigm of the nursing home began to shift. The nursing home was redefined as a provider of both health *and* social services. Resident

involvement, choice, and physical, mental and psychosocial functioning became primary concerns of nursing home care.

To facilitate this paradigm shift, many nursing home facilities have implemented culture change initiatives. There is no universal, operational definition for culture change and these initiatives vary in content and approach. Generally, culture change has been referred to as a movement to re-organize and deinstitutionalize nursing home care. Culture change can include multiple initiatives that involve staff, residents and/or the physical environment and usually are designed to promote individualized care and recognition of the resident as a unique individual, support residents to make decisions and put the resident's needs and preferences before the task (Robinson & Rosher, 2006).

The Wellspring Program, founded in 1994, is unique to other culture change initiatives in that it simultaneously “focuses on both clinical care and organizational culture change, with a high degree of interaction between these two core concepts” (Reinhard & Stone, 2001, p. 5). Wellspring is one of the oldest and most evaluated culture change initiatives in nursing homes. The Wellspring Program has been fully implemented in 35 facilities in Wisconsin, Maryland, Washington, D.C., North Carolina and South Carolina.

Beginning research has shown that it is not simply quality improvement programs directed at resident care that beget successful culture change in the nursing home environment (Anderson, Corazzini & McDaniel, 2004; Anderson, Issel & McDaniel, 2003). Rather, it is a combination of factors, within the context of optimal organizational culture, that produce ideal implementation of culture change initiatives (Anderson &

McDaniel, 1999; Banaszak-Holl & Hines, 1996; Bond & Fiedler, 1999; Reinhard & Stone, 2001). Nursing care itself should be a substantial component of any action, either organizational or resident-directed, in nursing homes. Yet, the organizational culture--or those patterns of basic assumptions which have been invented, discovered or developed in learning to cope with the problems of external adaptation and internal integration (Schein, 1987)--is not well understood within the context of a culture change initiative. Licensed nurses play a critical role in implementing culture change programs and their perceptions regarding organizational culture and work environment are integral to understanding culture change. This study was designed to explore licensed nurses' perceptions of organizational culture and work environment, as well as their perceptions of factors that influence the adoption of a specific culture change initiative, the Wellspring Program.

Using an adaptation of the Quality Health Outcomes Model (Mitchell, Ferketich & Jennings, 1998; Appendix A) as a guide, a descriptive qualitative study was conducted to answer the following questions:

- What are licensed nurses' perceptions of organizational culture and work environment in the presence of a culture change initiative?
- What are licensed nurses' perceptions of those factors of organizational culture and work environment that influence the adoption of a culture change initiative in nursing homes participating in the Wellspring Program?
- In what ways do the perceptions of licensed nursing staff regarding organizational culture and work environment illuminate their perceptions of and experiences with the implementation of a Wellspring culture change initiative?

The scope of this study was limited to formal long term care provided in the traditional United States skilled nursing facility (hereafter to be called "nursing home")

for the disabled and/or elderly resident. Because nursing homes employ Licensed Practical Nurses (LPNs) as well as Registered Nurses (RNs) to deliver, direct and manage care, both types of licensed nurses were included in this study.

Conceptual Framework

Little research has been published regarding the formal evaluation of culture change initiatives in the nursing home. The larger field of health services research, however, has developed the area of organizational evaluation and research over several years. The most common framework for assessing health care organizations is based on Donabedian's (1966) structure/process/outcomes work. Structure refers to "attributes of material resources (such as facilities, equipment, and money), of human resources (such as the number and qualifications of personnel), and of organizational structure (such as medical staff organization, methods of peer review, and methods of reimbursement)" (p. 1745). Process is "what is actually done in giving and receiving care" and outcomes are the "effects of care" (Donabedian, 1988, p. 1745). While most of nursing home evaluation research has been built upon this paradigm, most studies have lacked a conceptual framework that is tailored to the nursing home environment. Few researchers have provided conceptual frameworks for defining nursing home quality (Glass, 1991; Patrick, 1997; Noelker & Harel, 2001; Rantz, et al. 1999, 2004b; Unruh & Wan, 2004).

This study used an adapted framework originally developed by Mitchell and colleagues (1998; Appendix A). Although the original Quality Health Outcomes Model was not specific to the nursing home setting, it was based upon the structure/process/outcomes paradigm and has been validated in several studies. Mitchell

and colleagues adapted Donabedian's model to create one that is non-linear, dynamic and explicitly shows the interactions between structure, process, outcome and client factors. This multi-factor influence is reflected in the Wellspring Program's philosophy of simultaneously altering several aspects of care and care delivery.

Significance

Most nursing home quality research has been completed using large data sets, limiting the ability to recognize each facility's unique characteristics. In order to study closely the environment of the nursing home, careful attention is needed to characterize accurately the individual structures and processes involved in nursing home care. Before large-scale evaluation and generalization can be made, it is imperative to understand more fully the phenomena of organizational culture, work environment and culture change at an individual facility level.

Further, it has been noted anecdotally that licensed nursing staff can be one of the greatest impediments to implementing large-scale culture change programming (T. Lohuis, personal communication, August 9, 2005; J. Rabig, personal communication, November 20, 2005, Rabig, Thomas, Kane, Cutler & McAlilly, 2006). Little published research was found that examined licensed nurses' roles, experiences or effects on culture change. Thus, this study sought to study nursing homes individually, through licensed nurses' perspectives and in the presence of a formal culture change initiative.

Given their round-the-clock presence, nurses are in a unique position to affect resident outcomes. This inquiry identified, from the perspectives of licensed nurses, the characteristics of organizational culture and work environment that influence the

adoption of culture change initiatives. Findings from this study have the potential to influence practice and the establishment of an optimal organizational culture and nursing care structure within the nursing home.

The concept of organizational culture is important and applicable across health care settings. Although the results of this study were specific to the participant nursing homes' experiences, the methods and themes in this study have potential for application in future culture change studies. This study will be useful to the participating nursing homes and the Wellspring Program, providing an in-depth examination of the perspectives of licensed nurses and those factors that influence adoption of the Wellspring Program.

CHAPTER TWO

REVIEW OF THE LITERATURE

This chapter presents a review of the literature regarding the development of nursing home care, organizational culture and culture change, prominent culture change programs and nurses and organizational change. Gaps in extant knowledge are discussed. The review of the literature and variables for this study were guided by an adapted version of the Quality Health Outcomes Model (Mitchell, Ferketich & Jennings, 1998). The adapted model may be found in Appendix A.

Development of Care in the Nursing Home

Nursing homes have not always had a clearly defined place in the American health care system. Prior to 1935, the infirm elderly were cared for by family members within the home. Those without caregiver resources generally resided in almshouses. These institutions for the poor, mentally ill and elderly offered little in the way of health care provision and primarily functioned as custodial homeless shelters. Care outside the home for the infirm elderly became more commonplace in the mid-20th century in response to two large federal programs, the Social Security Act of 1935 and The Hill Burton Act of 1946.

Federal oversight in nursing homes was solidified after the 1965 initiation of the Medicare and Medicaid programs, which continue to fund a large portion of nursing home care today (Maas, Buckwalter & Specht, 1996). Dunlop notes that Medicare and Medicaid funding changed nursing homes from simply custodial environments to medical facilities, following a medical model of care (1979, p. 69). At this time the primary goal

of a nursing home shifted from custodial to medical, reflecting a physical environment and functions not unlike the heavily regimented ward activities found in the acute care hospital (Dunlop, 1979).

In the 1970s and early 1980s, a series of widely-publicized books provide an in-depth look at the nursing home environment for the first time. Published in 1975, Jaber Gubrium's ethnography, *Living and Dying at Murray Manor*, painted a thorough picture of the operations in a typical nursing home of the time. While this study was not overtly critical in nature, it emphasized a lack of free will and meaningful activity for residents of the nursing home. Shortly thereafter, in 1979, Carobeth Laird published *Limbo: A Memoir about Life in a Nursing Home by a Survivor*, a personal narrative describing her time spent in a nursing home. Laird added a different dimension to media reports and popular conceptions of the nursing home in the 1970s that detailed stories of poor care and neglect. She stated "If you expect a tale of horror, of filth and overt cruelty, read not further. This does not purport to be a sensational exposé of nursing home conditions. It is instead an account of one person's effort to hold onto sanity and identity in an atmosphere which was, by its very nature, dehumanizing" (Laird, 1979, p.1). Laird's text shed new light on the nursing home by depicting this environment as a lived experience, from the perspective of a former nursing home resident. Her account further emphasized and illuminated the lack of free will and meaningful activity detailed in Gubrium's book.

The 1970s marked an era that "[did] not require assessment of the quality of care being *delivered*; rather [required] assessment of the facility's *structural capacity* to provide care" (Institute of Medicine, 1986, p. 70, emphasis added). At that time, quality

simply referred to possessing the proper organizational attributes and resources to provide medical care, regardless of their use or outcome. In this sense, quality was determined solely using proxy structural measures, rather than including nursing care processes or resident outcomes.

At a time of increased attention toward quality concerns and outcomes research development in the nursing home, Bruce Vladeck published *Unloving Care: The Nursing Home Tragedy*, in 1980. In his text, Vladeck contributed to advancing the notion of a nursing home as a living environment, rather than a medical care institution, stating, “The ‘medical model’ in nursing homes is less appropriate than irrelevant. There is precious little medicine practiced in most nursing homes” (p. 155). Large-scale environmental changes did not occur in the majority of nursing homes, however, for almost another decade.

In 1986, the Institute of Medicine addressed the nursing home industry and its associated regulatory policies. The resulting report, *Improving the Quality of Nursing Home Care*, marked the beginning of watershed changes in nursing home quality assessment. First, and perhaps most important, the IOM defined the goals of the nursing home as providing both health *and* social services. Resident involvement, choice, and physical, mental and psychosocial functioning were listed as the primary concerns of nursing home care. While still omitting an explicit conceptualization of quality in the nursing home, the IOM advocated for a strong federal regulatory presence that based certification and reimbursement on a set of outcome and process indicators of quality of care and quality of life. Many of these indicators were resident-centered, although others

related to facility characteristics (IOM, 1986). The IOM's work suggested that the goals of a nursing home were different and extended beyond medically-based goals common to acute care.

Since the late 1980s, the research teams of Robert and Rosalie Kane have promulgated the notion that long term care, especially nursing home care, includes aspects of both health and social services (Kane & Kane, 1987). Beginning in the mid-1990s nursing home research started to adopt this conceptualization by incorporating quality of life concepts. In 1994, Burgio and colleagues reported a paradigm shift in long term care from a medical/custodial environment to a social-behavioral and rehabilitative focus. Taking a cue from the field of medical sociology, which began to address the emergence of quality of life as the major criterion for evaluation of health intervention (Levine, 1987), the IOM produced another report in 1996, this time clearly framing the nursing home as a health and social program, where quality of life concerns are essential to proper evaluation (IOM, 1996).

The most recent Institute of Medicine commentary on quality in the nursing home, *Improving the Quality of Long Term Care* (IOM, 2001), suggested that nursing home services be structured as consumer-centered, rather than provider-centered. The IOM took the stance that a consumer-centered approach to nursing home care is more likely to emphasize quality of life issues for the resident. In a response to the multiple definitions of nursing home quality found in the literature since the adoption of the Nursing Home Reform Act of 1987 (NHRA), the IOM attempted to meld quality of care and quality of life into one, comprehensive measure of nursing home quality:

A consumer-centered approach to long term care would necessitate a fundamental shift in the approach to determining and evaluating the quality of care... The *definition* of quality of care would need to be expanded beyond health and safety outcomes to include outcomes such as quality of life and autonomy. The *measurement* of consumer-centered care would be incorporated as a complement to those of patient health and safety, and effectiveness and efficiency of care. Outcomes and other indicators of the quality of care likewise would need to be extended from traditional clinical health assessment to include consumer reported experiences of care, processes of care, satisfaction with care, as well as consumer self report of the achievement of health outcomes and quality of life goals specified in a care plan (2001, p. 31).

Additionally, the 2001 report underscored the importance of differentiating appropriate care goals, outcomes and quality measurements of the nursing home from those of acute care. Moreover, the report reiterated that long term care includes both health and social care aspects. Although this report offered little in the way of providing a concrete framework for quality measurement, it did pay more attention to aspects of quality of life than did the previous literature. Unlike the 1986 report, the 2001 report did not yield additional regulation or federal involvement regarding quality of life aspects of the nursing home. The Center for Medicare and Medicaid Services has funded a large demonstration project to investigate the possibility and practicality of measuring and improving quality of life for the nursing home resident.

This brief look at the evolution of nursing home care and regulation shows how the nursing home has emerged from a medicalized, institutional environment to one that aims to integrate health and social aspects of care and living. As well, the nursing home literature consistently states that nursing home quality is multidimensional, inclusive of quality of care *and* quality of life elements. The concept of nursing home care has evolved as the industry has evolved. The most recent Institute of Medicine (IOM, 2001)

report regarding nursing home quality marked a distinct shift in the conceptualization of nursing home care, highlighting the social dimensions and quality of life implications found in consumer-directed, or resident-centered, nursing home care. As the overall conceptualization of the nursing home has changed, so have its environment and the thoughts and beliefs of nursing home staff, resulting in a shift in organizational culture.

Organizational Culture

Drawing from the traditions of three different disciplines, the definition of organizational culture is complicated by disagreements regarding what it should and should not include and how best to assess it. Although many theorists in the 1980s advanced the conceptual understanding of organizational culture, a select group has dominated the majority of culture research. Further, it is widely accepted that there is no singular, correct definition of culture. Van Maanen and Barley (1985) state, “The term ‘culture’ is powerfully evocative, but it does not come from anthropology as an intact structural package ready to serve as a paradigmatic foundation on which to build the analysis of organizations” (p. 57).

Through the continued work and conceptual development of such scholars as Edgar Schein, Mats Alvesson and Benjamin Schneider, some consistency of thought has arisen. A loose consensus of principles has guided much of the recent organizational culture inquiry (Siehl & Martin, 1983; Druckman, Singer & Van Cott, 1997).

Organizational culture exists.

Although this first tenet may seem simplistic, it took years of inquiry and theory to arrive at this conclusion that organizational culture exists. This debate is intimately

related to the next tenet of culture.

Cultures are inherently fuzzy in that they incorporate contradictions, paradoxes, ambiguities and confusion.

Throughout the development of the concept of organizational culture, it has been recognized that culture is not a surface phenomena. Rather, it is “infused with symbols and symbolism” (Druckman, Singer & Van Cott, 1997, p. 69) and is “undetectable most of the time” (Cameron & Quinn, 1999). The lack of tangibility and potential for confusion and inconsistency lend to complex assessment of the construct. This thought paradigm is more involved than the positivist tradition of business research, thus necessitating greater conceptual development.

Organizational culture is socially constructed, the product of groups not individuals, and based on shared experiences.

A core belief of organizational culture researchers is the group nature of the construct. Theorists have used this property to distinguish organizational culture from other, similar constructs, and to differentiate methods from previous work in organizational climate. Culture provides an organization’s members with a framework for understanding and making sense of their work environment and experiences (Siehl & Martin, 1983).

Each organization’s culture is relatively unique, malleable and subject to continual change.

Central to this tenet was the debate over whether culture is something an organization *has* or something that an organization *is*. Originally, anthropological scholars relied on their disciplinary traditions and asserted that organizations *were* cultures in

themselves (Rousseau, 1990). Additional research, however, has led to relative consensus that culture is a *property* that the organization possesses. Further, since culture is a possession, there is the sense that it can be controlled, or at the very least influenced and changed, by its members. Culture, therefore is developed over time and is not a static property. The assertion that culture is unique has led to some debate over how it is assessed. Generally, academic culture researchers believe that each organization's culture is distinct, although some instruments have demonstrated the ability to group cultures by broad themes. The notion that culture is malleable and subject to control was the attribute that was most attractive to corporate managers. Those who subscribed to this theory believed that molding organizational culture to an ideal form would thereby improve organizational output.

Although given this set of common agreements, there remain several accepted definitions of organizational culture used in the literature. Perhaps this is due to the epistemologic background or intent of the researcher. Most recent culture research either cites Schein's (1987) definition, or uses a derivation of his work. Schein's sociology roots and interest in the integration of new employees are apparent in his definition. Schein states:

Organizational culture is the pattern of basic assumptions which a given group has invented, discovered or developed in learning to cope with its problems of external adaptation and internal integration, which have worked well enough to be considered valid, and therefore to be taught to new members as the correct way to perceive, think and feel in relation to those problems...it is the assumptions which lie behind values and which determine the behavior patterns and the visible artifacts such as architecture, office layout, dress codes, and so on (1987, p. 383).

Schien's definition of organizational culture was used in this study.

Schein's characterization of organizational culture is divided into three levels (Schein, 1987). Schein describes artifacts as the most surface level of organizational culture. Artifacts are visible structures and processes of an organization. Schein's second level of organizational culture is values, the strategies, goals and philosophies of an organization. Schein states that values are less visible than artifacts. The final, and deepest, level of organizational culture is underlying assumptions. Schein defines underlying assumptions as the least evident, unconscious, taken-for-granted beliefs, perceptions, thoughts and feelings. These three levels were used to describe the organizational culture of each participant nursing home.

Assessing Organizational Culture

As the assessment of organizational culture has evolved and quantitative methods to measure it have gained popularity and acceptance, various instruments have been developed. It is important to note that some of these tools were developed for use by corporate consultants and were non-academic and atheoretical in content.

Most work on organizational culture concerns the traditional corporation. Therefore, some adaptation to the central goals and focus of a human services organization are necessary before application to a health care setting. Although not always explicit, it appears that Schein's conceptual work and theory have most influenced the study of organizational culture in health care. Schein is frequently cited as the conceptual reference for this inquiry. Sovie (1993) emphasized that health care organizations should be particularly concerned with organizational culture because "the shared beliefs, values,

and feelings that exist within an institution direct the perception of and the approach to the work that is to be done” (p. 72).

Two teams of researchers (Gershon, Stone, Bakken & Larson, 2004; Scott, Mannion, Davies & Marshall, 2003) have completed in-depth searches and evaluated tools used to measure organizational culture in the health care setting. Both teams reviewed biomedical literature via online databases and consulted with experts in the behavioral research field. Although most instruments were developed and published in the mid-1980s, Gershon and colleagues (2004) found that their application to health care was largely since the year 2000. Additionally, most studies were completed in hospitals and targeted nurses in their evaluations. They surmise that this could be in response to a 1999 Institute of Medicine report, *To Err is Human: Building a Safer Health Care System*, which advocated changing organizational culture in order to decrease medical error rates.

Gershon and colleagues also found, predictably, that terminology differed across instruments. Potentially, this contributes to the further confounding of assessment of organizational culture in health care settings. Reflecting frustration with the inconsistency of terms, the team stated:

If aspects of the organizational culture are ill-defined, frequently shifting, poorly communicated, not reinforced, and/or poorly supported administratively, both the employees’ collective perceptions *and their behaviors* (i.e., delivery of care, safe work practices, and teamwork) will be inconsistent (2004, p. 37, emphasis in original).

Gershon and team conclude, on the basis of reliability and validity, that the Organizational Culture Inventory (Cooke & Lafferty, 1986) is most appropriate for use in the health care setting.

A year previous to Gershon's article, Scott and colleagues (2003) performed a similar analysis of organizational culture instruments in health care. Scott et al. identified thirteen tools designed specifically to measure culture. Nine of these thirteen had been used in studies of health care environments. These researchers used Schein's conceptualization of organizational culture when analyzing each tool and only evaluated quantitative measures.

Rather than choosing one ideal instrument for cultural assessment, the team concluded "the choice of instrument should be determined by how organizational culture is conceptualized by the research team, the purpose of the investigation, intended use of the results and availability of resources" (2003, p. 923). In this way, the team's recommendations are appropriate to a wider set of applications for cultural assessment. Overall, however, Scott and colleagues devote a large portion of their concluding thoughts to advocating mixed methods. Citing their earlier work, Scott's team deemed it appropriate to study surface manifestations of culture with quantitative methods and follow up with assessment of underlying assumptions with qualitative technique. The team then provides examples of studies employing various types of mixed methods (e.g., Qualitative-quantitative versus Quantitative-qualitative). They determined that either order could be appropriate, depending on the goals of the study.

This dissertation study used Schein's (1987) definition of organizational culture, as it is the most commonly cited and inclusive of industry consensus. This study quantitatively measured organizational culture using the Organizational Culture Inventory (OCI; Cooke & Lafferty, 1986).

A concept closely related to organizational culture is social climate. Rudolf Moos has devoted his research career to identifying, assessing and analyzing various social climates. Social climate is defined as “the ‘personality’ of a setting or environment” (Moos, 1994, p. 2). Each setting has a unique personality, creating unity and coherence among its participants. Moos has developed a series of ten Social Climate Scales, designed to measure the social climate in a variety of settings from the military to the classroom to the workplace. Moos states, “The Scales give the people whom you help a framework for thinking about their environment,” essentially, a means to organize the patterns of basic assumptions employees form about the workplace (1994, p. 9). The scale used in this study, The Work Environment Scale (WES), measures the specific social climate of “work environment.” This instrument includes subscales designed to measure work environment during change -in the case of this study- culture change. The WES has been tested extensively in the health care environment.

Culture Change Movement in the Nursing Home

Following the passage of the Nursing Home Reform Act legislation (OBRA 1987), a series of quality improvement programs were implemented in nursing homes. By the mid-1990s, the culture change movement had begun to gain popularity. Culture change is distinguished from typical quality improvement activities in its attempt to simultaneously alter multiple aspects of care and caregiving in the nursing home. Culture change is so named because of its aim to adopt an entirely new philosophy in long term elder care; there is no universal operational definition of what constitutes culture change

programming (www.pragmaticinnovations.unc.edu). Culture change refers to the movement to re-organize nursing home care completely. Included under this umbrella are several different initiatives that address staff, resident, environmental or behavioral outcomes or some combination of these factors. Most culture change initiatives are focused upon resident-directed care, providing services that are directed by the strengths and preferences of the individual resident.

