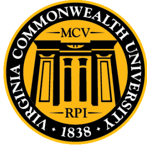

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TRANSITIONING FROM A TRADITIONAL NURSING HOME ENVIRONMENT
TO GREEN HOUSE HOMES:
WHAT ARE STAKEHOLDERS' ATTITUDES TOWARD AND SATISFACTION WITH THE SMALL HOUSE CARE ENVIRONMENT?

A dissertation in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University

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This dissertation is dedicated to my husband and best friend, Jonathan, and to our two beautiful daughters, Hannah and Abby. Without their love, humor, and encouragement, achieving this Ph.D. would have been impossible. This dissertation is also dedicated to the memory of my dear grandmother, Lois Rexroat Riley, who died during the first semester of my Ph.D. journey. Her memory inspired me to "keep calm and carry on."

During the past five years, I had tremendous support from family and friends who provided childcare, encouragement, and good wine. I am grateful for all that they have done for me. It truly takes a village to earn a PhD.

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Abstract

TRANSITIONING FROM A TRADITIONAL NURSING HOME ENVIRONMENT TO GREEN HOUSE HOMES: WHAT ARE STAKEHOLDERS' ATTITUDES TOWARD AND SATISFACTION WITH THE SMALL HOUSE CARE ENVIRONMENT?

By Christine A. Harrop-Stein, MS, PhD

A dissertation in partial fulfillment of the requirements for the degree of Doctor of Philosophy at

Virginia Commonwealth University, 2014

Co-Director: J. James Cotter, PhD, Professor, Department of Gerontology

Co-Director: E. Ayn Welleford, PhD, Professor, Department of Gerontology

This dissertation research was designed as two independent research studies. The first study, qualitative, and non-experimental, aimed to examine residents', family members', and staff members' (stakeholders') satisfaction with, and attitudes toward Green House living one month prior to moving and again at one and three months after moving. Focus groups were the primary method of data collection.

Thirty residents and 40 staff members transitioned to one of three Green House homes beginning January, 2013. Data collected began in December, 2012. Following each focus group, tape recordings were transcribed, and coded. Using grounded theory and the constant comparative method of analysis, themes emerged. Pre-move focus group themes revealed that stakeholders were concerned about (a) the quality of care in a system using fewer staff members and (b) the challenges associated with adjusting to a new environment. Post-move focus group

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themes revealed that (a) stakeholders remained concerned about staffing levels; (b) residents' had improvements in appetite, socializing, and ambulation; and (c) staff members struggled with autonomous work teams, but preferred the Green House model of care to that of a traditional nursing home. The final model reflects a synthesis of themes from which self-efficacy beliefs were hypothesized. Themes were also linked to existing gerontological theories: Person-Environment Fit, Place-Space, Thriving, and Personhood.

The second study, designed to explore the construct validity of the Person-Centered Care Attitude Tool (Per-CCat), consisted of 42 Likert-type questions divided into four sections that align with person-centered care principles. Eighty-six employees of Virginia Mennonite Retirement Community completed the survey; only 70 were analyzed due to missing data. Principal Components Analysis was the analytic approached used for these data. Bartlett's Test of Sphericity ($X^2 = 2006.56$, $p = 0.000$) and Keiser-Myers-Olkins measure of sampling adequacy (0.746) indicated that the data were factorable. The final four-factor 34-item solution aligned with the following person-centered care principals: resident autonomy, social interaction and community, work culture, and feelings toward work. Further validations studies of the Per-CCat are necessary. Given the trend in long-term care toward person-centered care, a validated survey will be useful for hiring and educating caregivers and other nursing home personnel.

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Chapter One: Introduction

During the past 25 years, the long-term care (LTC) industry has been undergoing a transformation. Traditionally, nursing homes have operated under the medical model of care, with a strong emphasis on expediency and economy (Haque & Waytz, 2012). This has had a dehumanizing effect on elders residing in nursing homes (Koren, 2010). Pressure from advocacy groups, reports about abuses, and greater oversight from the federal government have catalyzed nursing homes to change their approach to elder care (Institute of Medicine, 2010; Smith & Feng, 2010; Willging, 2008). New paradigms of care, collectively called culture change, were introduced in the early 1990's.

The Omnibus Reconciliation Act of 1987 (OBRA '87), a federally mandated policy intended to improve nursing home care, and preserve the rights of nursing home residents, set the stage for nursing home culture change. Culture change is both a philosophical and organizational change requiring the cooperation and buy-in from all nursing home stakeholders (administrators, staff members, residents, families, policy makers and the public). As a philosophical change, culture change endorses a movement away from the medical model of care to a more person-centered model of care. As an organizational change, culture change espouses (a) person-centered care, (b) a living and working environment that is more homelike, (c) decentralized management, (d) staff empowerment, and (e) continuous quality improvement (Harris, Poulsen & Vlangas, 2006).

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Innovative models of LTC like The Pioneer Network, Eden Alternative, Green House® Project, and Wellspring Model were created to bring personal care into the nursing home. Research examining the efficacy of culture change models of care suggested that (a) elders' health indicators improved, (b) facility quality indicators improved, and (c) staff turnover decreased (Doty, Koren & Sturla, 2008; Yeats & Cready, 2007). As of 2008, only 31% of nursing homes across the US had adopted all tenets of culture change (Doty et al., 2008). Understanding culture change models from multiple perspectives (e.g., quality of life, quality of work life, health indicators, implementation procedures, etc.) is important to the long-term health of the nursing home industry. Research outcomes may aide administrators, researchers, and educators to improve current models of care or catalyze the creation of new models of care.
A central tenet of culture change is person-centered care (Doty et al., 2008; Jones, 2011; Koren, 2010). Person-centered care (PCC) is a holistic approach to providing care to nursing home residents (Morgan & Yoder, 2012). PCC places the resident ahead of tasks, schedules and routines. Under PCC, the resident is empowered to make choices about his/her health care and schedule. PCC's goal is to maintain the autonomy and personhood of residents living in long-term care.

