A Cultural Shift

Resident-Directed Care at Providence Mount St. Vincent in Seattle Places Elders at the Center of the Universe

The daughter of a 92-year-old female resident of Providence Mount St. Vincent threatened to sue the nursing home when she learned the staff was serving bacon to her mother. The elderly patient was on a salt-free diet. Tense meetings with administrators and staff followed. In the end, however, the woman decided that her mother deserved the pleasure of crisp, smoky bacon — if that's what *she* wanted.

Since 1990, the Mount, as it is known to residents, has been one of a handful of pioneers in terms of catering to residents. It is a leader in a culture change movement that is questioning, challenging and transforming how long-term care facilities operate. Human dignity, relationships, community, individual rights and self-direction are of utmost importance.

As People of Providence, we reveal God's love for all, especially the poor and vulnerable, through our compassionate service. We abide by the core values of:

- **Respect** — all people have been created in the image of God
- **Compassion** — Jesus taught and healed with compassion for all
- **Justice** — this is what the Lord requires of you: to act with justice
- **Love** — with kindness and walk humbly with your God
- **Excellence** — much will be expected of those who are entrusted
- **Stewardship** — the Earth is the Lord's, along with all that is in it

Given that nursing homes have traditionally *not* been guided by such ideals, many people, if not most, are surprised to learn that a quiet revolution is altering deeply entrenched practices and aiming to return rights to residents. Yet, 2007 marked two important anniversaries: 20 years since Congress enacted the Nursing Home Reform Act and 10 years since a coalition of change advocates formed the Pioneer Network.

The occasion of these two landmark events is an appropriate time to review what has transpired at transformational facilities like the Mount, and to reflect on how Catholic health ministry might better serve older adults in ways consistent with our core values.

FACTS AND FIGURES

Traditional long-term care:
- Medical treatment is the focus
- Decision-making is centralized, done by the physician and nurse
- Nursing stations are the hubs of activity
- Staff assignments rotate
- Scheduling is suited to meet staff's, not residents' needs
- There is a hospital environment (e.g. overhead paging is a common feature)
- Residents have semi-private rooms and shared bathrooms
- Activities are tightly structured
- Residents are often isolated with no sense of community

LIFE AT THE MOUNT BEFORE CULTURE CHANGE

Perched atop a hill in West Seattle, overlooking Elliott Bay, the Mount opened its doors as St. Vincent's Home for the Aged in 1924. Its founders, a group of trailblazing Sisters of Providence, were passionate about their mission: providing loving, compassionate, respectful care for older adults.

Born of that mission, the home became successful and respected. Even so, it adhered to the norms of an institution-centered, as opposed to a person-directed facility. This was especially true after the emergence of Medicare and Medicaid in 1966.

BY CHARLENE BOYD & BRUCE JOHANSEN

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Author Beth Baker of *Old Age in a New Age: The Promise of Transformative Nursing Homes* (reviewed in this issue on p. 67) observes that it was during this period that long-term care facilities became the "total institution" sociologist Erving Goffman wrote about in *Asylums*. There was little about them that resembled home. They were places that people came to die, not live.[1]

Faced with new federal and state regulations, the staff's focus became the completion of tasks with greater efficiency. Rather than tending to residents holistically, they found themselves striving to meet arduous reporting requirements for reimbursement. Staff's schedules — what could be accomplished during a shift — took precedence.

Before its transformation, the Mount was organized in a centralized and hierarchical manner, like any hospital. Staff members viewed themselves as experts who knew what residents needed, always defined in medical terms. Residents, in turn, adapted to a culture that fostered dependence. From the activities they participated in, to the foods they ate, and when they took their medicines or meals, medical professionals made decisions for them. Life histories, long-held interests, and personal preferences were largely ignored.

Instead of being known by their names, residents were categorized by medical conditions, disabilities, diseases and the level of care they needed. Hospital-like language prevailed in other ways: "patient," "ward," "floor" and "unit."

The environment itself was sterile, marked by long halls and hard surfaces. It was immaculately clean.

Former administrator Bob Ogden told *The New York Times* that when he began in 1990, "care" meant protecting residents to the point they had no freedom, dignity or basic rights. "We didn't want them to fall. We (the administration) didn't want to be hurt by anything. The best thing we could think of to do was to put them away."[2]

At community meetings, residents acknowledged they felt well cared for. They also admitted to being bored, lonely and frustrated with the lack of control in their lives.