Minimal research has been done to evaluate various culture change initiatives; some models have been promulgated and replicated more than others, however. Lustbader (2001) notes that early culture change initiatives, although generally dedicated to the same principles of resident-directed care and home-like social structures, were unique from nursing home to nursing home. Despite the wide range of programming, Shields (2004) states that nursing homes that have engaged in culture change activities report less staff turnover, a stable administration and full occupancy.

In 1995, at a meeting of the National Citizen's Coalition for Nursing Home Reform (NCCNHR), a panel was convened of administrators whose nursing homes were engaged in culture change initiatives. This group grew in size and strength and became known as The Pioneer Network. Today, The Pioneer Network is an organization of facilities engaged in many diverse culture change initiatives, dedicated to a common set of values. These values include returning the locus of control to residents, enhancing the capacity of front-line staff to be responsive and establishing a homelike environment (Lustbader, 2001). Although many nursing homes have developed initiatives for reaching these

goals, the following sections will provide a review of the most prominent culture change models.

Prominent Culture Change Models

The Eden Alternative

The Eden Alternative originated in 1992 as a project of Bill Thomas, funded by the New York State Department of Health. Now a non-profit organization, The Eden Alternative states that by 2002, “there were over 7000 Eden Associates and more than 200 organizations which had joined The Eden Alternative organization and display its official seal” (Thomas, 2003, p.2). It is unclear what this means in terms of how many nursing home facilities have adopted fully the Eden model. Since its beginning, The Eden Alternative has undergone five major revisions, growing in complexity and scope with each. As Eden is revised, the founding principles of the initiative endure, while the techniques it suggests for implementation evolve with each revision (Thomas, 2003).

The Eden Alternative is predicated on the idea that the typical nursing home functions as a total institution, severely limiting the personal choices and lifestyle accommodations of the individual. Hence, Eden aims to improve quality of life for nursing home residents. The principles of The Eden Alternative emphasize the importance of meaningful activity, autonomy and decision-making, receiving as well as giving care and creation of a habitat inclusive of animal and plant life within the nursing home (<http://www.edenalt.com/10.htm>). The Eden Alternative also sponsors extensive training for nursing home professionals interested in implementing the initiative.

Little evaluative information can be found regarding The Eden Alternative, although there are a few testaments by individual organizations of the experience of implementation (Mackenzie, 2003; Monkhouse, 2003) or small-scale evaluations of one or two facilities. Ransom (2000) performed an evaluation study of seven Edenizing homes in Central Texas, finding reductions in behavioral altercations between residents, decubitus ulcers, bedfast residents, restraint use and staff absenteeism and increases in resident census and staff self-scheduling. Using a control and an Eden facility, Coleman and colleagues (2002) found, after one year, that the Eden facility had higher levels of resident falls, nutritional problems and lower functional status levels as well as higher levels of staff termination and turnover. Coleman's team states that qualitative observations "indicated that the change was positive for many staff as well as residents, suggesting that it may take longer than a year to demonstrate improvements attributable to the Eden Alternative" (p. 426). In 2004, Bergmen-Evans found that introduction of the Eden Alternative in one facility led to lower levels of boredom and hopelessness in residents, but showed no difference in levels of loneliness. Presently, a two-year evaluation of The Eden Alternative is being conducted at a Florida nursing home (<http://www.pioneernetwork.net/index.cfm/fuseaction/Initiatives.DocList/CategoryPK/Research.cfm>).

The Green House Project

Developed as a direct extension of The Eden Alternative, The Green House Project is based on many of the same founding principles, but with the idea that a more radical approach is needed to reinvent long term care. The Green House Project "is founded on

the idea that the physical and social environments in which we deliver long-term care can and should be warm, smart and green” (Thomas, 2003, p. 146). Emphasizing the Project’s vastly different approach, Green House administration point out that Green House is not a culture change initiative, but instead represents the “deinstitutionalization of the elderly” (J. Rabig, personal communication, November 20, 2005).

Green House facilities are small, housing six to eight residents at a time, and are architecturally designed as modified homes. Several houses are linked together into “neighborhoods,” with centralized administrative and clinical support resources. Green Houses are designed to deliver significantly higher nursing assistant hours per resident day than do typical nursing homes. Green Houses are served by a clinical support team consisting of nurses, a medical director, social workers, therapists, dieticians and an activities coordinator. The clinical support team is responsible for care planning, completion of the Minimum Data Set, delivery of clinical care and making regular visits to the Green House, behaving as guests rather than employees (Rabig, Thomas, Kane, Cutler & McAlilly, 2006). Nursing assistants are regarded as “universal workers” responsible for the direct care of residents as well as cooking, light cleaning and laundry. They report to an administrator, rather than to nursing staff, in contrast to the traditional nursing home hierarchy.

The first operating Green Houses were established in 2003. In an initial description and review, Rabig and colleagues (2006) report several challenges to Green House implementation. The research team noted significant resistance to the organizational redesign from licensed nurses. They reported that nurses were concerned about the new

roles for nursing assistants and, initially, insufficient numbers of nurses agreed to serve on the clinical support teams, necessitating additional hiring. Rabig and colleagues also found that more time and resources were needed to develop the roles of the clinical support team, but eventually many of the licensed staff became proponents of the Green House model. No specific data were provided about staff or resident outcomes, but the researchers reported lower nursing assistant absenteeism and turnover in relation to a comparison facility and no transfer-related injuries to staff. Additionally, the researchers noted that residents and families reported high levels of satisfaction with the privacy and comfort of the Green Houses.

The Wellspring Program

The Wellspring Program was initiated in 1994 in 11 not-for-profit, freestanding nursing homes in Wisconsin. The Wellspring Program is unique to other quality improvement initiatives in that it simultaneously “focuses on both clinical care and organizational culture change, with a high degree of interaction between these two core concepts” (Reinhard & Stone, 2001, p. 5). The Wellspring Program seeks to enhance the resident’s life through improving the quality of care while enhancing the quality of work life, focusing on front line workers, with the ultimate goal of creating a significant impact on resident quality of care and quality of life (www.wellspringis.org). The Wellspring Program promotes individualized care of the resident, teamwork and collaboration among all workers providing care, improving the skills and knowledge of all workers, accountability for care outcomes and “front-line decision making,” the empowerment of workers (licensed nurses and nursing aides) to make decisions regarding care at the

individual-resident level (Wellspring Program, unpublished promotional materials).

Wellspring consists of several components: The Alliance of facilities, clinical modules, Care Resource Teams, the Wellspring Coordinator, advanced practice nurses and the Wellspring Data System. Unless otherwise noted, the following descriptive information about the Wellspring Program was derived from www.wellspringis.org.

Wellspring nursing homes are organized into Alliances. An Alliance is a group of nursing homes that enter the Wellspring Program at the same time and are geographically proximal. The purpose of the Alliance is to facilitate regular facility meetings for sharing experiences and data concerning the Wellspring Program. Facilities are encouraged to abandon previous competitive behaviors and, instead, focus on ways to improve facility performance while working within the Wellspring Program. The Alliance structure is designed to sustain the Wellspring Program in the event of a change in facility leadership, a common barrier to culture change implementation. At present, there are four alliances: Charter facilities in Wisconsin, Mid-Atlantic Alliance (Maryland and Washington, D.C.), North and South Carolina Alliance and Greater Wisconsin Alliance. Facilities in this study are members of a single Alliance, each having been a part of the Wellspring Program since late 2003.

The Wellspring Program utilizes eight clinical modules, or learning packages of information (<http://www.wellspringis.org>). Clinical module training sessions are attended by several staff from each participating nursing home in the Alliance. The module sessions are held at regular intervals and repeated, with slightly different content, every two years. Clinical modules address clinical skills and knowledge, general

problem-solving abilities and leadership skills of participants. Using role-play, simulation and collaboration between facilities, participants learn how to implement culture change and changes in care in their facility.

The leadership module is the first module that is presented to all informal and formal leaders in the nursing home. This module is designed to develop leadership and independent decision-making skills of all staff and lays the groundwork for all further Wellspring implementation. In the leadership module, goals and markers for implementation of the Wellspring Program are defined. The remaining seven modules focus on clinical aspects of resident care. The modules are: The older adult, elimination, nutrition, falls/restorative, skin care, well-being and palliative care. These modules are evidenced-based and derive content from extant research, Agency for Healthcare Research and Quality best practice guidelines, American Medical Directors' Association guidelines and federal mandates. Sample forms for data collection are included for each module.

Clinical modules are presented to a Care Resource Team (CRT) of individuals selected by each nursing home. The CRT becomes the organizational resource for the clinical module content in each respective nursing home. The CRT is responsible for designing an implementation plan for the clinical module, suggesting organizational changes as needed and evaluating the success of the implementation. Each CRT is linked to a member of their facility's management team and it is expected that CRTs will be representative of employees from all worker groups and departments involved with the implementation of each clinical module. Additionally, the CRTs from each facility meet

regularly to update modules, share experiences and improve practices (Reinhard & Stone, 2001).

Each nursing home has a Wellspring Coordinator who is responsible for managing all Clinical Resource Teams. Although the specific responsibilities of the Wellspring Coordinator vary between nursing homes, the core responsibilities are the same. The Wellspring Coordinator is responsible for overseeing all Wellspring implementation activities including creating and maintaining CRTs, identifying necessary organizational changes to ensure the success of the Wellspring Program, managing the logistics of preparing and staffing the CRTs and clinical module attendance and serving as the official liaison between CRTs and management staff.

At least one advanced practice nurse (nurse practitioner or clinical nurse specialist) serves as an expert consultant to the Alliance regarding development of systems of care, data collection and interpretation and staff development. Like the Wellspring Coordinator, the advanced practice nurse is also a liaison between direct care staff (licensed nurses as well as nursing assistants) and each nursing home's management team regarding the development of systems of care and creation of an environment that is supportive of Wellspring Program culture change. Additionally, the advanced practice nurse serves as an expert consultant and educator for each clinical module and is available as a consultant to each nursing home in the Alliance.

The final aspect of the Wellspring Program is the Wellspring Data System. In addition to teaching each nursing home how to collect quality improvement data, Wellspring provides a data system. My InnerView is a web-based data system that

collects information regarding resident quality of life and quality of care, family satisfaction, state survey results, employee commitment and financial health of the nursing home. Participating in My InnerView data collection and sharing these data are required elements of the Wellspring Program.

Wellspring is one of the oldest and most evaluated culture change initiatives in nursing homes. With funding from The Commonwealth Fund, Stone and colleagues (2003) published a large-scale evaluation of Wellspring. Although results from this study were mixed, the majority of findings supported the Wellspring Program as an innovative and successful program of culture change. Findings indicated that Wellspring facilities have “higher immunization rates, fewer bedfast residents, lower restraint usage, more preventive skin care, fewer psychoactive medications, less resident incontinence (and) fewer tube feedings” than comparison homes (Kehoe & Van Heesch, 2003, p. 169). Further, after implementation, Wellspring homes had fewer state survey deficiencies and higher nursing staff retention rates than peer facilities (Kehoe & Van Heesch, 2003).

This study was conducted in Wellspring facilities for several reasons. First, Wellspring is one of the most mature and most evaluated culture change programs in nursing homes. Although results from Stone & colleagues’ 2003 study were mixed, the majority of findings supported the Wellspring Program as an innovative and successful program of culture change. Additionally, Wellspring simultaneously focuses on both clinical improvement and organizational culture change, unique in the area of culture change. Lastly, Wellspring administration has been eager to participate in several evaluative activities, including this dissertation study.

Nurses and Organizational Change

Although some evaluative research has been done on the various culture change programs, less research has been done regarding the relationship between organizational change and the health care provider. Most research in this area is either about the implementation of the organizational change itself or the management of the change process, rather than focused on the experience of the recipients of change. Kim and Kim (1996) looked at individual and nursing unit characteristics and their relationship to nurses' willingness to adopt a computer charting innovation. While the computer innovation is different than large-scale culture change, this study did examine the individual nurse's response to change. Measuring willingness to adopt an innovation, self-efficacy and cooperativeness, the study found that nurses reporting high levels of self-efficacy were more willing to adopt an innovation. Additionally, these results were clustered by nursing unit, noting that units with high levels of nurse self-efficacy were more likely to be supportive of the innovation.

Wallin and colleagues (2005) studied the staff experiences associated with the implementation of Kangaroo Mother Care on a neonatal unit. Using focus groups, the research team interviewed staff from two control and two intervention units. The study found that successful change was most impacted by actively involved leadership and the perception that staff actions were perceived to positively influence patients' well-being.

Organizational Change

Organizational change research is well developed and theoretically based, although little research in this area has been done in the health care setting. Generally, it is well

recognized that employees are stakeholders in maintaining the established organizational culture, as this provides maximum stability and clarity of expectations (Baronas, 1991; Singleton & Nall, 1984; Curtin, 1999). Therefore, change often produces resultant stress, uncertainty and role ambiguity (Hardy & Conway, 1988; Singleton & Nall, 1984; Schoolfield & Orduna, 1994; Lavoie-Tremblay, Bourbonnais, Viens, Vezina, Durand & Rochette, 2005). This discomfort is thought to be a coping mechanism of employees and often presents a primary barrier to enacting widespread organizational change (Robinson, 1991).

More recent research on organizational change in health care recognizes the importance of understanding the complexity of the change process. Ross and colleagues (2005) highlight the importance of understanding the context within which change is occurring in order to fully analyze the impact and sustainability of organizational change. Further, Pettigrew and colleagues (1992) list a supportive organizational culture as a critical and necessary element to successful service change in health care organizations. These studies further emphasize the need to examine organizational culture as well as nurses' experiences of change in order to understand fully its implementation.

Although it is recognized that the thoughts, beliefs and attitudes of employees are critical to implementing and to maintaining workplace change and innovation, most health care research in this area to date is theoretical or directed at management strategy, rather than the employee themselves (Examples: Baronas, 1991; Broome, 1990; Davidhizar & Bowen, 1990; Lukacs, 1984; Bice, 1990; Massey, 1991). One exception is a mixed methods study by Evans, Barstow, Hostvedt, Scalzi and Ratcliffe (2004) that

examined organizational culture in three traditional nursing homes and three that had engaged in structured culture change activities. It was determined that true embedding of changed values in an organization may take longer than 18 months, the length of time the culture change facilities had been engaged in their intervention. Full results of this study await publication.

Gaps in Knowledge

A search of Medline, CINAHL, Ageline and HealthStar databases yielded few studies on nurse or staff perceptions or experiences related to workplace change. Most studies concerning change provided management and planning strategies or were concerned with the patient outcomes associated with change. Change researchers have noted that few studies examine the recipients of change, those who implement and experience the organizational changes they did not initiate (Bartunek, Rousseau, Rudolph & DePalma, 2006; Balogun & Johnson, 2004; George & Jones, 2001). Further, change recipients are “often cast as resistant without further probing” (Bartunek, Rousseau, Rudolph & DePalma, 2006; Kuhn & Corman, 2003; Oreg, 2003). Personal communications with administration and implementation staff from both Wellspring and Green House initiatives note that the biggest barrier to culture change implementation is “direct care staff, particularly the licensed nurses” (J. Rabig, personal communication, November 20, 2005). No explanation was provided for this comment, and there seems to be little information regarding why licensed nurses may be resistant to participate in culture change.

The culture change movement in nursing homes is growing in popularity. Recently, research has begun to systematically evaluate culture change initiatives. All of this research is directed, however, at nursing home leadership and administration. A search of Medline, CINAHL, AARP Ageline and Ovid Healthstar databases yielded no research that focused on the experience or perceptions of licensed nurses involved in culture change. Rather, those works that did address care staff concerned evaluation or proposal of strategies to disseminate education or reduce turnover. No articles were found that examined the nurses' perspectives. It is critical that the nurses' experiences of culture change is understood because nurses monitor, direct, manage and deliver the majority of care provided to nursing home residents. The optimal way to gauge the experience and efficacy of culture change initiatives is to assess nursing staff directly, rather than rely solely on administrative data. Scott-Cawiezell (2005) emphasizes the need to explore, understand and influence nursing home culture as "often, it is the deep-seated assumptions, values, and norms of the nursing home that preclude new learning and the adoption of new beliefs" (p. 204). There is a gap in the literature regarding the nurse experience of culture change.

CHAPTER THREE

METHODOLOGY

Study Design

The purpose of this study was to explore, from the perspectives of licensed nursing staff, the experience of culture change in nursing home facilities participating in the Wellspring Program. A mixed methods design using qualitative description was the most appropriate to illuminate licensed nurses' experiences of culture change and perceived aspects of organizational culture that influenced the implementation of culture change. By definition, qualitative description involves no variable manipulation or hypothesis testing. Rather, it is a "comprehensive summary of events in the everyday terms of those events" (Sandelowski, 2000, p. 336). Licensed nurses from two nursing home sites were included in order to provide more compelling and robust results and to reduce the possibility of outlier cases (Yin, 1989).

Data collection was sequential Quantitative-Qualitative, with surveys followed by selected interviews. Data from surveys and interviews were weighted equally; therefore, results from one were not given more value over results from the other. Analyses of quantitative (OCI and WES surveys) and qualitative data were completed at the same time, so that survey results would not influence the researcher during the conduct of interviews. Mixed methods and data triangulation "provid(ed) an enlarged contextual and procedural framework within which to analyze and interpret the data, thus, increasing the understanding of the phenomenon being studied" (Tashakkori & Teddlie, 1998, p. 56).

In this study, quantitative survey data were used to identify licensed nurses' perceptions of their nursing home's organizational culture in the presence of a culture change initiative. A demographic form was also completed by each licensed nurse respondent. Qualitative interview data provided descriptions of licensed nurses' perceptions of those aspects of organizational culture that served as factors influencing the adoption of a culture change initiative in their nursing homes. Interview data were used to characterize the organizational cultures and allowed the researcher to probe more deeply into the perspectives, values and judgments of licensed nurses. Gaining this understanding would have been more difficult using a strictly quantitative design. Additional data regarding characteristics of each nursing home were obtained from a combination of field notes, direct observation, consultation with each nursing home's Director of Nursing and/or human resources contact person, the Wellspring Program Chief Executive Officer or Nursing Home Compare, a federal database of compulsory information reported by each Medicare and/or Medicaid certified nursing home in the United States (<http://www.medicare.gov/NHCompare/Home.asp>).

As discussed by Jick (1979), triangulation of data uncovered organizational factors affecting care delivery and resident outcomes. Triangulation was beneficial to data analysis because data from more than one measurement source was used to capture more fully the nurses' perceptions of culture change (Jick, 1979). Additionally, comparing findings from more than one source of data illuminated consistencies and inconsistencies in participant interpretations of a given phenomena (Patton, 2002).

Settings

All nursing home administrators in one state of the Mid-Atlantic Alliance of the Wellspring Program (N=9) were approached for participation. The study was limited to Wellspring nursing homes in a single state to minimize the potential for geographic variability, a principal factor explaining differences in cost and quality in nursing home research (HCFA, 2000). Confining participation to a single Alliance also assured that participating facilities had entered the Wellspring Program near the same time and were exposed to the same amount of formal training and evaluation.

In order to gain access to nursing home sites, the researcher first initiated contact with the Chief Executive Officer of Wellspring Innovative Solutions, Incorporated. When the CEO approved the study design, a series of emails and telephone calls transpired between the researcher, CEO and administrators of the Mid-Atlantic Alliance. The purpose of these communications was to introduce the study and create a plan to contact and request access to individual nursing homes. The researcher traveled to the Mid-Atlantic administrative headquarters and presented the study to Mid-Atlantic nursing home administrators. After this meeting, the researcher continued to communicate with administrators via a series of e-mail, telephone and letter exchanges. Once two administrators agreed to allow access to licensed nurses from their nursing homes, a letter of agreement from each was obtained.

Sampling Procedures and Sample Characteristics

Inclusion Criteria and Sampling Procedures

Licensed nursing staff in each of the participating nursing homes were eligible for participation if their primary job involved working in the nursing home for more than 20 hours per pay period (≥ 0.25 FTE). Working less than 20 hours per pay period was judged by the researcher as having too little contact and experience to make conclusions regarding the organizational culture of the nursing home and/or judgments about Wellspring implementation. Provided that they met the minimal work time requirements, agency staff who were licensed nurses consistently working within the nursing home were eligible for participation.

This study was designed as an exploratory analysis. Thus, the researcher first sought to survey the *entire* cohort of eligible licensed nurses employed at each nursing home in order to obtain information and perceptions from the population. The N of eligible participants was 49 in Facility One and 33 in Facility Two. Overall, there were 47 respondents, for a total response rate of 57%. Facility One's response rate was 55% (n=27) and Facility Two's response rate was 61% (n=20).

On the consent for participation form distributed with survey packets, respondents had the option to agree to be contacted for an interview. Interview participants were purposefully chosen using intensity sampling in order to select "information-rich cases that manifest the phenomenon of interest intensely (but not extremely)" (Patton, 2002, p. 234). Using intensity sampling to select purposively those licensed nurses with maximum exposure to the implementation of the Wellspring Program, preference was

given to interviewing those licensed nurses who had been employed at the given nursing home for the greatest length of time since the initiation of the Wellspring Program. This information was determined from responses on the demographic form accompanying each survey. Lincoln and Guba (1985) state, “In purposeful sampling...the sampling is terminated when no new information is forthcoming from new sampled units; thus *redundancy* is the primary criterion” (p. 202, emphasis in original). No formal sample size calculations were necessary due to the exploratory nature of this study (S. Ratcliffe, personal communication, November 29, 2005).

Once all completed and returned surveys were in the possession of the researcher, a spreadsheet of participants who were willing to be interviewed was compiled. These respondents were listed in order of their tenure at each nursing home. Of the 47 nurses who returned survey packets, 35 indicated willingness to be interviewed. Of these, the 14 with longest tenure were selected, taking care to include a mix from each nursing home, shift, primary job responsibility and RN/LPN license. Thirteen interviews were completed by the time data saturation had been reached. Due to time, practicality and cost constraints, interviews were concluded. Site and sample characteristics are presented in Chapter Four.

Study Variables and Instruments

A comprehensive chart of study variables, definitions and measurement tools can be found in Appendix B.

Organizational Culture

This study employed Schein's definition of organizational culture, the most commonly used in organizational culture measurement. Schein states that:

Organizational culture is the pattern of basic assumptions which a given group has invented, discovered or developed in learning to cope with its problems of external adaptation and internal integration, which have worked well enough to be considered valid, and therefore to be taught to new members as the correct way to perceive, think and feel in relation to those problems...it is the assumptions which lie behind values and which determine the behavior patterns and the visible artifacts such as architecture, office layout, dress codes, and so on (1987, p. 383).

Organizational culture was measured using the Organizational Culture Inventory (OCI; Cooke & Lafferty, 1986). The OCI is a 120 item instrument that uses a Likert scale ranging from 1 (not at all) to 5 (to a very great extent). Cronbach's alpha for the entire OCI instrument was calculated to be 0.74 in this study.

The OCI has twelve subscales, or cultural norms, which represent "general patterns of work-related behaviors and attitudes" (Human Synergistics, 2003, p. 3). Cultural norm scores were calculated by adding the Likert scores from each of the ten survey questions for that particular subscale. Results for an entire respondent group were calculated by finding the median value of each cultural norm for all participants. Subscale scores can range from ten to fifty. Cronbach's alpha coefficients for each cultural norm are reported by the manufacturer to range from 0.65 to 0.95 (Human Synergistics, 2003). Table 3-1 defines each cultural norm subscale as well as its calculated Cronbach's alpha value for this study.

Table 3-1: *OCI Cultural Norm Definitions*

	OCI Cultural Norm	Employee expectations	Cronbach's alpha
Constructive	Achievement	Set challenging but realistic goals, establish plans to reach those goals, pursue goals with enthusiasm	0.841
	Self-Actualizing	Enjoy work, self-development, take on new and interesting activities	0.828
	Humanistic-Encouraging	Supportive, constructive and open to influence in dealing with others	0.917
	Affiliative	Friendly, cooperative and sensitive to the satisfaction of the work group	0.953
Passive/Defensive	Approval	Agree with, gain the approval of and be liked by others	0.866
	Conventional	Conform, follow the rules and make a good impression	0.823
	Dependent	Do what they're told, clear all decisions with superiors	0.723
	Avoidance	Shift responsibilities to others, avoid any possibility of being blamed for a mistake	0.900
Aggressive/Defensive	Oppositional	Critical, oppose the ideas of others, make safe (but ineffectual) decisions	0.744
	Power	Take charge, control subordinates, yield to the demands of superiors	0.822
	Competitive	Operate in a "win-lose" framework, work against their peers	0.888
	Perfectionistic	Avoid mistakes, keep track of everything, work long hours to attain narrowly-defined objectives	0.786

Note. Cronbach's alpha reported for this study only.

The OCI also categorizes organizational cultures into three broad types: Constructive, Passive/Defensive and Aggressive/Defensive. Each organizational culture type is comprised of four of the cultural norms, or subscales. Overall cultural styles were computed by first transforming the respondent group's median raw score of each cultural norm to a percentile, using normative sample data. Then, the percentiles of the four cultural norms in each cultural style were averaged. The largest mean represented the prevailing cultural style. No reverse scoring was necessary for any of the items in the OCI.

Each culture type reflects how much the organization emphasizes a concern for people versus a concern for task and satisfaction versus security. Constructive cultures are defined by their emphasis on achievement, self-actualizing, humanistic-encouraging and affiliative norms, and “encourage their members to interact with *people* and approach *tasks* in ways that will help them to meet their higher-order *satisfaction* needs” (Cooke & Szumal, 2000, p. 148, emphasis in original). Passive/Defensive cultures emphasize approval, conventional, dependent and avoidance norms. Passive/Defensive cultures “encourage or implicitly require members to interact with *people* in ways that will not threaten their (employees’) own personal *security*” (p. 148, emphasis in original). Aggressive/Defensive cultures encompass oppositional, power, competitive and perfectionistic norms. These cultures “encourage or drive members to approach *tasks* in forceful ways to protect their status and *security*” (p. 148, emphasis in original). Cronbach’s alpha scores were computed for each cultural style to indicate reliability. In

this study, the Constructive style had an alpha value of 0.944, the Passive/Defensive style had an alpha of 0.829 and the Aggressive/Defensive style had an alpha level 0.825.

The OCI has been used for many purposes and is the most widely used industry tool for measuring organizational culture. It had been completed by over 2 million participants worldwide as of the year 2000 (Cooke & Szumal, 2000). Since this tool has been used widely, a large information base exists on organizational culture.

The OCI was derived from many organizational culture studies using factor analysis. Sub-constructs of the OCI have been empirically supported and validated by numerous studies (Cooke & Rousseau, 1988; Cooke & Szumal, 1993; Xenikou & Furnham, 1996). The normative sample of the OCI is composed of many different organizations of different sizes and industries. It has been “used extensively in the health care field” (C. Perry of Human Synergistics International, personal communication, January 10, 2007). At least one study has used the OCI to measure organizational culture in the nursing home (Evans, Barstow, Hostvedt, Scalzi & Ratcliffe, 2004).

The OCI has demonstrated consensual validity, construct validity and criterion validity (Ashkanasy, Broadfoot & Falkus, 2000). In further psychometric testing, the OCI has demonstrated internal consistency, interrater reliability and test-retest reliability on all constructs and forms using data provided by 4890 respondents (Cooke & Szumal, 1993). Further, inter-rater reliability is represented with F scores ranging from 1.32 to 4.10, with all scores, at minimum, significant at the $p < .05$ level. Construct validity of the scales is demonstrated with robust factor analysis. Criterion-related validity is supported as “all significant correlation coefficients are in the expected direction” (Cooke

& Szumal, 1993, p. 4-21). The widespread use and extensive psychometric testing of the OCI make it an attractive option for researchers investigating organizational culture.

Work Environment During Culture Change

Work environment during culture change was measured using the Work Environment Scale. Moos' measurement of work environment using the Work Environment Scale (WES; Moos, 1994) captures most of the same concepts recognized as comprising organizational culture, yet it is semantically different and conceptually slightly dissimilar. According to Moos, "The Scales give the people whom you help a framework for thinking about their environment," virtually a means to organize the patterns of basic assumptions about the workplace (1994, p. 9). Integral to this study, the WES is designed specifically to measure the environment *in the presence of change*.

The WES is a 90 item instrument that uses paired true/false responses. Its ten subscales are categorized into three domains: Relationships (involvement, peer cohesion, and supervisor support), Personal Growth (autonomy, task orientation and work pressures) and System Maintenance and Change (clarity, control, innovation and physical comfort). The subscales "measure the extent to which employees know what to expect in their daily routines and how explicitly rules and policies are communicated; the extent to which management uses rules and pressures to keep employees under control; the degree of emphasis on variety, change and new approaches; and the extent to which the physical surroundings contribute to a pleasant work environment" (Moos, 1994, p. 3). Each of the ten subscales are comprised of nine items and are scored as 1=true and 0=false. In this study, surveys were hand-scored and subscales were computed by summing the

appropriate items and summed totals ranged from 0-9. Scores for the entire cohort were calculated by finding the mean of all respondent scores for each subscale. Table 3-2 contains the definitions of the WES subscales and the calculated Cronbach's alpha for each in this study.

Table 3-2

WES Subscale Definitions and Cronbach's Alphas

WES Subscale	Description	Cronbach's alpha
Involvement	Extent employees are concerned about and committed to their jobs	0.792
Peer Cohesion	Degree of friendliness and support among employees	0.746
Supervisor Support	Extent management is supportive of employees and encourages them to support each other	0.819
Autonomy	How much employees are encouraged to be self-sufficient and make independent decisions	0.832
Task Orientation	Degree of emphasis on good planning, efficiency and getting the job done	0.814
Work Pressure	Degree to which high job demands and time pressure dominate the job milieu	0.846
Clarity	Whether employees know what to expect daily; How explicitly rules/policies are communicated	0.811
Managerial Control	How much management uses rules/policies to control employees	0.827
Innovation	Emphasis on variety, change, new approaches	0.744
Physical comfort	Degree physical surroundings contribute to a pleasant work environment	0.775

Note. Cronbach's alpha reported for this study only.

The Work Environment Scale was developed by Moos as part of a larger group of social measurements. Moos bases his work on the supposition that "work environment

influences employee mood, behavior, and social, personal and intellectual development,” thereby establishing the link between employee perceptions of the work environment and organizational culture (Moos, 1994). In this study, the WES was used to supplement the findings of the OCI. The WES contains subscales that regard system management and change dimensions (innovation, clarity, managerial control), which provided more detail regarding licensed nurses’ perceptions of the workplace in the context of culture change.

The WES was chosen for this study because it uses employee perceptions to characterize reactions to change. Moos developed another scale specific to the nursing home setting. This scale required input from nursing home residents, inconsistent with the design of this study. No studies have been found that used the WES in the nursing home setting, but it is valid and reliable across a range of health care settings. Validity has been established in multiple studies (Moos, 1994) and findings support construct, concurrent and predictive validities of the entire instrument (Staten, Mangalindan, Saylor & Stuenkel, 2003). Moos (1994) reports Cronbach’s alpha scores for the WES subscales ranging from .76 to .86.

Factors that Influence Adoption of Wellspring Program Culture Change

Licensed nurses’ descriptions of the aspects of organizational culture that influence the adoption of the Wellspring Program were determined during qualitative interviews. Interviews were conducted with a subset of licensed nursing staff within each nursing home, using the researcher as instrument (Speziale & Carpenter, 1999). Licensed nurses with the longest tenure working in their respective nursing home were targeted for participation in interviews. The semi-structured interview guide (Appendix C) was

comprised of closed and open-ended questions constructed by the researcher, based on theory and previous research regarding organizational culture and culture change. Since the quantitative surveys were designed to capture nurses' perceptions of organizational culture and culture change, interview questions focused upon the factors that influence culture change. As well, questions were designed to address anecdotal and interpretive gaps not satisfied by quantitative data. The interview guide was consistent with a qualitative descriptive framework, designed to provide a "comprehensive summary of events in the everyday terms of those events" (Sandelowski, 2000, p. 334). In order to ensure completeness and appropriate wording of questions, the interview guide was developed in consultation with an expert qualitative researcher.

Probes were used to clarify a point or to prompt the interviewees to elaborate on an issue. The interview format was semi-structured, allowing the researcher to maintain control of the interview while leaving room for contributions from the participants. For the purposes of confidentiality, participants were not addressed by name during the interview and no reference was made to the participating facility. With the exception of an interview with an agency staff member that was short (14 minutes), interviews were 22 to 47 minutes in length, averaging approximately 25 minutes. The researcher wrote memos of initial thoughts and impressions of the interview data immediately upon completion.

Nursing Home Characteristics

Nursing home ownership, age of plant, tenure of Medicare license, tenure of current administrator, tenure of current Director of Nursing, nursing hours per resident day (RN

and LPN), number of licensed beds and number of licensed nurses employed were determined initially using Nursing Home Compare (<http://www.medicare.gov/NHCompare/Home.asp>), then confirmed and/or supplemented by the Director of Nursing and/or Human Resources contact in each nursing home. A copy of the nursing home characteristics form may be found in Appendix D. Information concerning each nursing home's entrance and participation in the Wellspring Program was gathered from the Chief Executive Officer of Wellspring Innovative Solutions, Incorporated. This information was used to provide a more descriptive picture of each nursing home. Although information regarding state inspection survey results were publicly available in Nursing Home Compare, the researcher deliberately did not collect this information in an effort to avoid bias in data analysis.

The researcher's observations of each nursing home were recorded as observational data during and after each site visit. The researcher used Schein's three levels of organizational culture to provide a framework for describing observations.

Licensed Nurse Characteristics

A demographic form was included within each survey packet (Appendix E). The purpose of the demographic form was to provide background information on each licensed nurse respondent and the respondent's experience with long term care practice and culture change. Each demographic form contained a personal and nursing home identifier code. The nursing home identifier indicated the nursing home in which the respondent was employed. Personal identifiers were used to help identify those respondents with longer tenure who were then targeted for interview participation. Other

information on the demographic form included gender, age, type of license held (RN or LPN), tenure as a licensed nurse, tenure as a licensed nurse working in long term care, tenure as a licensed nurse working in current nursing home, employment status, usual shift worked, general job description and highest attained level of nursing education.

Data Collection

Procedures

After securing agreement from the administrator, the researcher identified a key gatekeeper who served as a principal contact and facilitated entry into each nursing home. In both facilities, the gatekeeper was the Director of Nursing. The Director of Nursing at Facility One arranged for the researcher to attend a meeting of the nurse managers one month prior to the commencement of data collection to present the study, answer questions and set a mutually convenient schedule for data collection. After a number of attempts by telephone and email, the Director of Nursing at Facility Two was reached and agreed that the format and schedule developed with Facility One would work for Facility Two as well. The researcher was unsuccessful, however, in scheduling any advance meetings with management or staff at Facility Two. The researcher also identified a contact person in each nursing home's human resources department to provide a list of nursing staff meeting inclusion criteria for the study as well as the location where each nurse worked.

In an attempt to alert nurses to the study, recruitment posters and small candies were placed throughout the nursing home where nursing staff would be most likely to see them. Upon arrival at the facilities, the researcher noted recruitment posters on the doors

of managerial offices (both facilities), at the time clock (Facility Two) and at all nurses stations (both facilities). Each time the researcher entered the nursing home, she notified either the Director of Nursing or the nursing supervisor on duty of her presence. In both facilities, leadership staff were accommodating to the researcher's presence, and often offered to give a tour, provide a list of nursing staff working at that time or facilitate introductions. During each visit to a nursing home as well as during each interview, the researcher recorded field notes to document observations, thoughts and feelings.

Over a period of one week, the researcher visited each shift (day, evening, night) at each nursing home a minimum of two times. The researcher wore professional, non-clinical clothing and a nametag that identified her affiliation with the University of Pennsylvania. The researcher systematically visited each floor in the nursing home and approached each nurse who was working. A brief overview of the study was given and the researcher referred to the recruitment posters found throughout the nursing home. Each nurse meeting the inclusion criteria was invited to take a survey packet. Survey packets included a cover letter, consent form, demographic form, Organizational Culture Inventory (OCI) and Work Environment Scale (WES) surveys, pencil and a small candy. If they chose to participate in the study, nurses were directed to return surveys in a sealed envelope to a large, locked box located centrally in each nursing home.

The researcher found it necessary to emphasize repeatedly that her affiliation was independent of the nursing home, corporate structure or the Wellspring Program. Once nurses realized that the researcher was a nursing student, most appeared interested and willing to participate in the study. Only two nurses (of 82) refused to take a survey

packet. Whenever a nurse agreed to take a survey packet, he or she was reminded that surveys were to be completed during non-work hours.

At the conclusion of the week, the researcher left several survey packets with the Directors of Nursing for distribution to nursing staff not previously encountered by the researcher. One week after the initial week of daily visits, the researcher returned to both facilities. The researcher removed surveys that had been completed and distributed \$15.00 gasoline gift cards to those nurses who had participated. The researcher also brought donuts and cookies to each nursing home as a thank you and to help maintain awareness of the study by nursing staff. The researcher also re-visited each floor to recruit additional nursing staff and replaced the original recruitment posters with posters reminding nurses that one week remained to complete surveys. At this time, the researcher also worked diligently to ensure that all nurses whom she had not encountered during previous visits received a survey packet and were offered the opportunity to participate. One week later, the researcher returned, collected the remaining surveys and lock boxes, distributed gift cards and removed all study-related posters and materials from the nursing home.

Upon receipt of the survey packets, the researcher first checked all consent forms for completeness and noted if respondents had indicated willingness to participate in an interview. The researcher then located the demographic forms for those respondents indicating willingness and targeted those with the longest tenure within their respective nursing homes. Over the following six weeks, the researcher telephoned these respondents on a rolling basis. All respondents chosen to participate in interviews had

been employed at their nursing home for the entirety of the Wellspring Program. The researcher then returned to the facilities to complete interviews that were scheduled at the convenience of each interviewee. Facility One reserved a small, private conference room for all interviews. Facility Two offered the use of a conference room, but at the times of the interviews, the manager on duty was either unable to locate the correct key, the lock was broken or the room was in use. Therefore, various small and private locations (break room, courtyard, chapel) were used to conduct interviews at Facility Two. All interviews were completed outside scheduled work time, often directly before or after an employee's scheduled shift. Due to time and practicality concerns, three interviews were conducted over the phone. All interviews were audio recorded. Immediately upon completing each interview, participants were given an additional \$25.00 gasoline gift card. Interviews were concluded when data saturation was reached as determined by ongoing review of audiotapes.

Data Analysis and Interpretation

The collection of quantitative data preceded the interviews. Once survey packets had been returned, only demographic data were processed to determine those respondents who would be contacted for interviews. Further analysis of quantitative data (OCI and WES surveys) was completed at the same time as the analysis of qualitative interview data to help ensure that the results from quantitative surveys did not bias the researcher during one-on-one interviews.

Quantitative Data

Descriptive statistics of respondents' demographic data were tabulated, both for the total respondent group as well as by nursing home. Using descriptive characteristics, the researcher determined how demographically representative respondents were compared to all licensed nurses working within each nursing home. Demographic data about respondents also were compared between nursing homes and between total respondents and the interviewee sub-sample.

The OCI data were entered, cleaned, cross-checked by hand and individual cultural norms were computed by Human Synergistics, Incorporated. Missing data were coded as missing and not included in any subscale or style totals. Per Human Synergistics, Incorporated, scale computation is precluded if greater than twenty percent of the items are missing. There were very few missing items from the sample, however, and all scales were computed for all respondents. The OCI data were not normally distributed, therefore the researcher calculated median values for each cultural norm. The cultural norm scores were compared to normative sample percentiles "based on the distributions of raw scores for 5,685 respondents (from 921 different organizational sub-units) in Human Synergistics' research sample" (Human Synergistics, 2003, p. 86). Organizational culture styles were then determined based on cultural norm scores. Scores from this study then were compared to an available dataset of professionals from three nursing homes that had undergone culture change to determine if scores were similar when the organizational setting was similar.

The researcher hand-scored the WES surveys. The WES was scored twice and double entered into SPSS to compare results for discrepancies. As with the OCI, missing data were entered as “missing,” but there were very few missing values. No values were imputed. Subscale means were calculated for the entire sample and compared against a normative sample of 4,879 employees working in the health care field (Moos, 1994).

Qualitative Data

Throughout data collection, the researcher maintained field notes of her impressions of each nursing home environment and its employees as well as memos regarding emerging themes, repetition of themes and issues needing further action. The researcher also maintained a reflexive journal, bracketing personal opinions in order to distinguish them from interpretations of the interviews. Data analysis began during each interview, with the researcher recording memos. Memos were used to identify initial impressions, to note repetition and issues needing follow-up and to bracket personal opinions. Following each interview, the researcher listened to recordings multiple times, concurrent with scheduling and conducting additional interviews, in order to determine when the point of data saturation had been attained.

A hired transcriptionist, independent of this project and any of its participants, transcribed each interview. After transcription, the researcher listened to the recordings again, comparing them against the transcripts for accuracy and emotional or vocal content that was not reflected in the pure written word transcription, revising transcripts as necessary. Upon completion of transcript revisions, recordings were destroyed and the transcriptionist was instructed to delete all electronic files. In order to ensure

confidentiality, each interviewee was given a numerical identifier representative of personal identity and nursing home. The researcher also removed all proper nouns and potential identifiers from each transcript and created a pseudonym list.

Transcripts were entered into Atlas.ti software. Data analysis began with a first, holistic reading of each interview in order to gain a sense of the whole and immerse the researcher in the data. At this time, the researcher wrote comments within the Atlas.ti software to summarize the text and note any initial thoughts and impressions as well as to become more familiarized with the data. Second, interviews were read line by line and codes were established. The researcher continued to make notes of her impressions, thoughts and initial analyses, creating additional categories that were reflective of more than one key thought, concept or code. Simultaneously, codes were defined. Ultimately, codes were grouped and clustered by relation and links to each other, resulting in the formation of three overarching categories. A table detailing the steps of qualitative analytic activities may be found in Appendix F.

The researcher used conventional content analysis in order to identify and to conceptualize the key elements of factors that influence Wellspring Program culture change implementation. Conventional content analysis is most often used to describe a phenomenon when existing literature on that phenomenon is limited (Hsieh & Shannon, 2005). The key advantage to using conventional content analysis is the ability to gain information from respondents without imposing predetermined codes and ideas (Hsieh & Shannon, 2005). A disadvantage to using conventional content analysis is the potential for decreased trustworthiness and authenticity of data. In order to maximize the veracity

in each interview, the researcher worked diligently to establish confidentiality and respect with each interviewee.

Following analysis of the qualitative data, the qualitative and quantitative results were examined in totality. The researcher viewed statistical findings of the OCI and WES as well as codes and categories from interview data to look for consistency and/or contradiction of findings. The researcher then identified in what ways the survey data illuminated licensed nurses' perceptions of and experiences with the implementation of a Wellspring culture change initiative that were detailed in interviews.

Methodological Rigor

This study used mixed methods in order to fully examine, from different sources, the factors that influence culture change from the perspective of the licensed nurse. Using more than one method provided a richer picture of this phenomenon than using survey or interview data alone. Triangulation of data also increased the trustworthiness and confirmatory validity of this study.

In order to maximize the dependability and confirmability of data analysis and results, the researcher must allow readers to "evaluate the adequacy of the analysis through following the decision-making processes of the researcher" (Holloway and Wheeler, 2002, p. 255). A meticulous audit trail was maintained in order to provide a template for other researchers seeking to perform similar inquiry in other settings (Speziale & Carpenter, 2003).