Administrators and staff were doing the best they could within the confines of a deeply embedded culture. As culture change specialist Sue Misiorski explains, cultural assumptions are taught to new members, explicitly and tacitly, as the correct way of doing things. In turn, they become norms that make life—and work—more predictable. Consequently, deep, systemic change of any kind, including the type being sought in long-term care, comes slowly.[3]

FACTS AND FIGURES

- The U.S. Census Bureau projects that the number of older people by 2030 will double from 35 million to 72 million
- 1.6 million Americans live in nursing homes; 900,000 in assisted living
- Nearly 20 percent of Americans 85 years and older are residents of nursing homes
- Almost half of all Americans who reach 65 are expected to spend time in a nursing home

THE MOUNT

- More than 400 older adults live at the Mount
- The average age is 89 (with a range from 29 to 103)
- The five-story, 300,000 square foot building opened in 1924, houses the following:
  - Eight 20- to 23-bed "neighborhoods" with skilled nursing services
  - A 20-bed, short-term, sub-acute medical rehabilitation unit
  - 112 studio and 1-bedroom apartments with assisted living services
  - An adult-day health program
  - A licensed intergenerational childcare learning center serving 125 children
- It employs 476 staff members from 32 countries and more than 140 volunteers
- By 1995, the major physical and program changes were in place
- Renovations cost $9 million
- Although residents in a typical nursing home spend 25- to 35-percent of their time engaged in some type of activity, that number rose to 42 percent at the Mount after culture change

THE BEGINNING OF A JOURNEY

Culture change is not a destination, but a journey. It's a work in progress. Because the Mount has maintained its commitment to delivering the best possible care, we have continued asking questions. What qualities in life promote growth and joy? What do we know now about our residents' priorities and values that we hadn't recognized before?

Questions like these have led us onto a new and exciting path. Two decades after Medicaid and Medicare went into effect, a shift began, one that propelled us forward.

Passed by Congress in 1987, the Nursing Home Reform Law was a corrective to conditions exposed by researchers, journalists and reform

advocates. Among other things, it promised residents their fundamental rights to dignity, respect and freedom; privacy and confidentially; full disclosure; and participation in their care.

This legislation was an impetus to serious self-examination and conversation that coincided with events stirring at the Mount. One was the growing awareness the Mount was housed in an outdated building that needed an extensive makeover. Funds were developed for improvement. Another was the hiring of a new administrator, who would oversee the renovations. He was intent on making sure that we did not recreate what was already in place.

The bottom line: culture change makes good business sense and that it's impossible to put a price on the most significant transformations that occur.

In 1990, Bob Ogden arrived from Anchorage, Alaska, where sisters had hired him to build and run the new Mary Conrad Center. His goal—one he successfully met—was to build from scratch a long-term care facility that felt like a home.

Among other things, an innovative "neighborhood" concept emerged. Neighborhoods, as opposed to long, sterile corridors, promoted social engagement, independence and a "homey" quality, all important steps in de-institutionalizing elder-care facilities.

Shortly after Ogden came to the Mount, a strategic planning session set the gears in motion for our transformation. Leaders were aware that traditional nursing homes offered a product nobody wanted. We recognized that residents deserved dignity, which necessitated a level of control over their lives that wasn't part of the traditional medical model we'd been using.

As challenging as it would be, we considered it our moral obligation to scrap the very model that had made us so successful.

A nine-member strategic planning team was formed. It was comprised of a psychologist/researcher, two architects, two nursing managers, a physical therapist, a social worker, Ogden and Charlene Boyd (co-author).

Ogden is a visionary. He poses big questions. He jarred those of us who were receptive to replacing the institutional thinking that had long prevailed at the Mount. Soon, we were re-thinking every existing physical and programming structure. Guiding us was a grand vision, the desire for a community directed by residents.

We were, and continue to be, compelled to seek changes for three main reasons.

First, always first, we pay attention to our residents. They tell us how they want to live their lives. To support their choices, we've needed to change how we operate.

The second incentive was economic. We recognized that it would be more cost-effective to respect individual preferences. From the standpoint of organizational structure, we were aware team members would become more connected, turnover would be reduced, and we would become the provider and employer of choice.

The third reason for change: We wanted to show others that it could be done. More than 17,000 licensed nursing homes in the United States and the vast majority can't afford to start from scratch. Neither could we. Fulfilling our dreams and mission requires that we continually find new ways to make the most of what we have. We then share that vision with others.

Our team launched the process of culture change with a series of meetings. We faced resistance from the start. Staff, residents and family members had grown comfortable with how things worked and had a difficult time accepting the transformations being espoused. Placing more control in residents' hands tested entrenched beliefs.

Undaunted, we moved forward, convinced that others would come around.

After one of the directors heard about intriguing changes at the Benedictine nursing home in St. Cloud, Minn., a team of employees visited the facility. Simply observing what a difference such changes as an open work station or a steam table make, proved to be a spark, a catalyst for stimulating our thinking.