Every effort, through the use of a reflexive journal and memos, was made to minimize researcher bias. Because this study was interpretive, it is inherent that a small amount of

bias will occur. Throughout the interviews, the researcher periodically paused to summarize or paraphrase the interviewee's words in order to confirm that the "interpretation is a true and fair representation of their (interviewee's) perspective," assuring credibility (Lincoln & Guba, 1985).

The researcher participated in regularly scheduled qualitative peer review group meetings with other qualitative researchers. The purpose of the qualitative peer review group was to review the researcher's codes and analyses done by the researcher for consistency, dependability and neutrality, serving as external validation and contributing to the truth-value of results and determination of data saturation (Guba, 1981). Group members were considered "co-analysts" and the peer group was instructed by two seasoned qualitative researchers. The qualitative peer review group also monitored the audit trail of decisions and analyses made by the researcher to ensure confirmability and objectivity. Additionally, the researcher met regularly with a qualitative data expert consultant in order to review analyses and conclusions.

Accuracy of Quantitative Data

The researcher hand-entered demographic and WES data into an SPSS file, establishing accuracy by using double entry, then comparing data sets to ensure all entered data were the same. Organizational Culture Inventory surveys were sent to Human Synergistics, Incorporated, which compiled the raw data, computed subscales and returned a cleaned and double entered data set in Excel and SPSS format to the investigator. Interpretation guides provided for both instruments were used to assist with data analysis.

Confounders

There were two potential confounders of the validity of nurse reporting. Since data collection involved more than one method, the data respondents reported during interviews may have been influenced by exposure to surveys. To minimize the influence the surveys may have had upon the interviews, effort was taken for interviews to focus on different, although related, subject matter concerning the factors that influence nursing home culture change. Further, all interviewees had been subjected to the same survey packet prior to interviews, assuring that any bias would be in the same direction.

Second, both survey and interview data were subject to recall bias from nurse participants. The interview, particularly, asked nurses to recall the organizational culture of the nursing home before and throughout Wellspring implementation. In order to capture the most accurate description of the nursing home's organizational culture throughout Wellspring implementation, various lead-in questions and prompts were used to cue the memory of the interviewees.

Ethical Considerations

Consent Procedures

Approval was obtained to execute this study under the supervision and standards of the University of Pennsylvania Institutional Review Board. This study inflicted no harm upon the licensed nurse or nursing home. Participants were informed at the time of consent that the de-identified findings from this study may be published. Agreement to return to each nursing home to present findings of the dissertation study after its deposit

was reached with nursing home management. Thus, participants will be given the opportunity to hear the results of the study. Every effort was made to ensure a representative sample of interviewees. Aside from candies and gift card compensation, there were no direct benefits to participation.

Before each stage of data collection the researcher reviewed the study with participants, explaining the risks and benefits of participation. A copy of the consent form may be found in Appendix G. Potential participants were advised that they could elect not to answer any survey or interview questions that they were uncomfortable answering. Each interviewee was reminded that all information would be kept confidential and that they could cease participation at any point without penalty. The hired transcriptionist deleted all transcripts from electronic hardware and software as soon as the researcher verified the transcripts for accuracy. All final transcripts were kept in a locked file and maintained in the researcher's possession. Since no resident data were used in this study, provisions of The Health Information Portability Assurance Act (HIPAA) did not apply.

Potential Risks and Risk Minimizing Precautions

The principal risk to participants was a breach in data confidentiality. Both surveys and interviews were de-identified and a code was used in place of proper name identification of the nurse participant. Facilities, as well, were given an identification code in place of using proper names. This removed the possibility of punitive or retaliatory action against nurse or nursing home if adverse results were determined. No attempt was made during data analysis to disclose the identity of the nurse participant or

nursing home. The list of participant identities and corresponding codes was kept in the possession of the researcher, separate from data, at all times. During the data collection phase, surveys were stored in a locked box in a centralized location. There was no evidence that the security of the locked boxes was breached during this study.

All data and consent forms were kept separate and within the possession of the researcher in locked files at all times. The computer used to analyze, store and report data was password-protected and accessible only by the researcher.

Anticipated Benefits

It is estimated that completion of surveys took approximately 20 minutes; interviews lasted an average of 25 minutes. In order to compensate participants for this time, gift cards for gasoline were given for each level of participation: \$15.00 for survey completion and \$25.00 for interview participation. Participation in this study provided an opportunity for nurses to voice opinions regarding an important innovation in long term care. Additionally, nursing home administrators will benefit from participation since the researcher will return to present study findings, providing insight into the nurses' experiences with Wellspring implementation. Finally, findings will be useful to the Wellspring Program and potentially to other culture change initiatives, providing an in-depth description of nurses' experience of culture change. This analysis will help future adopters design a culture change transition plan. The findings from this project will help to advance the understanding of nurses, organizational culture and culture change, since little to no formal evaluation of organizational culture or culture change has been done

from the nursing perspective. The benefits from participation in this study outweighed the risks.

Gender and Minority Inclusion

Due to the small sample size and potential for identification by demographic information, race and ethnicity data were not requested on the demographic form. Since survey data were sought from the entire licensed nursing staff, the sample was assumed to be representative of licensed nurses employed in nursing homes located in a large, metropolitan, East Coast area. Although interview participants were purposefully chosen on the basis of maximum tenure, effort was taken to see that the interview sample was representative of the demographic characteristics of the entire licensed nurse workforce of each nursing home.

Participation of Children and Older Adults

Since the study sample consisted of licensed nurses, no participants were under the age of 18. The State of Maryland does not offer nursing licensure to minors. Due to the typical retirement age of 65 years, it was unlikely that any of the nurse participants would be over the age of 70 years; in fact, the oldest reported age of a respondent was 63 years.

Summary

This mixed methods study examined nursing home organizational culture and culture change from the perspectives of licensed nurses in the presence of the implementation of the Wellspring Program. Data were collected from researcher observation, the Organizational Culture Inventory, the Work Environment Scale, demographic forms and interviews. All eligible licensed nurses were sought for participation in the survey

portion of this study. Intensity sampling was used to target for interview those licensed nurses with maximum tenure at their facility. Descriptive statistics were used to analyze quantitative data, while content analysis was used to examine qualitative data.

CHAPTER FOUR

RESULTS

In this chapter, results of the study are reported. The chapter begins with a demographic description of the participating nursing homes and licensed nurse respondents. This is followed by presentation of quantitative and qualitative data, organized by the three research questions.

Demographic Characteristics

Characteristics of Participating Nursing Homes

Information regarding the characteristics of participating nursing homes was obtained initially from Nursing Home Compare (<http://www.medicare.gov/NHCompare/Home.asp>), then supplemented and/or confirmed by the Director of Nursing or human resources contact person within each nursing home. Table 4-1 provides information on the characteristics of each participating nursing home. Data are intentionally non-specific to preserve the anonymity of the participating facilities.

Table 4-1: *Demographic Description of Participating Nursing Homes*

	Facility One	Facility Two
Bed size	>150	125-150
Age of plant	>10 yrs	>20 yrs
Tenure of Administrator	<1 yr	>5 yrs
Tenure of Director of Nursing	<2 yrs	< 3 yrs
Highest level of nursing education of Director of Nursing	BSN	MSN
RN/LPN staffing levels	Slightly above state average	Slightly below state average
Supplemental staffing	Internal: Flexible pool	External: Agency
Medicare certified	Yes	Yes
Medicaid certified	Yes: Only after private pay terminates	Yes: Accounts for high percentage of residents
Dementia care	"Aging in place" in all units	Separate, locked unit

In a few aspects, participating nursing homes had comparable characteristics. Both were not-for-profit, although each had a different governing structure. Each nursing home was engaged in Wellspring implementation for two-and-a-half years at the time of data collection. Both facilities were substantially larger than the state average of 114 beds. Facility Two was older and more established in its surrounding community than Facility One. Likewise, the Administrator of Facility Two had a much longer tenure than the Administrator of Facility One. Both nursing homes had relatively new Directors of Nursing. Licensed nurse staffing levels at each home, measured in hours per resident

day, were within minutes of each other and clustered around the state average of one hour and twenty-four minutes per patient day. One nursing home was located in close proximity to a large metropolitan area and the other nursing home was located in a small town, but within commuting distance from a large metropolitan area.

Facility One relied upon an internal flexible staffing pool to fill staffing shortages whereas Facility Two engaged an external staffing agency, using approximately 700 hours of agency staffing per month during the data collection period. Both facilities had separate in-house units, or “neighborhoods,” dedicated to subacute care and each accepted Medicare reimbursement. Facility Two had a higher proportion of younger Medicaid residents who required long term care, whereas the payer mix of Facility One was almost exclusively private pay and Medicare; Medicaid was accepted only when residents’ personal savings were exhausted. Facility One integrated dementia care into each unit, employing an “aging in place” philosophy, while Facility Two designated a separate, electronically locked unit for residents with advanced dementia. All units in Facility One were electronically locked.

Schein’s three levels of organizational culture (1987) are used to categorize further descriptions of the two nursing homes. Information for this description was obtained through direct observation, recorded as field notes.

Level One: Artifacts

The lobby of Facility One was medium-sized, colorful and modern and contained a large receptionist desk where information about recent inspections, licensing and organizational mission were found. Recent newsletters and free coffee for staff and

guests were also available. At the time of the researcher's first visit, there was a large freezer of free ice cream in the lobby, a special "staff incentive" for the week. The receptionist was welcoming to the researcher and to all guests arriving at the facility. In each subsequent visit, the receptionist provided the researcher with a list of nursing staff who were working that day. The majority of administrative offices were located in an area behind the receptionist's desk, separate from residential units. On the doors of administrative offices there were multiple contest announcements for staff as well as flyers seeking nursing staff volunteers for overtime coverage.

Residential units were located behind locked doors, accessible by a coded keypad on the wall nearest to each unit's entrance. Although the units had proper names, and were officially termed "neighborhoods," staff frequently referred to them by their geographical location within the building (Four East, etc.) or as "units." This report will use the everyday language and terms used by staff members, rather than proper names or culture change terms. All areas within this nursing home were carpeted and colorful, with multiple paintings hanging on the walls. Each time the researcher visited, she noted that the environment was quiet to moderately noisy and that unpleasant odors were at a minimum. Unit managers' offices were in a central location on each unit.

Each unit had its own, large eating area. Residents were frequently observed in hallways and common areas. Many of the units had pets and/or plants, with one mini-greenhouse, a cat, two bird cages and a fish tank. Two dogs were observed in administrative office areas. Nursing assistants were often gathered at their unit's central nursing station desk. Nurses were often standing with a medication cart in the hallway or

completing paperwork in an area secluded from the central nursing station. Each resident room had a doorbell or knocker. Outside each resident room, there was a shadow box that included a photograph of the resident as well as personal information such as place of birth, likes and dislikes and family details. All resident rooms were private and privacy was protected with doors, most often found closed.

The lobby of Facility Two was large, decorated with many antique-style furnishings and very clean. The small receptionist desk did not contain any information regarding the nursing home. Instead, there were smaller tables scattered throughout the lobby containing information about recent inspection and licensing, mission of the organization, recent newsletters and community events. It was noted that halfway through data collection at this nursing home, materials were added to an informational table regarding The Wellspring Program. It is not known if this was related to the researcher's presence in the nursing home. In one corner of the lobby there was an area for free visitor coffee, although whenever this researcher visited the machine was not plugged in. In the lobby were a large bird cage and access to a few administrative offices. As in Facility One, the receptionist was always helpful in locating the nursing supervisor on duty. On the off shift hours, a security guard sat at the receptionist's desk. Most administrative offices were located in a closed hallway, separate from residential areas.

As in Facility One, the units had proper names and, while formally called "neighborhoods," staff frequently referred to them by their geographical location within the nursing home (Four West, etc.) or as "units." The residential areas of Facility Two were impeccably clean. Several times staff mentioned this cleanliness as a point of pride.

Staff were congenial and it appeared that many staff members were familiar with each other as well as with the family and personal lives of one another. Nurses and nursing assistants would congregate in various places around the unit, at medication carts, outside resident rooms and at central nursing stations. Residents were far more likely to be found in their rooms, in bed, than in Facility One.

All but one residential unit was open, with the locked unit reserved for residents with severe dementia. Residential units consisted of long, white hallways with hardwood or tile floors. There was very little carpeting in Facility Two, save for an occasional rug or small common area in each unit that housed a television, small table and 2-3 chairs. The researcher observed several bulletin boards and menu boards, always with outdated materials. Units were moderately noisy to loud, with most noise coming from television sets. Unpleasant odors were not uncommon during the researcher's visits.

Staff members at Facility Two were eager to show the researcher the new low bed and satellite television equipment that was installed in each resident's room. Outside each room was the name and picture of each resident, sometimes with a favorite quotation, Bible verse or football team logo. All rooms were shared with other residents.

Level Two: Strategies, Goals and Philosophies

Only some of the strategies, goals and philosophies representing a less visible level of organizational culture, were observed by the researcher. Data from this level were captured more completely by the quantitative and qualitative data.

Upon entering Facility One, there was a large Bible verse carved prominently into a column near the entrance. Throughout the nursing home, there were company logos on

documents, walls, staff clothing, lunch bags, coffee mugs, pins and some uniforms. In casual conversation and during interviews, several nurses spoke of the organizational values as integral to their conduct on the job. A framed copy of the nursing home values was noted hanging on the lobby wall.

In Facility Two, there were no formal value, strategy, goal or philosophy statements observed in public places. As far as this researcher could determine, Facility Two did not have any sort of corporate or nursing home logo. Facility Two had a small chapel located near the main entrance. A framed, Christian prayer hung on the wall just outside the chapel. Various bulletin boards within resident care areas addressed efforts to improve care.

Level Three: Underlying Assumptions

The researcher did not record any underlying assumptions, as Schein defines them as the least evident, unconscious, taken-for-granted beliefs, perceptions, thoughts and feelings. It was expected that underlying assumptions would be revealed through analysis of quantitative and qualitative data.

Sample Characteristics

Information regarding characteristics of the total sample was obtained from the demographics form contained in each survey packet. There were a total of 47 respondents, 27 from Facility One and 20 from Facility Two.

Ninety-six percent of respondents (n=45) were female. Two-thirds (n=31) held an RN license and 34% (n=16) held an LPN license. An effort was made in sampling to ensure that respondents represented all shifts and each type of employment status: full-time,

part-time, per diem, agency. The most commonly reported primary shift was eight hour day shift, totaling 54% (n=25) of respondents, although all shifts (8 hour, 12 hour, day, evening, night, other) were represented. Seventy-five percent of respondents (n=35) reported that they worked full-time for their nursing home.

Nearly two-thirds (n=30) of respondents listed hands-on resident care as their primary job responsibility. Twenty-six percent (n=12) listed management, defined as immediate supervision of those workers providing direct resident care. Nine percent (n=4) classified their primary job responsibility as administrative, defined as a nursing home-wide position or program director, but directly involved in the supervision of people. Two percent (n=1) of respondents listed their primary job responsibility as other.

Interviewees

The 13 interviewees represented all genders, licenses, shifts, types of employee statuses and primary job descriptions. Ninety-two percent (n=12) of interviewees were female. Sixty-one percent (n=8) of interviewees were RNs and 39% (n=5) were LPNs. Sixty-one percent (n=8) of interviewees reported that they primarily worked eight hour day shifts and 69% (n=9) reported working full-time. In terms of primary job responsibility, respondents indicated the full range, with 61% (n=8) in hands-on resident care, 23% (n=3) management and 15% (n=2) administrative.

Representativeness

A Mann Whitney U test was used to determine demographic differences between interviewees and non-interviewees. It was determined that there were no significant differences in age, license tenure or tenure in long term care. As expected, there was a

significant difference ($p=.004$) in the nurses' tenure at their respective nursing homes, as interviewees were targeted deliberately for their longer tenure. Table 4-2 provides information on the characteristics of licensed nurse respondents and interviewee subset. Since demographic data were not normally distributed, the range, median and interquartile range are reported for each characteristic. All numbers are rounded to the nearest year, interquartile ranges are rounded to the nearest tenth. Table 4-2 also lists the calculated p-value for differences between interviewees and non-interviewees in each demographic. Since this was an exploratory study, a significance value of $p<.10$ was used.

Table 4-2: *Age and Experience of Non-Interviewees (n=34) and Interviewees (n=13) (Range, Median, Interquartile Range)*

	Non-Interviewees	Interviewees	p-value
Age (Yrs.)	29-63, 47, 13.5	34-63, 47, 14.5	0.549
License Tenure (Yrs.)	1-44, 15, 16.8	10-44, 19, 13.5	0.289
Long Term Care Tenure (Yrs.)	1-25, 9, 6.5	3-16, 10, 8.5	0.358
Facility Tenure (Yrs.)	1-25, 5, 7.3	3-14, 7, 8.0	0.004*

* $p<0.10$

The researcher was unable to obtain formal data regarding the demographic characteristics of the licensed nurses from Facility One. The human resources contact, however, was able to estimate that Facility One's licensed nurse workforce is 45% RNs and 55% LPNs. It was also estimated that 80% of nurses were full-time employees and 20% part-time. The contact stated that licensed nursing staff were "predominately female, have been (employed) at (Facility One) for over five years and predominately in

their late 30s to mid 40s” (Personal communication, Facility One human resources contact person). Comparing these estimates with the demographics of the respondents, it appears that LPNs, per diem nurses, nurses with longer tenure at Facility One and older nurses may be underrepresented in the respondent sample.

Using data provided to the researcher by Facility Two’s human resources contact person, it was determined that respondents overrepresented RNs and grossly underrepresented the per diem staff. This may be due to inclusion criteria specifying that respondents work more than twenty hours per two week pay period. More management and administrative nurses in Facility Two may have responded to the survey; however, a breakdown of primary staff responsibility among total licensed nurse employees was not available for comparison. Older licensed nurses and licensed practical nurses were slightly overrepresented in the Facility Two respondent group. Respondents were representative of gender.

A Mann Whitney U test was used to determine demographic differences between respondents from each nursing home. Since this was an exploratory study, a significance value of $p < .10$ was used. It was determined that there was no significant difference in age, license tenure, length of time working in long term care or length of time working at each respective nursing home between Facility One and Facility Two.

Research Question One: What are licensed nurses’ perceptions of organizational culture and work environment in the presence of a culture change initiative?

In this section, results from two surveys are presented. All analyses were completed using SPSS software and the value for significance was set at $p < .10$.

Organizational Culture: OCI

Licensed nurses' perceptions of organizational culture in the presence of the Wellspring Program culture change initiative were measured by the Organizational Culture Inventory (OCI). Cultural norm scores were calculated by adding the Likert scores from each of the ten survey questions for that particular subscale. Results for the entire respondent group were calculated by finding the median value of each cultural norm for all participants. Table 4-3 provides descriptive statistics for raw cultural norm scores of all respondents and the median values from the normative sample. The normative group scores were compiled by Human Synergistics, Incorporated, and are "based on the distributions of raw scores for 5,685 respondents from 921 different organizational sub-units in Human Synergistics' research sample" (Human Synergistics, 2003). Table 4-3 also lists the calculated p-value for differences between median raw scores for all respondents and the normative median raw score.

Table 4-3: *OCI Cultural Norms Descriptives for All Respondents (N=47)*

Cultural Norm	Range	Median	IQR	Normative Median	p-value
Achievement	18-50	38	9.0	37	0.889
Self-Actualizing	16-48	32	10.5	34	0.127
Humanistic	17-50	40	14.5	36	0.241
Affiliative	12-50	41	10.8	39	0.575
Approval	13-46	28	12.8	27	0.777
Conventional	16-47	31	13.0	28	0.049*
Dependent	18-45	30	12.5	30	1.000
Avoidance	10-49	23	13.0	20	0.172
Oppositional	12-44	22	9.0	22	1.000
Power	13-49	23	10.8	25	0.516
Competitive	10-48	21	12.0	22	0.576
Perfectionistic	16-48	32	11.8	29	0.947

*p<0.10

Using non-parametric runs testing, only the median of the Conventional cultural norm was determined to be significantly different from the normative sample median (p=.049). A high Conventional cultural norm score characterizes a traditional and bureaucratic organizational culture. Expected behaviors in a culture with a Conventional emphasis are conformity, avoiding confrontation and always following established policies and practices. Innovation and adaptation to change are often difficult in a culture with Conventional behaviors (Human Synergetics, 2003). When transformed into percentiles based upon normative values, respondents also scored high on Perfectionistic, Avoidance and Humanistic-Encouraging cultural norms. Perfectionistic behaviors encourage the

avoidance of mistakes and careful documentation of all details. Employees in Avoidant cultures avoid mistakes at all costs, frequently shifting blame to others. Members of organizations with high Humanistic-Encouraging scores are supportive, encouraging and show concerns for the needs of each other. Figure 4-1 is a graphic representation of the median scores for each cultural norm and the normative sample median score for each.