Since we were restricted to working with the building we had, we found ourselves thinking intently about programming. We looked at all of the services we offered, how we delivered them, and broke them down. What we discovered was the care we provided was based more on our needs than on those of the people we were serving. That needed to change.

Subsequently, we entertained how we could create an environment that would fit new programming within the confines of our physical space. As we proceeded, we remained keenly aware that we had to attend to the economics of running a long-term care facility. And it was a priority that we create a model that could be shown, taught and shared with others.

Building a Sense of Home and Community

Building community and a sense of home became two primary goals. We began with assisted living. Apartments would be remodeled to remove architectural barriers that residents faced. So, for example, showers with grab-bars replaced bathtubs. More assistance was provided for daily activities: dressing, bathing, personal care, medication reminders and therapy. Most significantly, each resident, alongside family members and staff, would negotiate what services they needed. This program came to be known as "Hand to Hand."

Dividing the nursing home into "neighborhoods" of 20 to 24 residents was our most radical change. Instead of the long corridor that defines most nursing homes, each neighborhood would be designed with its own kitchen and dining room and personal care. New systems would be developed independently as each neighborhood's needs arose. Eventually, the larger network would adopt best practices.

Making a kitchen, every neighborhood's heart was essential to creating a homelike atmosphere. Eating areas would become places where people gathered, enhancing a sense of community. Not only that, the kitchen would offer residents choice and independence. They could have a snack or cup of coffee when they wanted. Food would be accessible at all times.

Residents would also be given freedom to furnish their living spaces as they chose, surrounding themselves with familiar objects. Plants would become a part of their daily environment, as would dogs and cats. Children would, too, especially with the presence of a large, on-site, licensed day-care center. All of these elements would provide welcome stimulation.

In the process of these changes, care would be enhanced. Each of the nine neighborhoods would have its own coordinator, a newly created position, and a staff comprised of nurses, resident assistants, chaplains, recreation professionals, housekeepers, therapists and social workers.

Decentralizing the nursing center was another key physical change that fed into broader social changes. Instead of being on constant rotation, each resident assistant would belong to a team providing care for the residents of a specific neighborhood. What's more, rather than being huddled together at their station, staff would spend time interacting with the elders they cared for—and in ways more intimate than ever before. As a result, residents would become more than medical patients to them. Staff and residents alike would learn about one another's lives, hobbies and interests.

Adding the child-care center was the most dramatic way of moving the environment away from the old medical model. Children and their teachers would move throughout the building, using shared spaces on various floors. They would also have a permanent intergenerational classroom on the third floor nursing neighborhood where they could interact regularly with the community.

The Challenges and Rewards of Living Our Values

Integrating residents with dementia proved to be the most controversial change we implemented. Under the old model, residents who needed the most care were moved to the fourth floor. "Closer to heaven" was how residents described it. For those housed there it meant containment, a secured space.

Conventional thinking was that a highly controlled environment benefited those with the highest level of needs, including residents with Alzheimer's and dementia. We were looking out for their safety, we assured ourselves, while simultaneously cutting our risks.

The decision to stop this practice was the result of many conversations among the team. If we were going to live the values of culture change, we agreed it no longer made sense to do things the way we had. Moving residents to a secured place meant tearing them away from everything that was familiar at a time when their inner worlds were becoming more chaotic.

As trying as it may be at times, the presence of those with dementia, Alzheimer's and related illnesses is a sign that we truly are a community. Residents, family and staff are learning that, as in any family or community, each person contributes something in their way.

Breaking down the barriers of the old system had another positive effect. It alleviates the terror

RESIDENT-DIRECTED CARE

- Transforms traditional, institutional models into person-directed models
- Both residents and staff are empowered in decision-making; residents make decisions about daily routines and service
- Staff assignments do not rotate, making their jobs relationship-centered
- Schedules are arranged to reflect residents' individual needs and preferences
- Residents feel at home and valued, as members of a community
- Activities are spontaneous and more frequent
- The environment created has the feeling of home
- Residents have independence, privacy; a sense of home, and dignity; they have choices about when they eat; how their living space is furnished; when they get out of bed; what they do; and who they will see

residents once had of being moved to the fourth floor.

In this evolving culture, with its decentralized environment, staff members are attuned to the *whole* individual and less fixated on the tightly regimented, finely calibrated medical diets and care they had been. They take time to visit with and listen to residents, who are now receiving the dignity and respect they deserve.

It's because of this transformation that a 92-year-old woman on a salt-free diet may be granted her wish to have bacon at breakfast. Or that some residents feel free to sleep late. Or a group takes an outing to a park or a pub. Why should they stop having fun?

Quality of life has clearly shifted for the staff, too. Instead of being a job of last resort, this has become work we choose and feel honored to do. Just as it has at other transformational homes serving the elderly, turnover at the Mount has shrunk drastically.