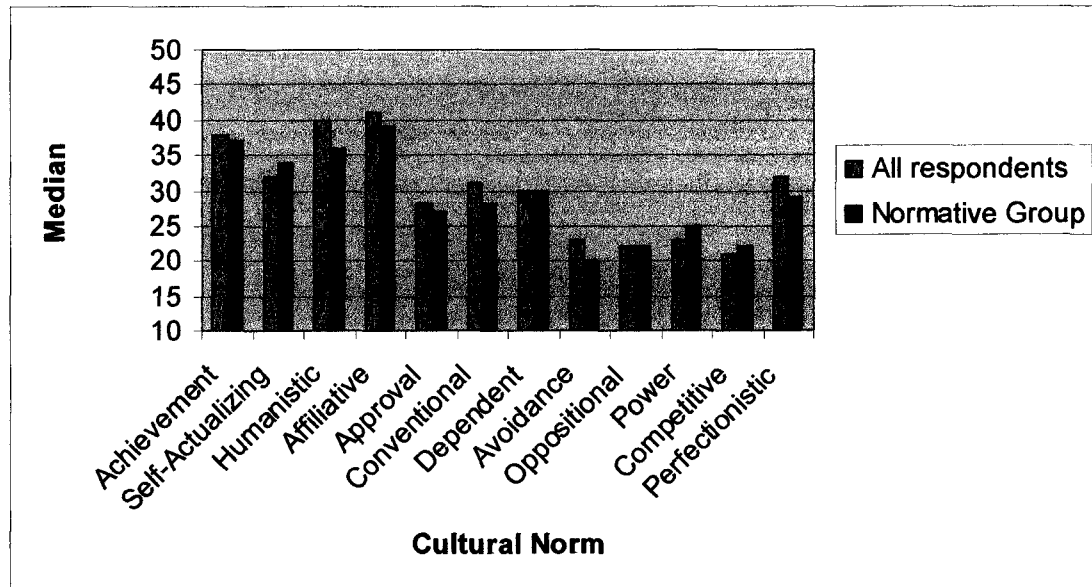


Figure 4-1. OCI Cultural Norm Scores, All Respondents (N=47)

Organizational cultures can be classified as one of three overall styles: Constructive, Passive/Defensive or Aggressive/Defensive¹. Human Synergistics Incorporated ® suggests using the circumplex format as a graphic aide in order to present cultural norm data, thereby visually displaying which overall cultural style respondents favor. Figure 4-2 is a circumplex that shows the cultural norm scores of all respondents, transformed into

¹ The Organizational Culture Inventory ® and all associated terms (e.g., Constructive, Passive/Defensive, Aggressive/Defensive) are from *Organizational Culture Inventory ® Interpretation & Development Guide*. Plymouth, MI: Human Synergistics ® International. J. L. Szumal, 2003. Copyright © 1989-2007 by Human Synergistics ® International. Adapted by permission.

percentiles based upon normative values, in order to show which cultural norms predominate, and, therefore, which cultural style is indicated.

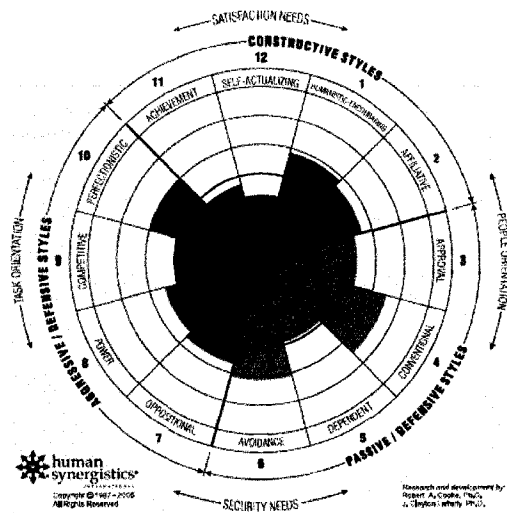


Figure 4-2. Circumplex of OCI results

Note: Research and Development by Robert J. Cooke, Ph.D. and J. Clayton Lafferty, Ph.

D. Copyright 1973-2006 by Human Synergistics International. Used by permission.

Overall cultural styles were computed by first transforming the respondent group's median raw score for each cultural norm to a percentile score, based on normative sample data. Then, the percentiles of the four cultural norms in each cultural style were averaged. The largest mean represented the prevailing cultural style. The mean of percentile scores for cultural norms comprising the Constructive Style (Achievement, Self-Actualizing, Humanistic-Encouraging and Affiliative) was 49, the mean of percentile scores for cultural norms comprising a Passive/Defensive Style (Approval, Conventional, Dependent and Avoidance) was 60 and the mean of percentile scores for cultural norms comprising an Aggressive/Defensive Style (Oppositional, Power, Competitive and Perfectionistic) was 56.5. This indicates an overall cultural style of Passive/Defensive.

Due to concerns regarding the applicability of the normative sample to the sample of respondents in this study, cultural styles were re-computed without using normative percentile data. The median raw scores of cultural norms comprising each style were summed and the totals were standardized to z-scores. A Friedman's test was used to compare for differences between overall styles and it was determined that overall style scores were significantly different from each other at the $p=.012$ level, with the Passive/Defensive style predominating. Therefore, it could be determined that cultural norm scores indicated a Passive/Defensive style at a significantly higher level than other cultural styles.

The Passive/Defensive style is marked by an orientation to people over task and an emphasis on security needs over satisfaction needs. This means that employees interact

with each other, but in a manner that does not threaten their individual job security. Members of Passive/Defensive cultures are often pressured to think or behave inconsistently with how they personally think or behave (Human Synergistics, 2003). This cultural style places a high emphasis on approval from others, especially superiors, and avoids interpersonal conflicts. Rules, procedures and orders are valued highly and personal beliefs, ideas and judgments are often ignored. Passive/Defensive cultures are often marked by unresolved conflict, employee turnover and low employee satisfaction (Human Synergistics, 2003).

Data from the present study were compared to an available dataset of 34 professionals, primarily licensed nurses, from three nursing homes that had undergone culture change (Evans, Barstow, Hostvedt, Scalzi, & Ratcliffe, 2004). A Mann-Whitney U test was performed to detect differences in medians between samples. Table 4-4 provides medians of cultural norm scores of licensed nurse respondents from the present study and medians of cultural norm scores of professionals from the available dataset. Table 4-4 also lists the calculated p-value for differences between median scores for licensed nurses in the present study and professionals from the available dataset. Only two cultural norms, Conventional ($p=0.068$) and Perfectionistic ($p=0.011$), were significantly different at a $p<.10$ level.

Table 4-4: *OCI Cultural Norm Medians Present Study (N=47) versus Other Study (n=34)*

Cultural Norm	Licensed nurse median (present study)	Professional median (other study)	p-value
Achievement	38	35	0.209
Self-Actualizing	32	30	0.509
Humanistic- Encouraging	40	36	0.325
Affiliative	41	40	0.117
Approval	28	26	0.172
Conventional	31	27	0.068*
Dependent	30	28	0.196
Avoidance	23	21	0.226
Oppositional	22	21	0.337
Power	23	23	1.000
Competitive	21	19	0.391
Perfectionistic	32	27	0.011*

*p<0.10

Respondents from the present study scored higher on every cultural norm except Power, where median scores were equal. This could be an artifact of the larger sample size in the present study. Respondents in both studies indicated an overall Passive/Defensive cultural style. Due to small sample sizes in both studies, additional research is warranted

to confirm findings and to validate further the use of the Organizational Culture Inventory in the nursing home setting.

Work Environment: WES

Licensed nurses' perceptions of work environment during change were measured by the Work Environment Scale (WES). It was determined that WES data were approximately normally distributed; therefore, subscales were calculated by finding the mean scores of each subscale for all respondents. Table 4-5 provides descriptive statistics for subscale scores of all respondents and normative means and standard deviations. Table 4-5 also lists the calculated p-value for differences between mean scores for all respondents and the normative mean.

Table 4-5: *WES Subscale Descriptives for All Respondents and Normative Sample (N=47)*

	Min, Max	Mean (S.D.)	Normative Mean (S.D.)	P-Value
Involvement	3, 9	6.4 (2.0)	5.4 (2.3)	0.001*
Peer Cohesion	1, 9	5.7 (2.0)	5.2 (2.0)	0.085*
Supervisor Support	0, 9	5.4 (2.3)	4.8 (2.2)	0.116
Autonomy	3, 9	5.6 (1.7)	5.2 (2.0)	0.161
Task Orientation	3, 9	6.8 (1.4)	5.7 (2.2)	0.000*
Work Pressure	0, 9	6.5 (2.3)	5.7 (2.0)	0.019*
Clarity	3, 8	6.1 (1.5)	4.5 (2.0)	0.000*
Managerial Control	2, 9	7.1 (1.8)	5.6 (1.9)	0.000*
Innovation	0, 9	4.6 (2.7)	3.9 (2.3)	0.106
Physical Comfort	1, 9	5.8 (2.0)	3.8 (2.2)	0.000*

P<0.10

Figure 4-3 is a graphic representation of the mean of all respondents for each subscale and the mean of the normative sample of 4,879 employees working in the health care field (Moos, 1994).

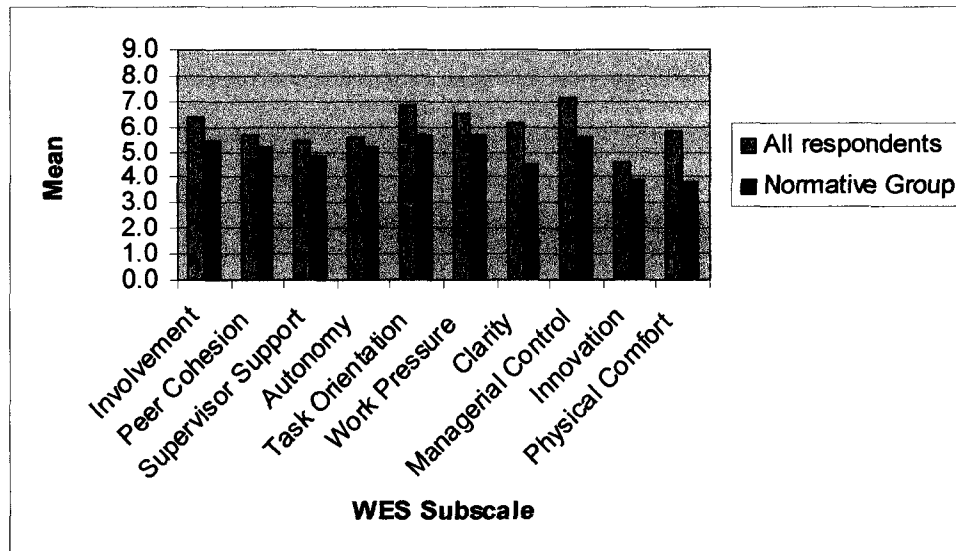


Figure 4-3. WES Subscales: All Respondents (N=47)

Respondents scored higher than the normative mean on every subscale. A t-test indicated that supervisor support, autonomy and innovation were the only subscales that did not significantly differ from the normative mean and that respondents differed the most from normative means in the subscales of task orientation, clarity, managerial control and physical comfort. Scores indicated that respondents had a higher than average concern for and commitment to their jobs and that planning, efficiency and completing the job at hand were important. Scores also indicated that there were high work demands and time pressure involved in respondents' jobs and a high degree of managerial control using rules and procedures. These results were consistent with and

reflective of the characteristics of a Passive/Defensive culture with a Conventional emphasis, as indicated by OCI results.

Summary of Quantitative Data

Respondents scored highest on the Conventional, Avoidance, Perfectionistic and Humanistic-Encouraging OCI cultural norms. Taken together, the subscale scores indicated a Passive/Defensive cultural style that emphasized the needs of people but to an extent that does not threaten job security. The Passive/Defensive cultural style places a high value on rules and procedures that are often inconsistent with employees' personal beliefs or values. Independent thinking and action are not valued in this cultural style and seeking approval from others, particularly superiors, is common.

According to WES results, respondents scored highest on task orientation, clarity, managerial control and physical comfort. This indicates a high level of perceived clarity in job expectations, rules and policies as well as a high level of comfort in physical surroundings. The WES results also mirror the OCI results in the concern for rules, procedures and high work demands as well as planning, efficiency and task orientation.

Research Question Two: What are licensed nurses' perceptions of those factors of organizational culture and work environment that influence the adoption of a culture change initiative in nursing homes participating in the Wellspring Program?

This section addresses those aspects of organizational culture that served as factors influencing the adoption of a culture change initiative. These data were gathered in thirteen recorded interviews. Due to time, cost and practicality constraints, ten interviews were completed face-to-face and three were completed via telephone. The results were

organized into three broad categories: Confusion, Conflict and Commitment. Table 4-6 shows these three categories, and their associated subcategories.

Table 4-6

Qualitative Results: Categories and Subcategories

Confusion	Conflict	Commitment
Unfamiliarity with terms	Staff exclusion	Accommodating schedules
Documentation	Staffing levels and prioritization of Wellspring Program	Teamwork and support
Renovations and roll out issues	Unfamiliarity with environment and coworkers	Resident-centeredness
	Task orientation	
	Front line decision making	

Confusion

Unfamiliarity with Terms

During the interviews, it was immediately apparent to the researcher that there was much confusion among participants surrounding the terms “culture change” and “organizational culture.” Only three of thirteen interviewees initially understood the terms culture change or organizational culture to be related to the work environment. Instead, most interviewees associated these terms with racial, ethnic or anthropologic meanings. This is noteworthy considering that Wellspring Program training materials repeatedly refer to Wellspring as a “culture change” or “organizational culture change” program (Norton, n.d., p.1).

The following are examples of answers given when the researcher asked, “What do the words ‘culture change’ mean to you in terms of your job?”

The people are a wide variety of cultures that you run into, the residents, and you have to acknowledge and respect (them) once you come upon it.

Well, when someone says culture to me... like the survey wasn't anything what I thought it was going to be like, to be honest. I thought it was going to be about different ethnicities and that type thing and I didn't find that on the survey.

Culture change, yeah. I mean, well, for instance just over the last few years a lot of nurses and nursing assistants are from Africa or the different islands and things like that, so their culture's different than mine and they talk different than me so it's hard for me to understand them and for them to understand me. So, to me culture is different backgrounds, different ethnic origins, that kind of thing.

The confusion often extended further when the researcher addressed the Wellspring Program specifically. All interviewees had, at the very least, heard of the program and/or acknowledged seeing materials about the program around their nursing homes. There was great variety, however, in which aspects the interviewees attributed to the Wellspring Program. One manager mistakenly confused Wellspring with another culture change program, The Eden Alternative.

They're doing a lot of renovations to become more like... I don't know whether you want to call it the Eden Alternative 'cause I've never seen anybody, I've never seen that situation.

Other interviewees simply acknowledged not remembering or understanding the details of the Wellspring Program.

I mean, other than hearing the word all the time, Wellspring... I would never know that there was any -like- any major thing going on around here or any change other than, hey, we're gonna do it like this now... instead of doing this, we're gonna do this, but we're gonna call it "gentle bathing." You know?

One administrator acknowledged this confusion, stating:

Well, one of the big culture changes is that (Facility) administration is working towards getting everybody on board with the Wellspring Program and that's been, you know, one of our biggest culture changes, is trying to get, trying to get the staff to understand exactly what Wellspring is and why we have joined the Alliance in the Wellspring committee.

Interviewees also associated changes in documentation, introduction of computer-based charting, standardization of procedures across units and all workplace improvement programs in general with the Wellspring Program. Some interviewees saw the Wellspring Program as a staff education program (how to do things "right," "better," or "according to new policy") or as a means to develop better working relationships between all staff members. Several interviewees thought that the Wellspring Program solely addressed the manner in which licensed nurses deliver care to meet the physical needs of residents, without acknowledgement of psychosocial care, organizational culture changes or leadership training. One nurse said:

Well, I mean my knowledge of Wellspring is limited but I mean I think we do a good job of taking care of the residents and that's the main goal of Wellspring.

It should be noted that all interviewees had been employed at their nursing home throughout -and many before- the implementation of the Wellspring Program.

Documentation

A common theme for every interviewee was the perception of increased documentation and paperwork requirements that accompanied Wellspring implementation. Whether or not documentation was related to the implementation of the Wellspring Program, interviewees spoke at length about its burden. Interviewees seemed to associate paperwork with change over time. One nurse stated:

There's a lot more forms to fill out; now I don't know whether that's specific to Wellspring or specific to this place because this place always has to have a paper trail and a long one. And I don't know whether that's just Wellspring but it seems that for every new initiative that comes out there's a packet of paperwork at least four to five pages thick...

Another nurse, interviewed after a long day working on a short-staffed unit, stated:

We get burnout because of too much documentation.

Participants acknowledged, after probing by the researcher, that many of the negative feelings and beliefs about increased documentation did not stem from the paperwork requirements themselves. Instead, it appeared that many of the interviewees were concerned that increased documentation requirements removed them from their "essential jobs," or hands-on care of the residents. One manager spoke of the barrier that added documentation posed for the licensed nursing staff in implementing Wellspring.

But even before Wellspring it was becoming a lot of paperwork. You know, and some of it is repetitive...lots of paperwork that has to be completed and they (licensed nursing staff) feel like it takes time away from their actual hands-on care.

This nurse believed that documentation was an interruption to her job:

(Less paperwork) would give me more time to really circulate with the residents and see some of their other problems they're having, that sometimes are overlooked because we're not spending enough individual time with each resident, it's brief...That's the biggest thing for me. It's like I said, involving more time, more patient care time.

Others seemed to feel uneasy about documentation due to a lack of clarity or knowledge about how to complete it correctly. Negative feelings and beliefs about documentation were linked to this nurse's perceptions of culture change.

Culture change to me is... I just... we're getting into more and more paperwork, you know, coding residents for various things they can and cannot do and declines and things like this. And I find that very hard for me and my boss knows because I've talked to her many times about it. I find that very hard because, I guess, you have to have more of a background for that.

Per the CEO of Wellspring Innovative Solutions, Incorporated, the Wellspring Program does not have any specific documentation requirements, but examples of forms that allow for quality improvement data collection are provided with each learning module (Personal communication, T. Lohuis, January 10, 2007.) Many of the interviewees, however, persisted in linking the documentation burden to the Wellspring Program. This accounted for many negative feelings and beliefs about implementation of the Wellspring Program.

Renovations and Roll Out Issues

Among many of the interviewees, it was a commonly held sentiment that culture change or Wellspring implementation "was just not there yet." Several interviewees linked Wellspring implementation with planned renovations to the physical plant. This interviewee acknowledged her difficulty in understanding the Wellspring Program before renovations were completed:

I don't understand it that well yet. I think I grasp the very general picture of what they're trying to do and, once again, with our limited resources, with the way that the place is laid out right now it makes it more difficult to do the job.

This manager also acknowledged the difficulty in getting staff to understand culture change without seeing the actual renovations.

But without the renovations, without the dining room being open longer and things like that, it's hard to move people forward. I'm thinkin' once the renovations are done it'll be a lot easier 'cause I'll just like "plant ideas (with nursing staff)."

Other interviewees indicated that there had been a lot of planning and organization to prepare for the implementation of the Wellspring Program, but that it had not fully rolled out to the units. Although both nursing homes had been enrolled in the Wellspring Program for approximately two-and-a-half years, and staff at both nursing homes had attended all training modules at least once, a few of the interviewees who were managers or administrators indicated that Wellspring implementation “had not yet occurred.” This manager spoke of her plan to introduce Wellspring on a continual basis to her staff:

It’s not here yet. The paperwork and the idea is here but actually putting it into place isn’t really here and that’s, I guess, why I’m working every staff meeting to give my staff another idea.

These managers detailed their perceptions of how Wellspring roll out had affected licensed nursing staff who performed hands-on resident care.

I don’t think it’s really affected, as far as the performance of, the nurses. I don’t think any of Wellspring modules have really made an impact at all yet because they’re just, they’re just not getting out there yet, they’re not in that portion where, you know, it’s gonna go out to the floor. Gentle bathing, that’s out there, you know, but I don’t really see the difference.

But, yet they’re not seeing that impact. They definitely will see that impact but it’s still too early in the Wellspring game right yet to do that.

The CEO of Wellspring Innovative Solutions, Incorporated, noted that evidence of change can be observed within the first six to nine months after implementation has begun (Personal communication, T. Lohuis, April 11, 2007).

Conflict

Staff Exclusion

The researcher noted that some interviewees, when stating that they were unfamiliar with or did not understand the Wellspring Program, excused their lack of knowledge as an expected artifact of working the evening or night shift, working weekends-only or working for a supplemental staffing agency. It should be noted that although one interviewee was from a supplemental staffing agency, this nurse had significantly more experience in the participant nursing home than many other respondents. Explaining their lack of understanding of the Wellspring Program, these nurses stated:

Ah, yeah, I've heard of the Wellspring Program. But, I'm agency so they don't tell us. I mean I'm not into the program so I don't know what it is.

I have heard people talk about that but since I'm only here on the weekends I miss a lot that goes on here. I mean I have heard it and I've seen flyers about it, but I don't know a whole lot about it.

Other interviewees, however, expressed that there was a breakdown in the consistency of communication to all nursing staff. This RN expressed her frustration and hurt with what she believed was incomplete communication and exclusion of weekends-only staff.

Well, sometimes there is confusion about what the changes are and, again, by working on the weekends, a lot of the upper management is not here, so you can't go (to) them and ask questions...sometimes you get the feeling when you're working weekends that you're kind of forgotten about or whatnot and it's like you feel like the... I don't know if you wanna call them the main people, but the people that work Monday through Friday, they're like, whew, it's the weekend, let's just let them flounder the best they can and muddle through and then when Monday comes we'll pick up the pieces. You know, the weekend crew can just muddle through. What difference does it make? Well, it does make a difference to us.

Other interviewees who worked an off-shift felt excluded because the training and meetings for Wellspring Program activities were held at times incompatible with their working schedules.

They invite everyone. No one is turned away, they invite everyone... The last general meeting that we had with (Administrator's name)...they was trying to recruit more night participants. And they said the training would be two days. Nights does not... night shift does not compute with days. If you want me to actually go somewhere and sit down and listen to someone for two days, when ten o'clock comes my eyes tell me goodnight, you know. That's it. I will not... I don't care if I slept the night before, my eyes tell me goodnight. When six P.M. comes or when it gets close to six P.M. my body starts doing the automatic shutdown again. You know, I need to go to bed because I trained my body... my body has trained me to do this and I can't see going somewhere and goin' to sleep, so it would be difficult to go to training. You know, if they had it at night that would be something different. I could definitely go... I'm so sorry that I cannot participate in it because I would love to give in-service at night. That would be one of the things that I would be doing if I was involved in Wellspring. I'd go from unit to unit and tell them, okay, this is what I learned this week, okay.

It was apparent that nurses believed that working the off-shifts, weekend shifts or for supplemental staffing agencies was a significant factor that inhibited their participation in the implementation of the Wellspring Program.

Staffing Levels and Prioritization of Wellspring Program

When asked what factors influence the adoption of the Wellspring Program, all interviewees referenced staffing levels. Interviewees frequently used words such as "shortage," "crisis" or "short staff." For many of the interviewees, it appeared that staffing issues were perceived as a root cause of their *ability to participate* in the Wellspring Program. These interviewees illustrate that the care of residents was the top priority and that Wellspring activities could be diverted if adequate staffing were not available.

Well, there was a time when people were supposed to be on and then have to go back to the floor to work because staffing changed. Yeah, you know, people called in or cancelled or, you know, and then you have to pull a person from Wellspring (meetings) to go work on the floor and that was not helping the program.

What also makes it difficult is short staff. We've had a lot of that (short staffing) lately, so it's hard. I know on my shift, they'll split one nurse between two units... the GNAs sometimes, they have twenty patients in each... that's a lot and that part is really hard. That makes it hard and it makes somebody tired.

One manager detailed the difficulty of finding the time to participate in Wellspring implementation or activities. This manager also shared thoughts about how nursing staff feel when a co-worker is removed from the floor to participate in Wellspring activities.

Well, it has to start from the top down because the difficult thing is getting off the unit to go participate and when you take a body off that is taking care of fifteen residents and those fifteen residents get dumped on four other people that doesn't make the four other people very happy. So I think just staffing has the biggest effect because nursing assistants really don't like to dump their residents on other nursing assistants because they know how hard the job is. And to have to do that to go to a Wellspring meeting or go perform a duty assigned to them, such as auditing a chart or putting up a bulletin board or whatever, you know, the Wellspring coordinator has asked them to do that day, to leave the unit to do it, and leave the residents with someone else, that doesn't sit well with them.

Another manager stated why it was often difficult for managers to support the Wellspring Program.

It's middle managers, people on my level, that don't wanna let their staff participate because they can't afford to lose somebody off the unit.

Those interviewees who were managers or administrators often openly acknowledged that staffing levels were not optimal.

But how do you tell your staff that you've got to work with three people? Three nursing assistants to take care of fifty-two people. I mean that's...that's pretty hard.

This manager talked about how difficult it was to maintain motivation for the Wellspring Program when it added responsibilities to nurses' already-busy schedules.

...If it's to actually go out on the unit and do an audit for Wellspring or go to the meetings, it's hard for them to find time to do that, to take it away from the time they should be spending doing their real job versus an added chore. I think that's how they look at it. And so you have to try to keep people motivated on a daily basis because just to add one more thing to them sometimes gets very frustrating to them...It's hard to get them involved. They look at it as it's just one more added thing, one more added meeting, one more added chore, when they can't get their job done as it is and now they've got to do this. That's how they look at it, so it's very hard to get people motivated to do this. They wanna do the fun stuff that's involved with it.

Many interviewees perceived the Wellspring Program as something *additional* to their jobs, rather than *part of* their job.

Unfamiliarity with Environment and Coworkers

Many interviewees also stated that being required to work in areas that were short-staffed, or being “pulled” to other units, created difficulties both with their “typical” job responsibilities as well as Wellspring Program initiatives. This nurse spoke of the fear felt when working on a different unit.

So when you're pulling people from long-term care to assisted living or skilled, I think it generates some fear in people who haven't been there or delivered to that kind of an opportunity or their skills just aren't up to par for certain areas. I'm not really sure what it is. I know that there is a lot of dissent among the employees when they get pulled to those areas.

At times, interviewees related “being pulled” to concerns for continuity of care to the residents. When asked about her feelings regarding change, this nurse talked about “being pulled.”

That's why I like to be on the same team. Some people don't mind floating here, there and everywhere. I personally am not that flexible and because I'm only here (weekends) I like to at least stay with the same group of patients, 'cause even though they're gonna have changes in their routine, at least it's the same people, so it helps me a lot.

These nurses spoke of the problems that arise when inadequate staffing levels result in per diem or agency staff working on their units.

I see a lot of sloppiness because of nurses rushing. You know, I see that when my regular partner is off and I'm working with someone else. I see nurses...that are just here every now and then...they're not as attentive to the patients because...when I work with somebody else...I think they're rushing through and not completing their work, giving the attention to the residents.

(I do not enjoy) working with agencies that don't have ownership of the unit or the facility. They're (agency) there to do their eight hours and go, so things don't get followed through.

Some interviewees expressed unease about working with per diem or agency nurses. One nurse alluded to feeling responsible for making sure the agency staff provided adequate care to the residents, making it difficult for her to focus on her own responsibilities.

Task Orientation

At the beginning of each interview, the researcher asked each interviewee to describe a typical day at work for them. Without exception, all interviewees recounted their daily routine in a mechanistic, task-oriented manner. Management and administrative interviewees also relayed detailed schedules task by task. This interviewee provided a description of the typical day of a day shift licensed nurse:

I mean I get here in the morning and I get report, of course, and do the narcotics count. And then you jump in and you do your morning insulins and then the breakfast trays come and (I) usually help feed patients. Then you start in with your ten o'clock meds because the medicine aide doesn't do the G-tubes, so you have to give medications to the G-tube patients and their neb(ulizer) treatments and then the IVs that you might have. That's kind of infrequent, but once in a while. And then the treatments that we have to do. And then you just go through your day, you know, and whenever the treatments are due then the medications and I try to fit in my documentation. A lot of times I don't get to that until the end of the day and I'm always late leaving.

The researcher noted, in addition to the heavy task orientation of each description, interviewees often had a clock orientation, outlining their days in terms of what tasks should be done at what times.

A central tenet of the Wellspring Program and other culture change programs is the transformation of the nursing home from an institutional, task-oriented setting to a home-like, resident-centered environment. It was not clear how nurses were expected to integrate their task-oriented habits into a resident-centered, home-like environment. Of the licensed nurses interviewed who provided hands-on care of residents, none gave any indication of how they would plan or provide care within a resident-centered paradigm. Managers, on the other hand, specified that this issue would present a conflict as the Wellspring Program became further integrated into their nursing home. This manager stated:

Of course, everything here is so task-oriented I think it's gonna be a major hurdle to get people over it, but I love the idea (of resident-centered care)...I think the nurses will do much better changing than the GNA staff; they're very task-oriented, gotta get these people (residents) done and I bathe 'em at this time and I do this at this time...I don't know how to get out of the task-oriented mode, though.

This manager elaborated on how she was beginning to help her licensed nursing staff conceptualize how to do their jobs while working with the residents' preferred schedules.

We have some residents who like to get up later in the morning and like to go to bed later in the evening. And the staff is still fixated on well, we do our documentation between ten and eleven, so to put her to bed it's just like this impossibility, so then why can't you do your documentation a little earlier, knowing that she likes to go to bed later. I said, you have to start thinking out of the box here, think what would it be like if this was my grandmom and she wanted to do this, because it's coming to that.

This manager further described the conflict between the task-orientation of the nurses' traditional shift work and a resident-centered paradigm.

Yeah, it's better for the residents but not necessarily better for the nurse because we're always like task-oriented, you know. They (residents) gotta be up, they gotta be in the dining room, they gotta...you know...where are they? I gotta get their meds in 'em...oh, they're still back in their room,...you know, whereas, it's better for the residents and if you have the time to chase 'em around or look for 'em then that's ok. But it would probably be much easier for nurses, you know, if everybody was on the same routine or schedule, but that's unrealistic; I mean, this is their (residents') home.

Management and administration anticipated that the transition from a task-oriented paradigm to a resident-centered model would be a significant hardship in implementing the Wellspring Program, although they also indicated that this was not yet a significant issue for most licensed nurses providing hands-on care.

Front Line Decision Making

A core principle of the Wellspring Program is the accountability and empowerment of “front line” staff to make many resident care decisions. The term “front line staff” refers to those staff members engaged in direct, hands-on care of the resident as their primary responsibility. Front line staff includes both nursing assistants as well as licensed nurses who provide hands-on resident care. A key element of empowering staff is fostering the ability to make decisions regarding the most appropriate care for each individual resident. Several interviewees commented that the delegation of some decision making to front line staff via Wellspring Program principles was helpful in positively affecting the organizational culture. This manager spoke of her thoughts regarding front line staff empowerment:

We really didn't see that big of a change at (Facility Two) as far as involving front line staff because we always involved front line...but I think they like the fact that I allow them to do self-scheduling, allow them to make any decision as far as hands-on patient care, allow them to make that decision as long as it's not detrimental to the care that they give and, therefore, they have ownership of their decisions... it's probably helped because the nursing assistants now feel a comfort level of decision-making and they know that their voice counts.

Another manager outlined her feelings and beliefs regarding the involvement of all areas of staff.

Especially like dietary and housekeeping and laundry and GNAs who have been there forever who have never really been incorporated into a committee or any kind of meetings and then when they're asked and selected they're just delighted that, you know, hey, I finally get my chance to be on a committee. So I think that, yeah, for certain people, yes, it's brought a lot of positives. They feel more accepted, they feel more part of the facility, they feel like they have more of a say.

On the other hand, one interviewee stated that she still had some difficulty with delegating decisions and was not comfortable with the independent thinking skills of the nursing assistant with whom she worked.

I have to go through her assignment very carefully because she's not... she doesn't think independently, she's... I don't know... she just doesn't think independently... correctly, I should say. So we went over her assignment, I told her which people to get up, which people are getting baths, which is something she should know, but we went over everything (gestures defensively).

Overall, there were mixed beliefs about the practicality and success of delegating and decentralizing decision-making to front line staff.

Commitment

Accommodating Schedules

Several interviewees expanded upon how adequate staffing was related to their availability and commitment to participate in Wellspring Program activities. This manager explained:

If it's left to the staff to say, okay, the meeting is posted for this time and for them to actually leave the floor, that's not gonna fly. You have to be scheduled off for that time and have someone else come in; otherwise, there's no guarantee you can leave... you know, things happen.

Most of the interviewees who provided hands-on resident care placed the adequate staffing and scheduling responsibilities with their floor manager or with the Wellspring Coordinator. When asked what factors would help with Wellspring participation, this nurse stated:

Cooperation from your leaders, so they can get you off schedule, just to make it smooth so that you can be there (participating in Wellspring meetings).

This manager further expressed frustration with the interactions between staffing and the Wellspring Program.

You know, I cover the staffing... there was a for instance several months ago where we had a Wellspring team and it was during the cold and flu season and then we had a bunch of call-offs and we pulled that committee. Two of the nurses that were on that committee, we pulled them to work back on the unit, but they weren't upset and they kind of knew that, you know, resident needs came first and we can work on our Wellspring stuff later. And I did eventually... I think it was the next week... scheduled them both off and I was able to replace their shift with other nurses, so they could get back on their Wellspring...

Despite this frustration, it was clear that all interviewees believed that care for the residents took higher priority than working with the Wellspring Program implementation. There was a generalized sentiment that Wellspring changes would be positive, but that the time and availability that nursing staff had for participating in planning and implementing the changes limited their commitment to the program.

Teamwork and Support

Interviewees from both nursing homes, particularly Facility Two, spoke highly of the interpersonal relationships between staff members. The majority of interviewees

indicated a high level of cooperation, teamwork and support from co-workers at all levels. Teamwork and collaboration are key elements of the Wellspring Program. The following are two examples of interviewees' characterizations of coworker support.

There's a lot of support here, from the staff nurse all the way up to administration.

We all work together. If we ever have a question or concern...say, for instance, I have difficulty starting an IV, we're always right there to help each other. I don't think our staff feels like there's never anybody there to help 'em; I think the cohesiveness and the teamwork is one of the biggest positives at (Facility Two).

This nurse extended her concept of support and service to include the residents.

There's a big push on customer service here right now, where our customers are not only our residents but they're the people that we work with, too. Like I said, there's plenty of support.

These nurses extended their thoughts about teamwork and support to include how they influenced the adoption of Wellspring in the workplace.

But if everybody is supportive and (uses) teamwork and (is) helpful, then it makes it a lot easier. You know, like Wellspring, everybody is involved, housekeeping, secretary, social work, you know, it's your patient, and everybody helps each other. It's not like, oh, that's not my job.

I mean when there are changes you might get a little grumbling and griping but generally people just go ahead and do what they gotta do and make the changes and we all pitch in together. Everybody tries to help each other. So that makes it easy to make changes.

Interviewees from both nursing homes spoke highly of the management at their respective facilities, although in most instances interviewees referred to a particular manager or administrator when speaking of management. Those managerial attributes that were most frequently mentioned as positively affecting Wellspring implementation were a willingness to participate physically in resident care, visibility, approachability and responsiveness. This nurse spoke highly of her manager's willingness to help.

The supervisor that I work with is extremely helpful. She's very friendly, very nice; she will actually... she won't just tell you what to do, she'll actually pitch in and help you. She'll call a pharmacy for you and do a lot of things that a lot of other supervisors, you know, they don't. And she comes to every nurse... I don't know about the aides, but I know she comes to every nurse to say how are you doing, how's your day going...

This nurse valued her manager's familiarity with staff and residents as well as her openness and responsiveness.

I have a tremendous nurse manager that used to be our evening supervisor who knows us well, you know, because she was our boss for evenings for a couple years and so she knows me from working on the floor my skills and who I am and what I'm all about. So she's very good. Most of the management here, our direct bosses, are very good with us. I mean her door is open all the time. I've gone in there and totally cried with frustrations already and she listened to me and said, calm down, (interviewee's name), and let's talk about this. So she's very good. And I think that's very helpful to have somebody over you that understands your frustrations, you know...

This nurse emphasized the importance of being able to rely on the support of management in the event of problems.

But here you have a supervisor to fall back on if you have problems. There are times here that I have to cover two units and that can be interesting, but like I say there's somebody you can call. You can call the supervisor to fall back on, or if there's something, like if I'm not gonna get the chart checks... if I got forty to do here and I can't do forty over there, you know, she might go over and do the chart checks on the other side or whatever.

Any negative feelings toward managerial and administrative staff were generally reserved for those at higher levels within the nursing home. It appeared to the researcher that the further away from resident care an employee was, the more open to criticism from interviewees. This manager expressed her frustration with the demands of higher administration:

I think it's very difficult; it's not easy. It's not that the work is hard, it's the amount of work and the time frame that they want it in. It's just... it's... actually, the corporate... I call them corporate because, you know, that's usually where it comes from and they're not... they've either never been a nurse, never worked on a unit, or have worked on it but have been so far gone from it that they really do forget, you know, what it's like. And it makes a difference, you know, and it's a lot of work. You know, I turn in a stack of incident sheets to my boss... ok, you're supposed to get these within five days... I said, I know that, you know. What I wanna say is, I know that, but the... what do you want me to do? But I don't... I say I know that. But this is... you know, this is what I have. You know, and they already go into the computer... it's a matter of me going back into the computer, you know, after the nurses put them in there and then do the follow-up. You know, and that's where the, you know, the distance is...it's difficult.

Overall, it appeared to the researcher that interviewees had positive feelings and beliefs about the teamwork and support from their immediate coworkers and middle management, but had mixed feelings regarding higher level administration.

Resident-centeredness

Despite some negative feelings and frustrations, most interviewees ultimately reported positive feelings toward their jobs. Almost all interviewees conveyed pride and strong dedication to their job, some indicating that resident care was more than a job, rather a personal mission or a passion. Interviewees frequently indicated that, despite their frustrations, their core job was providing quality care to residents. These interviewees stated their dedication to their residents.

The patients are your consumers so your job is to give them the highest satisfaction.

The bottom line is making sure the people are getting the care they deserve.

Often, interviewees used phrases like “satisfaction,” “focus on the resident” and “resident preference.” This is consistent with creating a resident-focused environment, a core principle of the Wellspring Program.

That's the great thing about this place, everything is patient-oriented, you know. I mean the incontinence program, that's not for me, that's for them, and... but, you know, I benefit, too, because I learn their schedules and what's going on and if anything changes I know there's a problem. Yeah, I mean, it's great.

(Wellspring) It's good for them...the residents.

Many interviewees conveyed a strong sense of dedication to providing the best care at all times. This manager stated:

My primary job is to manage the clinical staff, which is nursing and GNAs to make sure that our residents are getting the best quality care... I think most of them (hands-on care nurses) care about doing a good job and taking care of the patient residents well.

Relating her job to the Wellspring Program, this nurse stated:

You try to function at top priority all the time, and not necessarily doing it only because of Wellspring. You try to do your best at all times.

Several interviewees displayed confidence and pride in the care provided at their nursing homes. Two nurses stated:

I would have to say the care, the care they get here is exceptional. I mean, I've worked at a few places and for the most part... if my parents had to go some place, I would bring them here because the care is really good.

The care here is fantastic. So I would say, if anything, it's always evolving or improving, it's always improving.

Finally, a few staff members chose to share personal stories regarding the care provided at their nursing homes. In two separate instances, staff members from the participating nursing homes (not participants in this study) tearfully told the researcher about relatives who had recently died. Both staff members detailed the decision of whether or not to place their relative in the nursing home where they worked. Although one staff member ultimately did not place her family member in the facility, both

passionately spoke of the dedication of staff and quality of care provided in their nursing homes. The researcher did not solicit this information and was surprised and humbled by the emotion and sincerity displayed by staff. It was clear that, for many staff members, participants or not, their jobs were a personal dedication rather than simply a vocation.

Echoing these sentiments, one manager stated:

The focus is about quality care...the human that I am, I would not want to work in a facility where I wouldn't trust my family member and I've never had that doubt and, you know, my mom was sick and dying five years ago and, you know, I was seriously thinking about putting her there. And I don't think I could work in a place if I don't think I could put my mother or father there.

Summary of Qualitative Data

In all, interviewees reported similar experiences, facilitators and frustrations with implementing the Wellspring Program. There was much confusion regarding the terms “culture change” and “Wellspring Program” as well as what documentation and changes could be attributed to the Wellspring Program, creating some negative feelings about Wellspring. Nurses appeared to have a limited view of the Wellspring Program as a set of resident care programs (e.g., bathing, incontinence), rather than a set of values and principles that guide behaviors and practices. Some interviewees attributed confusion to incomplete or evolving roll out of the Wellspring Program.

Interviewees also reported conflicts surrounding the exclusion of “off shift,” “weekends-only” or agency staff from Wellspring information and participation. Interviewees reported that adequate staffing levels and unfamiliarity with the working environment and coworkers interfered with the ability to participate in Wellspring activities, often resulting in Wellspring taking a lower priority than resident care.

Interviewees also described their jobs with a strong task orientation, some noting the conflict of integrating task orientation and resident-centeredness. Interviewees had mixed beliefs about front line decision making and accountability.

Despite these conflicts, interviewees cited accommodation of schedules, teamwork and support and resident-centeredness as themes that positively influenced their commitment to culture change. Although many interviewees expressed frustrations with their organizational culture and aspects of implementing the Wellspring Program, overall most appeared satisfied with their jobs. The researcher noted a striking amount of pride and dedication from some staff as well.

Research Question Three: In what ways do the perceptions of licensed nursing staff regarding organizational culture and work environment illuminate their perceptions of and experiences with the implementation of a Wellspring culture change initiative?

From both the survey and interview data, it is clear that there is not a single, uniform perception of organizational culture or the implementation of the Wellspring Program among licensed nurses. Additionally, there was a significant amount of confusion surrounding exactly what was involved with changing the organizational culture, namely implementing the Wellspring Program. Taking these factors into account, there were some consistencies throughout the data.

Respondents scored highest on the OCI Conventional cultural norm. The emphasis on conforming and following the rules is consistent with respondents' high WES scores for managerial control and clarity as well as the highly regulated environment of nursing homes in general. The rules and routines of a Passive/Defensive cultural style were

emphasized in the interviewees' conflicted beliefs about front line decision making, a concept that is contrary to the typical chain of command in a nursing home.

Respondents also scored highly on the OCI Perfectionistic cultural norm, which emphasized avoiding mistakes and keeping careful documentation of details. This was buttressed by respondents' WES scores emphasizing managerial control via rules and regulations and work pressure exerted through high job demands and time pressure. As well, interviewees commented frequently about their dismay regarding documentation requirements.

Respondents scored highly on the OCI Humanistic-Encouraging cultural norm, evincing supportive and constructive relationships with others. These results were consistent with high WES scores for peer cohesion, indicating friendliness and support between employees. Interviewees also frequently referred to teamwork and support from coworkers and management. Many interviewees positively referred to efforts to create a resident-centered environment and noted that this atmosphere would be in the best interests of the residents.

Respondents also scored highly on the WES subscales of task orientation, work pressure and managerial control. When recounting their typical work day, interviewees often displayed a task-oriented mindset, recounting task by task what was involved in a typical day, rather than providing a more general description of what their jobs involved. High amounts of work pressure were indicated by interviewees as they detailed issues such as adequacy of staffing or the stress they faced with increased documentation that resulted in a perceived loss of resident care time. Interviewees' perceptions of

Wellspring as affecting care delivery to meet the physical needs of residents, without acknowledgement of psychosocial care, organizational culture changes or leadership training, help to explain high WES results for managerial control through rules and policies. Passive/Defensive cultures are marked by the devaluation of personal beliefs, ideas and judgments. This style was echoed by some interviewees as they spoke of their difficulty implementing front line decision making.

There was inconsistency between quantitative and qualitative data regarding clarity and confusion. WES scores indicated a high level of clarity, or the degree to which employees knew what to expect daily and how explicitly rules and policies were communicated. Interviewees, on the other hand, almost universally did not know or understand correctly the terms “culture change” or “Wellspring Program.” Several interviewees attributed activities or documentation requirements to Wellspring that were not at all related. The confusion in terms appeared to the researcher to increase when the interviewee worked primarily during the “off shift” or “weekends-only” or if the interviewee was from an outside staffing agency. Some interviewees also attributed the confusion to incomplete rollout or the lack of integration of the Wellspring Program into daily routines.