Today, the sense of community that residents and staff experience inside the Mount spills out beyond the walls of the building. We belong to a neighborhood and we're a good neighbor. We invite people in—most notably through our intergenerational childcare center. We also hold events outdoors, including concerts in the park that attract 200 people.

Change isn't easy. Sometimes it has to be forced. However, resistance fades as people observe the results. They see a vibrant environment, residents enjoying life, or hear the stories of a man who renewed his love of piano or of a woman who began socializing again.

LESSONS LEARNED

It took five years and $9 million in renovations before the major physical and program changes were in place. It's important to note that costs vary widely based on facility size and other factors. Also, overall expenses go down in the long run.

The bottom line: culture change makes good business sense and that it's impossible to put a price on the most significant transformations that occur.

As roles and responsibilities are better understood, some of the more difficult organizational changes occur. Many jobs change. Other positions are eliminated. Tasks formerly done by administrative and licensed nursing staff are now shared by the team. By decentralizing services, we put more money into direct-care work. At the Mount, 35 middle-management positions were eliminated. Meanwhile, all floor staff shares in food service and other tasks.

Huge savings result from a happier staff, which translates to a high level of retention. After culture change occurs, the turnover rate among all staff is drastically cut. In an industry where turnover is 70 to 100 percent annually, transformational homes see drops to 10 to 15 percent. This is significant, given the cost of rehiring and retraining amounts to more than $4 billion annually in the United States. Baker of *Old Age in a New Age* breaks this figure down. She notes that it costs a nursing home at the bare minimum $2,500 in advertising, recruitment, and training to replace a single resident assistant. In sum, the average nursing home spends $150,000 on turnover and an additional $75,000 on absenteeism each year.[4]

When residents, families, and staff are happier, there are also fewer lawsuits. Bonnie Kantor, executive director of the Pioneer Network, says "the best way to keep lawsuits away is to have good relationships." Baker concurs: "Drawing on lessons learned from malpractice suits of physicians, one can infer that the stronger and more open the relationships among employees, administrators, residents, and family members, the less likely that a nursing home will be sued."[5]

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Transformations of this kind cannot take place without visionaries and bold leaders. In order to sustain change, leadership has to be supportive of whatever the changes are. They must understand that it's not only behavior, but the deeper systems that must be transformed. Distance between residents and administration must be flattened.

What we're talking about is not skilled nursing, but a philosophy that permeates how we engage with the elderly regardless of where they are.

TURING RIPPLES INTO WAVES

So much has changed since 1990. Most significantly, the culture change movement has shown that people's lives can have meaning no matter where they live.

The Mount is not alone in making this and

other discoveries. The Pioneer Network formed in 1997 because leaders at long-term facilities scattered around the United States were engaged in similar experiments and seeing similar results. Two years earlier, several of these visionaries were on a panel during the National Citizens' Coalition for Nursing Home Reform. Inspired by interactions there, a meeting scheduled in 1997 brought 33 leaders together from across the country. It was out of that gathering that a coalition was formed dedicated to transforming the culture of aging in the United States.

Nationally, nearly 30 statewide coalitions are in various stages of development working on changing the culture of aging. Yet, at this stage, only 200 to 300 of the more than 17,000 nursing homes have undergone transformation.

The goal of the Pioneer Network is to see more than 10 percent of long-term care facilities overhauled during the next 10 years and to build coalitions that aren't just nursing home-focused. The network is interested in transforming the culture of aging across the board, taking into account a full range of living situations — in congregate settings as well as in home and community-based services — all places where elders and staff are able to express choice in meaningful ways.[6]

Clearly, we're not yet at the "tipping point" where culture change has become the norm, the accepted way of doing thing. But we're inching closer. Momentum will build as the sheer mass of baby boomers (80 million people, according to the U.S. Census Bureau) face decisions about the last chapters of their lives. In fact, the first wave of boomers (3.2 million) will start collecting Social Security this year, according to the bureau. This demographic milestone, in combination with heightened awareness about options available for aging with dignity, should provide a huge call to action.

If and when that call is answered, we'll see ripples turned into waves, and a seismic shift in the culture of aging in the United States. ■

NOTES

1. Beth Baker, *Old Age in a New Age: The Promise of Transformative Nursing Homes*, Vanderbilt University Press, Nashville, 2007, p. 29.
2. Sara Rimer, "Seattle's Elderly Find a Home for Living, Not Dying," *The New York Times*, Nov. 22, 1998.
3. Susan Misiorski, "Pioneering Culture Change," *Nursing Home Magazine*, October 2003.
4. Baker, p. 69.
5. Ibid., pp. 193-194.
6. www.pioneernetwork.net/who-we-are/our-history.php.