Summary

Analysis of the quantitative and qualitative data revealed the underlying assumptions, or the least evident, unconscious, taken-for-granted beliefs, perceptions, thoughts and feelings of licensed nurses (Schein, 1987). There were no universal truths regarding licensed nurses’ perceptions of their organizational culture or the factors that influenced

changing the organizational culture; however, there was some consistency in the results. Overall, the quantitative and qualitative data were largely consistent. One exception was the high levels of clarity reported on the WES contrasting with interviewees' high levels of confusion.

Combined, data could be classified into the larger categories of confusion, conflict and commitment faced by the licensed nurse in the presence of a culture change initiative. Licensed nurse respondents report high levels of clarity regarding daily expectations, rules and policies but interviewees showed near universal confusion or misperception of the Wellspring Program, indicating confusion. Respondents demonstrated conflict as they characterized an organizational culture that was rules-directed and conformity-driven while attempting to integrate major organizational change. Finally, in both surveys and interviews, licensed nurses reported commitment, highlighting teamwork, support and cohesion.

CHAPTER FIVE

DISCUSSION

Using surveys and interviews, this study asked nurses to share their perceptions of organizational culture and work environment in the presence of a specific culture change initiative, the Wellspring Program. Results from this study provide some insight into why licensed nurses are often viewed as primary barriers to organizational change: What is perceived by administrators as “resistance” may, in fact, be a struggle by licensed nurses to make sense of the motivation and reasoning for changes or to understand the actual changes and their roles in change.

Results also indicated that licensed nurses were confused, characterizing an organizational culture with high levels of clarity for expectations, rules and policies while, at the same time, reporting misperceptions about the Wellspring Program and culture change. Further, nurses were conflicted, operating within an organizational culture that was dominated by rules and minimized innovation and independent thinking, while attempting to implement a culture change program that encouraged resident-centeredness and front line decision making. Nurses expressed difficulty with integrating resident-centered care values with task-oriented roles. Nevertheless, nurses showed commitment to their jobs, to each other and to the residents, reporting high levels of teamwork, support and dedication. This chapter discusses the findings of this study in relation to previous research, the contributions of this study to the science, limitations, implications for practice and policy and directions for future research.

Comparison of Findings to Previous Research

Confusion

The survey portion of this study did not address the Wellspring Program specifically. Survey results indicated a high degree of clarity regarding nurses' expectations of daily routines, rules and policies. It was not until the researcher addressed change in the workplace, specifically the Wellspring Program, in the interview portion of this study, that respondents showed a substantial level of confusion. Although all interviewees acknowledged that they had heard or seen information about the Wellspring Program, both managers and nurses who provided hands-on resident care openly admitted that they were not clear about the nature of the Wellspring Program. They often attributed any new practices, policies and documentation requirements to Wellspring. This was significant, because it frequently resulted in negative feelings and beliefs about the Wellspring Program when, in fact, not all changes were related to the program. Those interviewees who worked the "off-shift," in particular, reported frustration with unclear or non-existent communication regarding new programs and policies.

When asked what a "Wellspring facility" looks like, the CEO of Wellspring Innovative Solutions, Inc. stated that there is no formulaic Wellspring environment, per se. He maintained that the Wellspring Program is more of a philosophical shift, rather than a tangible or architectural change, with the goal that Wellspring becomes "standard operating procedure" in each nursing home (T. Lohuis, personal communication, November 27, 2006). The fact that Wellspring Program changes are not intended to be tangible changes to the nursing home physical plant, unlike many other well-known

culture changing programs, may account for some of the nurses' confusion. It may also be, since the Wellspring Program is a *work in progress*, that nurses are unsure of how new changes and policies will affect their jobs and the overall structure of long term care provision once Wellspring changes are more fully implemented in the future. Perhaps a full understanding of the Wellspring Program and all of its details is not critical for all licensed nurses, but striving to communicate and educate all nurses about the reasons for participation in the Wellspring Program and the expectations for positive resident and staff outcomes is necessary for positive, sustainable change.

In direct contrast to the confusion surrounding the Wellspring Program, nurses reported high levels of clarity regarding the expectations of the job, rules and policies. They also spoke about their confusion regarding their roles in Wellspring. In a study that examined how change recipients interpret and make sense of organizational change, Bartunek and colleagues (2006) noted that there is often a considerable gap in understanding of and motivation for organizational change between change initiators (typically administration) and change recipients. Balogun & Johnson (2004) noted that knowledge gaps can be considerable within levels of management, as well. Often this is due to a difference in motivators for change. For example, the change initiators (administration or management) may be responding to external motivators such as financial incentives or quality ratings, while change recipients may be responding to internal pressures such as pressure to conform to new rules or policies.

Bartunek and colleagues found that consistency of understanding and motivation for change between change initiators and change recipients was critical to a smooth

transition. The team stated, “Major change...typically motivates change recipients for whom the initiative is novel to make sense of what is going on, gathering information and processing it cognitively to create meaning...It is through the meanings recipients form regarding a change that change initiatives have the impacts they do” (2006, p. 186). Findings from the present study were consistent with the findings of Bartunek and colleagues. In the present study, administrators, when interviewed, spoke at length about the details and planning for the Wellspring Program and how it would benefit their nursing home. Managers, when interviewed, reported intermediate levels of confusion, often grasping the core elements of the Wellspring Program, but voicing confusion over how to implement changes with staff who provided hands-on care. The most confusion was noted from those nurses who provided hands-on care.

While nurses in the present study perceived that they were clear about their day-to-day responsibilities and roles, reporting high levels of clarity and scoring highly on the Conventional cultural norm, there was also some confusion over how roles might transform when Wellspring culture change became more integrated into their jobs. In a study about hospital reengineering programs, Kroposki and colleagues describe role ambiguity as a phenomenon “result(ing) from having inadequate information to perform a job properly” (Kroposki, Murdaugh, Tavakoli & Parsons, 1999, p. 28). Kroposki’s study found that higher levels of role ambiguity were associated with lower levels of organizational commitment and job satisfaction. Kroposki and colleagues also found that RNs experienced higher levels of role ambiguity with hospital reengineering than did non-RN staff.

It was not the aim of this study to measure intent to leave or job satisfaction. Overall, despite their confusion with Wellspring and various job-related frustrations, interviewees were devoted to their jobs, often invoking phrases such as “dedication” and “more than a job.” WES results showed that respondents reported average levels of commitment and concern about their jobs. These results are inconsistent with the findings from Kroposki and colleagues.

In order to facilitate successful organizational change, Kroposki and colleagues suggest that nurse managers take an active role in educating those staff who work directly with patients about organizational changes (Kroposki, Murdaugh, Tavakoli & Parsons, 1999). Despite being involved in the Wellspring Program for two-and-a-half years at the time of data collection, the results of the present study showed significant levels of confusion among licensed nurses. This suggests that *all* nurses -bedside care providers, management and administration- need to be given adequate time to learn, negotiate and integrate changes. Kroposki et al.’s study also notes the need to define clearly the licensed nurse’s role during and after the change process. In light of the present study’s results, the need to address role expectations during and after change is a particularly critical step to rolling out large-scale changes.

Conflict

Respondents in the present study characterized their organizational culture as dominated by rules and respect for conformity. As well, interviewees in this study reported various factors that affected their ability to participate in the Wellspring Program including adequate levels of staffing and familiarity with assigned tasks, unit and

coworkers. Considering these findings in the context of an organizational change program that encouraged resident-centeredness and front line decision making, it was clear that nurses were struggling to integrate conflicting concepts. The organizational culture had a high respect for rules, policies and managerial control, but the Wellspring Program pushed the concept of individualized, resident-directed, preference-oriented care. Conformity to rules was emphasized in the organizational culture, but the Wellspring Program emphasized independent, front line decision making from hands-on care staff. It appeared that the existing organizational culture was often at odds with Wellspring values.

Quadagno defined role conflict as “occur(ing) when the demands of two or more roles held by a person are incompatible, and the demands cannot be simultaneously met” (1999, p. 407). Kleinman (2004) noted role conflict is most likely to develop when nurses have to manage two or more competing roles. One example of role conflict mentioned by interviewees was the balance of resident preferences with task completion in an orderly and timely manner and within the intensely regulated nursing home environment.

Several studies have found job dissatisfaction and negative organizational outcomes to be associated with role conflict (Gray-Toft & Anderson, 1985; Sowell & Alexander, 1989; Bacharach, Bamberger & Conley, 1990). The present study did not measure job satisfaction or organizational outcomes. Further, Kroposki and colleagues stated, “High levels of role conflict are associated with staff inefficiency and dissatisfaction with the organization of the specific job” (Kroposki, Murdaugh, Tavaloki & Parsons, 1999, p. 28).

While the present study did not address the efficiency of nurses, it was noted, in both WES results and interviews, that respondents widely reported feeling overwhelmed by a task orientation and work pressure.

Misiorski and Kahn state, “In traditional long term care facilities, organizational *values in action* typically include respect for medical authority, efficiency, and staff and resident compliance” (2005, p. 139, emphasis in original). Nursing work in the nursing home is typically very task-oriented, formulaic and designed to accommodate the demands of the institution, rather than the preferences of the resident. In a study examining burnout, Acker (2003) noted incongruence between the present jobs and the educational training, experience and desires of mental health workers. A similar conflict was noted from nurse participants in the present study, as they repeatedly voiced anguish over activities related to increased documentation, care management, delegation and tasks that removed them from their “essential job” of hands-on, resident-centered care.

At its core, culture change is aimed at transformation of the nursing home into a home-like and resident-centered environment. It must also be recognized, however, that residents live in a nursing home based on defined levels of functional and medical limitations. Therefore, nurses are expected to balance their responsibility to provide nursing care with an added layer of resident-centered culture change expectations and little insight into how these two paradigms are best integrated. In an examination of different culture change interventions, Bond and Fiedler found that,

“Cherished management theories regarding job descriptions, performance evaluation and organizational structure, when applied to long term care institutions, typically reinforce the status quo and in fact serve as major barriers to change. For example, most job descriptions identify the health and safety responsibilities or ‘tasks’ of nursing personnel but fail to consider the intangible tasks, such as psychosocial well-being, that promote the neighborhood (culture change) ideas” (1999, p. 42).

The conflict between the stated contractual and legal requirements of nursing staff and the expectations imposed by culture change further the potential for role conflict.

Additionally, Esposito (1998) found that realigning the work environment to a patient-focused model of care further contributed to task orientation, as nurses struggled to delegate many hands-on tasks to assistive personnel. Esposito’s findings were reflected by the task-oriented, rules-driven characterization of a Passive/Defensive culture, as found in the present study. To ease the transition during organizational change, Kleinman suggests that management and administration should “develop an appreciation for the scope and types of role conflicts that nurses experience” (2004, p. 323). This forethought may be critical to negotiating the integration of medical, task orientation with resident-centered, preference-driven orientation.

Commitment

Despite some frustrations, nurses showed evidence of dedication and commitment to their jobs, to each other and to the residents. Nurses were enthusiastic about participating in this study and often began to tell the researcher anecdotes about their job even before accepting a survey packet. Interviewees often went out of their way to meet with the researcher and two noted that participating in research made them feel important and that they were eager to share stories about their jobs. One administrator repeatedly refused to accept gasoline card compensation, preferring that the researcher save them for other

participants instead. Nurses scored highly on the OCI Humanistic-Encouraging subscale, evidence of a supportive and helpful culture between coworkers and a high commitment to the organization. Further, respondents reported higher than average concerns for and commitment to their jobs on the WES Involvement subscale. Interviewees confirmed these results with frequent reports of teamwork and support from both coworkers and management. Interviewees also spoke passionately about care-giving and the creation of a “home” or “resident-centered” environment that was in the best interests of the residents, yet it was unclear what this environment might look like.

There is very little in the literature regarding culture change implementation and most research focuses solely on general programmatic descriptions or the barriers to implementation. One exception is a study by Scalzi, Evans, Barstow & Hostvedt (2006) that discusses both barriers and enablers to changing organizational culture in nursing homes. Scalzi and colleagues found that having a critical mass of “change champions” who share common goals and values was critical to committed organizational culture change.

Scalzi et al. (2006) also found that a management style that was congruent with the underlying culture change values, respectful of others and that valued person-centered care and quality of work life enabled successful culture change. Managers interviewed for the present study acknowledged the difficulty finding time and staffing resources for participation in Wellspring activities, but they all mentioned the concerted effort to reward staff and to accommodate work schedules to permit participation. Respondents reported average levels of WES Supervisor Support.

Both nursing homes had been engaged in Wellspring implementation for two-and-a-half years at the time of data collection. Changing the decision-making structure and hierarchy was a work in progress. Front line decision making is a core tenet of the Wellspring Program. Several articles suggested that a flattened hierarchical structure that encourages front line decision making was helpful to accomplish meaningful organizational change. Bond and Fiedler (1999) noted that this behavior was most critical at the “sub-organization level,” in the case of the present study, the individual unit. Chenoweth and Kilstoff (2002) found that flattened organizational structures that enabled front line decision making and sincere managerial support for staff- and resident-initiated decisions were most supportive to change. Misiorski & Kahn noted that flattening the traditional hierarchy and involving residents and nurses in the planning and implementation of change were key factors in ensuring the transformation of the nursing home to a “true home” (2005, p. 145).

The commitment to change can be complicated by perceived benefits or losses. Bartunek and colleagues stated, “...(change) recipients often gauge organizational change in terms of their own perceived or anticipated gains or losses from it, the extent to which change makes the quality of some aspect of their work or work life better or not” (2006, p. 188). In contrast, nurses in the present study, both during interviews and anecdotally, frequently spoke of their commitment to creating a “home” that was respectful of the residents’ wishes. While interviewees shared frustrations regarding the workplace, there was a strong sense that they were committed to creating an environment that was in the best interests of the residents and that nurses’ desires were secondary to that ideal.

Contributions to the Science

This study adds to a slim body of research regarding understanding the perceptions of the change recipient. More specifically, this study provides insight into the thoughts and perceptions of the licensed nurse in the presence of nursing home culture change. Understanding the confusion and conflicts that licensed nurses experienced when implementing the Wellspring Program will provide guidance for administrators and change initiators. When attempting to implement widespread organizational change, it is imperative that change initiators are aware of the time, effort and clarity necessary for licensed nurses to create a resident-centered culture.

Further, results from this study provide some insight into why licensed nurses are often viewed as primary barriers to organizational change. What is perceived by administrators as “resistance” may, in fact, be a struggle by licensed nurses to make sense of the motivation and reasoning for changes or to understand the actual changes and their roles in change. Nurses in the present study also faced conflict when they were attempting to integrate concepts and programs that were contrary to the existing organizational culture.

“Resistance to change” may be best addressed by improved communication and attention to providing the resources necessary for licensed nurses to learn about change and to create and integrate an environment that is conducive to the primary goals of the change program. Culture change programs must be presented clearly, with a vision that is easily articulated to all staff, concentrating on those who will be implementing the majority of changes. The culture change process itself should take into consideration the

conflicts inherent in transforming a task-oriented paradigm into a resident-centered environment. Training and implementation of the culture change program should provide numerous, concrete problem-solving strategies for staff in order to minimize confusion and frustration.

The present study revealed that, despite confusion and conflicts, licensed nurses were committed to their jobs, to each other and to the residents. None of the nurses interviewed indicated that they were deliberately impeding the change process. They exuded an overall dedication that suggested resistance to change was not the primary motive, but perhaps a surface manifestation of confusion and conflict.

Limitations

Sampling

There were several limitations to this mixed methods study. There was an adequately sized sample to draw conclusions from qualitative data; however, the overall sample was too small to make generalizations from the quantitative findings. The quantitative portion of this study was based on a convenience sample, further limiting the generalizability of findings. Although attempts were made to involve licensed nurses representing all demographics, shifts and job, some groups remained underrepresented in the final sample and no information is known about the non-responders. Moreover, the interviewee sample was purposively selected based upon length of employment tenure in each nursing home. This method deliberately excluded those licensed nurses with less tenure, and potentially neglected important findings from them. Nevertheless, it was determined that the quantitative sample was reflective of each nursing home's overall

licensed nurses and, with the exception of tenure in the job, the interviewee sample was not statistically different from the survey respondents.

Potential for Obscured Results

Another major limitation to this study was the potential for obscured results. In order to increase the pool of potential respondents, licensed nurses from two nursing homes were invited to participate in this study. Ostensibly, it could be argued that each nursing home yielded a different organizational culture, thereby also affecting the perceptions and thoughts of nurse respondents. While it was true that each nursing home had unique issues (for example, only one nursing home employed agency staffing), the overall identified themes of confusion, conflict and commitment held strongly across facilities. This limitation could be addressed in future studies by altering the study design to an in-depth case study of one nursing home or, alternatively, to measure more global aspects of organizational culture across several nursing homes undergoing similar changes in culture.

A major theme of the qualitative findings was the confusion surrounding the Wellspring Program. Several interviewees stated that they were unsure of what the Wellspring Program was or incorrectly attributed other workplace changes to Wellspring when, in fact, the changes were likely unrelated. Further, some interviewees who were knowledgeable about Wellspring and its implementation noted that their nursing home was not yet “into” culture change and that Wellspring changes had yet to fully affect all staff members. Although the present study was designed to identify those factors influencing the adoption of the Wellspring Program, the confusion surrounding this

program may have obscured results. Nevertheless, the confusion noted from licensed nurses was a significant and major finding regarding job clarity and communication in the nursing home. Licensed nurses reported their perceived realities regarding the Wellspring Program, and therefore, despite confusion, data were qualitatively valid.

Exploratory Design

Since this study was designed as an exploratory analysis, a wider p-value of $p < .10$ was used to detect significance of results. Conventional research generally uses a $p < .05$ level of significance. Since the p-value in this study was larger, it is possible that some results were identified as significant, when in fact, the results were artifacts. As well, it is possible that no differences were found where differences actually existed. Using a wider p-value, however, allows the researcher to identify areas and themes worthy of future inquiry.

Additionally, this study was not sufficiently powered to detect for statistical differences between groups. Although an exploratory analysis of findings by demographic groups could be performed, it could not be said with certainty that these results would be valid due to the small sample size. An exploratory design and analyses, however, could provide findings that may be used as a pilot study to direct future inquiry or study design.

Organizational Culture Inventory

Although the OCI is the most widely used tool for measuring organizational culture, it was constructed using a normative sample of many different organizations of varied sizes and industries. It has shown strong psychometric properties and reportedly has been used

extensively in the health care field. The OCI normative sample, however, has questionable representativeness of gender and race. Given that the licensed nurse workforce is predominately female, this may affect the validity of the OCI for the nursing home workforce population. A representative of Human Synergetics International was unable to provide information regarding representativeness in the normative sample or the extent of use of the OCI in the nursing home setting (C. Perry, personal communication, January 10, 2007). Further instrument testing is needed to determine if the OCI is a valid and reliable instrument in the nursing home.

Implications for Practice and Policy

Findings from the present study emphasized that the nursing home environment is constantly changing. Nursing homes, in particular, are experiencing a need to change in the face of an aging population and competition from less “institutional” environments such as assisted living facilities. Culture change programs are now “a significant part of the national agenda in long-term care” (Misiorski & Kahn, 2005, p. 138). Nursing homes will continue to change and administrators need to be prepared to work with licensed nurses to accomplish culture change. Kroposki and colleagues acknowledge this, stating, “In an atmosphere where jobs are redesigned and new practice roles created, the nurses’ role is also changing. These role changes confer ambiguity on nursing roles and contribute to role conflict (as role responsibilities change or overlap)” (Kroposki, Murdaugh, Tavakoli & Parsons, 1999, p. 33). Acknowledging and anticipating the potential for role ambiguity and role conflict during times of change may be a critical behavior to the successful adoption of culture change. Role ambiguity and role conflict

must not be viewed as failures of the implementation process, but instead as artifacts common to widespread change programs. Accounting for these factors should be part of the timeline and training for all staff involved in culture change.

Bond & Fiedler (1999) found that planning for programmatic change must be as rigorous as if a complete physical plant renovation were being planned. Regarding culture change specifically, Bond and Fiedler remarked that in order to support a true change in organizational culture, careful thought must be given to provision of necessary resources before action is taken. Robinson and Rosher (2006) acknowledged that culture change programs are evolving, long-term projects. They suggested starting with easily-implemented and attainable changes, emphasizing positive outcomes with staff and providing encouragement and buy-in for future changes. Based on the results from the present study, it is important to secure staff buy-in, support and participation from the beginning of the implementation of culture changing programs. Clearly communicating the goals and expectations for culture change is a managerial imperative for successful implementation.

In the policy arena, the Centers for Medicare and Medicaid Services (CMS) oversees a network of 53 Quality Improvement Organizations (QIOs) whose purpose is “to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries”

(http://www.cms.hhs.gov/QualityImprovementOrgs/04_9thsow.asp#TopOfPage). Every three years, CMS issues a new Statement of Work, or statement of priorities, for health care improvement. In 2005, CMS issued the 8th Statement of Work, focusing on person-

centered care across health care settings. Results from the present study can be used to inform future policy and Statement of Work initiatives by extending the understanding of the role of licensed nurses in creating a person-centered environment. Although the 8th Statement of Work requires measurement of staff and resident satisfaction annually, it is suggested that CMS research more thoroughly nurses' involvement in person-centered care. This could mean funding demonstration projects that show sustainable person-centered care models and that minimize nurses' confusion and conflict and reward commitment.

Directions for Future Research

The findings from this study suggest several potential avenues for future research. Misiorski & Kahn noted that culture change is vulnerable to "misunderstanding and misinterpretation" (2005, p. 138). Further, the Executive Director of the Pioneer Network stated, "Perhaps the most vulnerable aspect of this misunderstanding is the difference between implementing a program, and genuinely changing the culture" (Pioneer Network, 2005). These statements were clearly supported by the confusion shown by nurse participants in the present study. The intent of the present study was to examine licensed nurses' perceptions of organizational culture and work environment during a culture change and not the actual change in culture. It is possible that nurses were actually living culture change, but did not have the words to describe it. Observational, ethnographic study of the everyday operations of the participant nursing homes would be necessary to test this hypothesis.

As the culture change movement expands, it is imperative to distinguish between programmatic changes and the deep, organizational transformations associated with culture change. There is concern that culture change will become a meaningless buzzword instead of a profound shift in the conceptualization and implementation of long term care (Angelleli & Higbie, 2005). Research that determines if culture change is in alignment with its espoused values and actually representative of resident-centered care that values the individual is critical to ensuring an honest shift from an institutionalized environment to home-like care.

Further conceptualization of the meaning of culture change and an agreement among industry stakeholders is needed to improve the integration and evaluation of these programs. As conceptualization and standardization of the meaning of culture change become clearer, exploring the conflicts inherent in meeting the medical needs of residents while maintaining a non-institutional, resident-directed environment is a critical step to securing the sustainability of culture change programs. As well, additional research regarding the integration of front line decision making in the highly-regulated nursing home environment is needed.

Further, the conceptualization and clarification of culture change will help determine a realistic timeline for its implementation. Interviewees in the present study repeatedly mentioned delays in the roll out of the Wellspring Program. Often, business managers are interested in short-term evaluations and outcomes from programming such as Wellspring that requires much time, resources and investment from the nursing home. It is disingenuous to evaluate large-scale organizational change such as the Wellspring

Program before changes have been implemented at a level and length of time sufficient to generate adequate data. The CEO of Wellspring Innovative Solutions, Incorporated, indicated that participant nursing homes should start to show *beginning* evidence of change six to nine months into the initiation of the Wellspring Program (T. Lohuis, personal communication, April 11, 2007). It was unclear what kinds of change could be detected by this time.

It would be of value to examine other Wellspring Program facilities to determine if findings from the present study are typical or isolated to the licensed nurse participants in this study. As well, including the perspectives of residents, their families and non-nursing staff would help to provide a more complete picture of the Wellspring Program and its implementation. These groups are each critical stakeholders in the nursing home environment. Understanding culture change from the perspectives of residents, families and non-nurses may provide greater clarity and insight into deep organizational change.

Summary

This purpose of this study was to examine licensed nurses' perceptions of organizational culture and work environment in the presence of a culture change initiative, the Wellspring Program. Additionally, this study sought to identify nurses' perceptions of those factors of organizational culture and work environment that influence the adoption of the Wellspring Program. Quantitative findings revealed that nurses believed that they operated in a task-oriented, rules-bound environment with high work pressure that encouraged conformity and discouraged innovation. Clearly, it was a struggle to integrate nurses' perceptions of their organizational cultures with the defined

goals of a culture changing environment. Nurses also reported a strong commitment to their jobs, to each other and to residents. Qualitative data revealed significant confusion regarding the Wellspring Program, as well as several issues of conflict between roles and expectations of the licensed nurse engaged in culture change.

Communication and clarity regarding job expectations is crucial to successful culture change. This communication must be inclusive of all nursing staff, regardless of the typical days or shifts that are worked. The present study also indicated that more attention should be paid to the integration of a traditional, task-oriented paradigm with the resident-centered ideals of culture change. In order to invert the decision-making hierarchy, bringing care decisions to the resident and front line nurses, sufficient time and staff education, modeling and support are needed. Licensed nurses in this study also reported that accommodating schedules and teamwork from coworkers and management are necessary to support a sustained effort for organizational change.

Previous research regarding programs of culture change omitted the voices of licensed nurses. This study showed that licensed nurses are an important element in culture change and are essential to implementation. “Resistance to change” may be a surface manifestation of confusion and conflict that arises from culture change. The dedication of licensed nurses to providing humanistic, resident-centered care should not be underestimated amidst the challenges associated with deep organizational change. Adequate role definition and support for the licensed nurse is critical if culture change that is meaningful to both the organization and resident is to be accomplished.

“In the end, programs come and go, but cultures live on”
(Misiorski & Kahn, 2005, p. 146).

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Appendix A
Adapted Conceptual Model

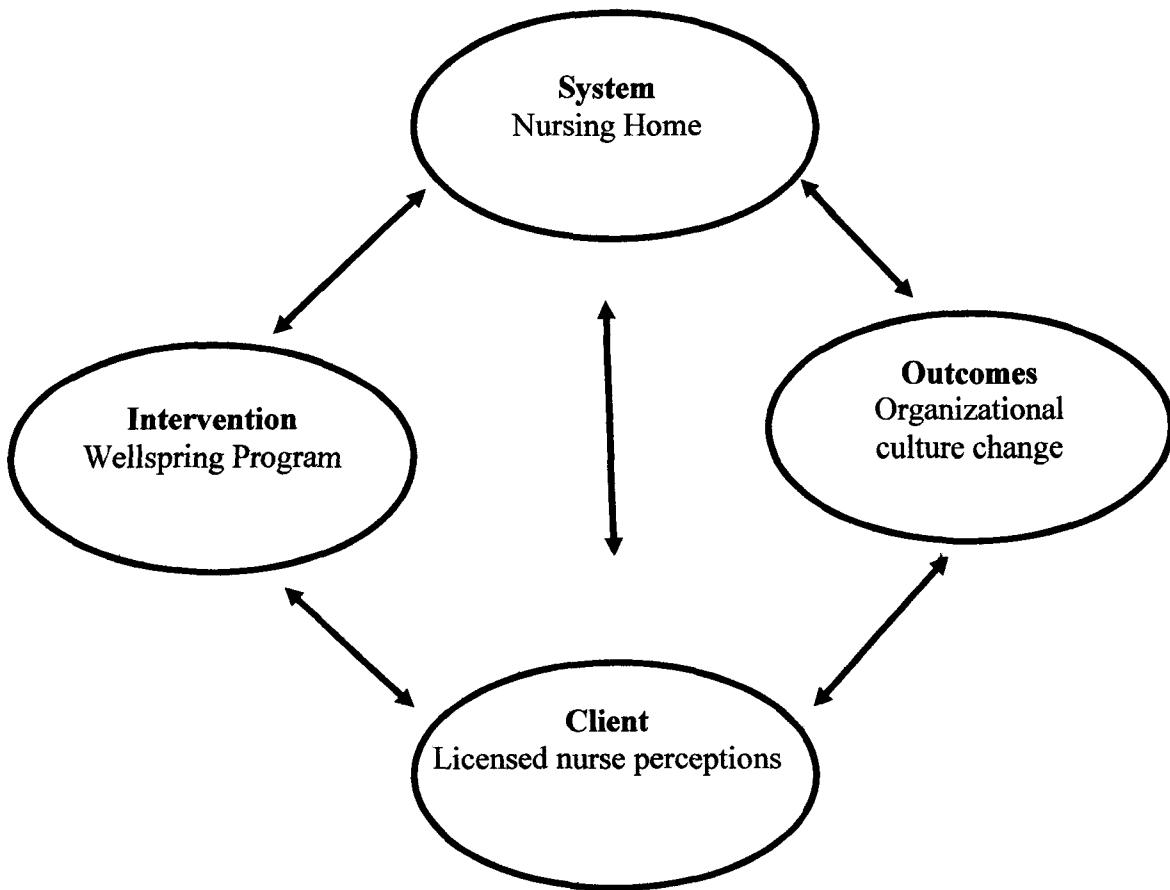


Figure 1. Adapted from the Quality Health Outcomes Model, Mitchell et al., 1998

Appendix B
Chart of Study Variables, Definitions and Measurement Tools

Variable	Definition	Measurement
Organizational Culture	“...the assumptions which lie behind values and which determine the behavior patterns and the visible artifacts such as architecture, office layout, dress codes, and so on” (Schein, 1987)	Organizational Culture Inventory (OCI)
Work Environment during culture change	Licensed nurses’ perceptions of the organizational culture of their nursing home <i>during</i> Wellspring Program culture change.	Work Environment Scale (WES) Semi-structured interviews
Facilitators and Impediments to Wellspring Program Culture Change	Licensed nurses’ descriptions of the factors of organizational culture that influence the adoption of the Wellspring Program in their nursing home	Semi-structured interviews
Facility Characteristics	Facility ownership, age of plant, tenure of Medicare license, tenure of current administrator, tenure of current Director of Nursing, nursing hours per resident day (RN and LPN), number of licensed beds and number of licensed nurses employed	Nursing Home Compare Facility administration verification
Licensed Nurse Characteristics	Gender, age, type of nursing license held (RN or LPN), tenure of nursing license, length of time working in long term care as an RN or LPN, length of time working in present facility as RN or LPN, employment status (full time, part time, per diem, agency), typical shift worked, primary job responsibilities (direct care, supervision, administration, other) and highest level of nursing education attained	Demographics Sheet

Appendix C
Interview Guide

<i>Concept</i>	<i>Topic</i>	<i>Questions</i>
Background	-Personal -With LTC -With Wellspring	<p>1. Could you tell me about your nursing experience?</p> <p>Probes: Experience in nursing, how long, what areas?</p> <p>2. Tell me about your experience in long term care. Nursing homes?</p> <p>Probes: What brought you into long term care? This facility? How long have you been here? How many hours do you work a week? What do you feel is your primary job at this nursing home? (direct patient care, administration, etc.)</p> <p>3. What do the words “culture change” mean to you in terms of your job?</p> <p>4. Tell me about your experiences with nursing home culture change programs. The Wellspring Program?</p> <p>Probes: Do you know what the Wellspring Program is? Have you had any specialized training in Wellspring implementation or in nursing home culture change specifically? Prior to this job, did you have any experience with nursing home culture change programs?</p> <p>5. When did you learn about the Wellspring Program? Tell me how you learned about this program. Tell me how you were oriented to the program.</p> <p>6. Were you working at this nursing home when the facility started participating in Wellspring?</p>

<p>Current Responsibilities</p>	<p>-Current responsibilities</p> <p>-Relationship w/ other responsibilities</p> <p>-Workload burden</p>	<p>1. Tell me about the responsibilities of your current job. Describe a typical day at work.</p> <p>Probe: In what parts of your job are you involved with the Wellspring program? Do/did you do any planning with the implementation of the program?</p> <p>2. Tell me about your general impressions of the work environment. What do nurses here like about their jobs? What makes it difficult for nurses to do their jobs?</p> <p>Probe: Can you tell me a story that would give an example?</p>
<p>Before Wellspring and Wellspring participation</p>	<p>-Perceived differences</p> <p>-Factors influencing implementation</p>	<p>If you worked at this nursing home before Wellspring, I am going to ask you to try to remember what working at this facility was like before the Wellspring Program began.</p> <p>1. Tell me how your job was different two years ago.</p> <p>For everyone:</p> <p>2. How do you think participation in the Wellspring Program has affected the nurses (RNs and LPNs) in this facility?</p> <p>3. How has it affected the jobs that nurses do? Tell me a story about how Wellspring has affected the jobs of nurses here.</p> <p>4. Tell me about the benefits nurses perceive participating in the Wellspring Program. Are there things about the</p>

		<p>Wellspring Program that nurses like? That make your job better or easier? What about the work environment here makes it easier for nurses to participate in the Wellspring Program?</p> <p>5. Tell me about what you think is the hardest part of participating in the Wellspring Program. What about the work environment makes it difficult for nurses to participate in Wellspring?</p>
Care Perceptions	<p>-Delivery affected by Program</p> <p>-Quality affected by data collection</p> <p>-Nonsense and burden</p>	<p>1. Do you perceive that the care delivery in this facility better or worse with the Wellspring Program? Is it easier or harder for nurses to do their jobs now than when you started working here? Do you feel that nurses provide better, worse or the same level of care to your residents since the Wellspring Program began?</p> <p>2. Do you perceive that the quality of the care nurses give is affected at all by participation in the Wellspring Program? Tell me a story to give an example.</p> <p>3. Are there any parts of the Wellspring Program or of nurses jobs that you feel are useless, nonsense or overly burdensome? Tell me a story to give an example.</p> <p>4. Are there any key areas that you feel Wellspring does not address?</p>
Effects	<p>-Job related</p> <p>-Facility related</p> <p>-Resident related</p>	<p>1. Do you feel that nurses jobs have been positively, negatively or not affected by participation in the Wellspring Program? How do you feel your facility's participation in Wellspring affects nurses' ability to do their jobs? Give me an example.</p>

		2. In what ways do Wellspring responsibilities affect the nurses' other responsibilities?
Future	-Trends -Personal involvement	<p>1. Where do you see the future of your job? Do you plan to remain in this facility? Where do you see the future of your facility's participation in the Wellspring Program?</p> <p>2. Are there any other parts of your job or about your facility's participation in the Wellspring Program that you would like to tell me about?</p> <p>Probes: Ask for stories to illustrate answers.</p>

Appendix D
Nursing Home Characteristics Form

Facility Code _____

Facility ownership _____

Age of plant _____

Tenure of Medicare license _____

Tenure of current administrator _____

Tenure of current Director of Nursing _____

Nursing hours per resident day (RN and LPN) _____, _____

Number of licensed beds _____

Number of licensed nurses employed _____

Appendix E
Nurse Demographics Form

1. Please circle your gender: Male Female
2. What was your age on your last birthday? _____ years
3. Please circle what type of nursing license you hold. RN LPN
4. To the nearest year, how long have you been an RN or LPN? _____
5. To the nearest year, how long have you worked in long term care (this or any other nursing home) as an RN or LPN? _____
6. To the nearest year, how long have you worked in THIS nursing home as an RN or LPN? _____
7. Please circle your employment status at THIS nursing home:
- Full time Part time Per diem/pool Agency
8. Please circle your highest level of NURSING education:
- Diploma Associate degree Baccalaureate degree Masters degree
- Other (please specify) _____

Thank you. Please proceed and complete the survey packet.

(Researcher Use Only; DO NOT COMPLETE)

Facility ID _____

Appendix F
Qualitative Analytic Activities Chart

Analytic Activity	Purpose	Analytic Focus (Unit: Inter, Intra)	Product
Corrected transcripts, developed pseudonym list	Ensure accuracy, reduce possibility of subject identification	Both	Clean and accurate interview data
Listened to recordings as interviews were scheduled and transcripts were prepared	Listen for saturation, initial impressions	Intra	Overall sense of interviews, noting repetition and new issues for follow up
Simultaneously kept: Audit trail Memos Field notes	<ol style="list-style-type: none"> 1. Can re-trace analyses 2. Helped with determining saturation, initial thematic ideas, issues needing follow- up 3. Impressions of environment & subjects; reflexive bracketing 	Both	Insights and patterns within and across interviews
Started regular meetings with qualitative peer group	Maintain validity of data analysis	None	Advice on data set- up, help with determining saturation, analysis and methods
Met with qualitative mentor	Maintain validity of data analysis	None	Plan for continued data analysis
Did holistic reading of each interview, created extensive comments	Allowed researcher to “re-tell” the story of that interview based on the notes I made, familiarized myself with the data before coding began	Inter	Memos and initial coding scheme

Read interviews line by line, developed codes	Initial codes allowed researcher to see “building blocks” for later overarching themes	Intra	Initial coding scheme, continued
Continued to make notes of impressions, thoughts and initial analyses, created additional categories that were reflective of more than one key thought or concept	Coding scheme refined and revised for accuracy and repetition, overarching categories identified to help “tell the story”	Both	Codes and categories
Simultaneously, continued meetings with peer group, qualitative mentor, committee chair	Maintained validity of data analysis	None	Revisions as needed

Appendix G
Consent for Participation

Title of Research Study: Consent Form for Participation in: A Descriptive Study of Nursing Home Organizational Culture and Culture Change from The Perspectives of Licensed Nurses

Principal Investigator: *Jennifer Bellot, RN, MHSA, 617 E. Mt. Airy Ave. Philadelphia PA 19119, (215) 206-1190; Email: jseamon@nursing.upenn.edu*

Co-investigator: Lois K. Evans, Ph.D., RN, FAAN, 420 Guardian Drive Philadelphia PA 19104, (215) 898-2140; **Email:** evans@nursing.upenn.edu

Emergency Contact: *Jennifer Bellot, RN, MHSA, 617 E. Mt. Airy Ave. Philadelphia PA 19119, (215) 206-1190; Email: jseamon@nursing.upenn.edu*

You are being asked to take part in a research study. Your participation is voluntary which means you can choose whether or not to participate. If you decide to participate or not to participate there will be no loss of benefits to which you are otherwise entitled. Before you make a decision you will need to know the purpose of the study, the possible risks and benefits of being in the study and what you will have to do if you decide to participate. The researcher is going to talk with you about the study and give you this consent document to read. You do not have to make a decision now; you can take the consent document home and share it with friends and family.

If you do not understand what you are reading, do not sign it. Please ask the researcher to explain anything you do not understand, including any language contained in this form. If you decide to participate, you will be asked to sign this form and a copy will be given to you. Keep this form; in it you will find contact information and answers to questions about the study.

What is the purpose of the study?

The purpose of the study is to learn more about culture change in nursing home settings. The researcher would like to know how RNs and LPNs experience culture change and what about the work environment makes it easier or harder to participate in and achieve culture change. This study is being conducted as a doctoral dissertation project.

Why were you asked to participate in the study?

You are being asked to join this study because you are an RN or an LPN who works in a nursing home that is participating in the Wellspring Program. In order to participate in this study, you must work a minimum of twenty hours per pay period and speak and write English.

How long will you be in the study? How many other people will be in the study?

The study will take place over a period of one year. There are two parts to this study. ALL participants will be asked to complete a packet of surveys that describes the environment in which you work. SOME study participants also may be asked to participate in a one-on-one interview with the researcher. The surveys are expected to take you about 30 minutes to complete. The interview is expected to last 45 minutes to one hour.

You will be one of about 50 licensed nurses in the study.

Where will the study take place?

You will be asked to complete the surveys on non-work time. If you are asked to participate in an interview, the researcher will arrange a time and place at your convenience, not on paid work time.

What will you be asked to do?

You will be asked to complete a packet of surveys about your work environment in the nursing home. You MAY also be asked to participate in an interview. The interview will include questions about your work environment in more detail, your experiences with culture change and those things about your work environment that have made it easier or harder to participate in and achieve culture change.

What are the risks?

There are no physical risks to you. There is minimal likelihood that you may become upset by answering survey or interview questions about culture change and your work environment. There is a risk of possible breach of confidentiality in the case that your information is accidentally seen by someone other than the researcher. Procedures to minimize this risk have been put into place such as using a locked box to collect the report forms in sealed envelopes and keeping the data secure. All surveys and interviews are confidential.

How will you benefit from the study?

There is no direct benefit to you. However, your participation could help us understand the nurses' experience of culture change. In the future, this may help other nursing homes to implement culture change with the nurses' experiences in mind.

Will you be compensated for participating in this study?

In compensation for the time you will give to answering surveys and participating in the interview, you will receive a gift certificate for gasoline for each stage of the project in which you participate.

What other choices do you have?

Your alternative to being in the study is to not be in the study.

What happens if you do not choose to join the research study?

You may choose to join the study or you may choose not to join the study. Your participation is voluntary.

There is no penalty if you choose not to join the research study. You will lose no benefits or advantages that are now coming to you, or would come to you in the future. Your employer will not be upset with your decision and participation will not affect your job.

When is the study over? Can I leave the study before it ends?

The study is expected to end after all participants have completed all surveys and interviews.

You have the right to drop out of in the research study at any time during the study. There is no penalty or loss of benefits if you do so.

If you no longer wish to be in the research study, please contact Jennifer Bellot, at (215) 206-1190 to say that you are no longer interested in participating.

How will confidentiality be maintained and your privacy be protected?

The researcher will make every effort to keep all the information you tell her during the study strictly confidential, as required by law. The Institutional Review Board (IRB) at the University of Pennsylvania is responsible for protecting the rights and welfare of research volunteers like you. The IRB has access to study information. Any documents you sign, where you can be identified by name will be kept in a locked drawer in the researcher's office. These documents will be kept confidential. All the documents will be

destroyed when the study is over. The surveys will be identified using a code that represents the nursing home in which you work. No further identification information will be used. The interviews will be tape recorded, but your name will not be used during the interview. After the interviews have been transcribed, the tapes will be destroyed. The data will be stored on a password-protected computer hard drive that is only accessible to the researcher. The original paper copies of these data will be kept in a locked file cabinet in a locked office to which only the researcher has the key. If any publications or presentations result from this research, you will not be identified by name. All the documents will be destroyed when the study is over.

What happens if you are injured from being in the study?

If you are injured and/or feel upset and emotional discomfort while participating in the study you may contact Jennifer Bellot using the information on the first page of this form. If you feel emotional discomfort from being in the study, appropriate care will be provided without cost to you, but financial compensation is not otherwise available from the University of Pennsylvania. If you are injured and/or feel emotional discomfort while in the study but it is not related to the study, you and your insurance company will be responsible for the costs of that care.

Will I be compensated for participating in the study?

To show our appreciation for your time, the researcher will give you gift certificates for gasoline after you return the completed survey packet and, if selected, after you participate in an interview.

Who do you contact if you have questions about your rights and welfare?

If you have questions about your rights and welfare as a volunteer in the research study please contact the Office of Regulatory Affairs at the University of Pennsylvania at 215-898-2614 and/or Jennifer Bellot.

Who do you contact if you have questions about the study?

If you have questions about the research study please contact Jennifer Bellot at the information listed on the first page of this document or any of the other persons identified.

Consents and Signature

I have been given a chance to ask questions and feel that all of my questions have been answered. I know that completing the survey and participating in the interview is my choice. I have been given a copy of this consent form to keep.

I have read the part of this form that describes the survey and interview parts of the study. My choice about completing the survey under the conditions described is (please check ONE option):

_____ I agree to complete the survey.

_____ I do not agree to complete the survey.

My choice about participating in the interview if contacted under the conditions described is (please check ONE option):

_____ I agree to participate in the interview if I am contacted.

_____ I do not agree to participate in the interview if I am contacted.

If you are selected for an interview, we will need a phone number in order to contact you.

**Phone number of
Subject** _____

Signature of Subject

Print Name of Subject

Date