This research project had two foci: the first was to focus on stakeholders (residents, family and staff members) making the transition from a traditional nursing home to a Green House nursing home. Green House, a new innovation in LTC, is a radical departure from traditional nursing home care (Rabig, Thomas, Kane, Cutler, & McAlilly, 2006). Green House homes accommodate up to ten residents, allowing them to form strong relationships with each other and staff members. This paradigm was designed to: (a) increase residents' mobility and autonomy; (b) provide elders with access to the outdoors; (c) encourage elders to visit with one

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another, staff, and family in a homelike environment; and (d) decrease loneliness, boredom and hopelessness (Rabig et al., 2006; Green House Project).

The second focus was to explore the construct validity of the Person-Centered Care Attitude Test (Per-CCat). The Per-CCat was developed to measure nursing home staff members' attitudes toward PCC.

Background

Poorhouses were the precursor to contemporary nursing homes in the United States and trace their roots back to early days of colonization (Smith & Feng, 2011). Johnson and Grant (1985) in their history of elder care stated that in the 17th century almshouses were established to take care of those people in society who could not care for themselves, either because they were frail, old, physically or mentally ill, or poor Living conditions and care in almshouses were substandard. By the mid-19th century, private citizens, religious groups and ethnic-specific groups established "old age" homes or settlement houses. These alternatives were a vast improvement over the care that people received in almshouses. It was not until the Social Security Act of 1935 that elders could pay for their own care and continue to live in the community (Johnson & Grant, 1985).

After World War II, there was a push to modernize US hospitals. Through the Hill-Burton Act of 1946, money was provided to non-profit and public hospitals to expand their campuses and outfit their facilities with modern equipment (Johns & Grant, 1985). Eight years later, the Hill-Burton Act was amended to include nursing home construction. However the money was conditioned upon the nursing home operating in conjunction with a hospital (Vladeck, 1980). The buildings that were erected resembled hospitals in both architecture and climate. Nursing homes were no longer part of the welfare system; rather, they became part of

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the health care system. As such, nursing home care became more mechanized, sterile, and depersonalized as the medical model of care was adopted by nursing home staff and administrators (Vladeck, 1980).

In 1986, the Institute of Medicine (IOM) published its "Improving the Quality of Care in Nursing Homes" report which exposed the nursing home industry's failings. The resulting legislation, OBRA '87, protected the rights of nursing home residents, and demanded that nursing homes adhere to specific standards in order to be eligible for Medicare/Medicaid reimbursement (Willging, 2008). In addition, OBRA '87 also mandated the minimum data set, which tracks quality indicators, and the Centers for Medicare and Medicaid (CMS) nursing home compare, which made nursing home "report cards" available to the public (Smith & Feng, 2011).

Soon after this legislation was passed, the culture change paradigm was introduced to the nursing home industry. Culture change espouses person-centered care, resident autonomy, staff empowerment, a flattened hierarchy, and continuous quality improvement (Doty et. al., 2008; Harris et al., 2006). Over one-half of all nursing homes in the US have adopted some (25%) or all (31%) of the culture change principles (Doty, et al, 2008). The Pioneer Network, established in 1997, was formed to advocate for culture change by helping nursing homes make culture change, providing education about culture change, and offering opportunities for research in the field (Pioneer Network).

Eden Alternative and Green House are two culture change models that were conceived by Bill Thomas, MD, a geriatrician (Eden Alternative). Thomas recognized that his nursing home patients were bored, lonely, and feeling helpless. He conceptualized a nursing home environment that felt like home, complete with plants, animals, and children. Eden Alternative nursing homes do not have a nursing station, residents' rooms contain furniture brought from

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home, and meals, and bathing happen at the residents' convenience, not the staffs'. Staff members are encouraged to work as a team, to make up their own schedules, and to share information among each other. Staff members keep family members apprised of any changes in their loved one's status and are encouraged to be a part of the nursing home community.

In 2002, Bill Thomas established the first Green House in Tupelo, Mississippi with funding by the Robert Wood Johnson Foundation (Rabig et al., 2006). This model of elder care is gaining momentum in the nursing home industry: as of 2011, there were 97 Green House homes on 26 nursing home campuses in 17 states. At that time, another 130 homes were in development on 25 campuses in an additional 10 states (Jenkens, Sult, Lessell, Hammer &, Ortigara, 2011).

The Green House Project takes the concept of Eden Alternative another step further. Green House is a system-wide change to the nursing home structure and culture (Rabig et al., 2006). Architecturally, a Green House building is designed to look like a home (Green House Project) not an institution, as is the interior and the furnishings. As in most homes, the kitchen and great room (living room or hearth room) are the center of a Green House. The dining room utilizes a large dining table that is able to seat all of the residents and staff, and the kitchen is open and inviting. Sun rooms and patios also help minimize the institutional feel by allowing the residents to be closer to nature. But while the dining, kitchen, and recreational areas are communal, residents have their own private bedrooms and bathrooms. Second, Green House promotes relationships between staff members and residents through sharing meals, playing, and working together. Third, job descriptions and titles are different from standard nursing homes: certified nurse aides (CNAs) are called *Shahbazim* (*Shahbaz* is the singular) rather than CNAs. *Shahbazim* are required to have certification and to be trained in Green House practices. The

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Shahbazim are cross trained to do cooking, laundry and cleaning. Nurses (RNs, CRNP) and other administrative staff, called Guides, provide coaching and supervision to the Shahbazim. Finally, the organizational structure is a radical departure from standard nursing homes (Rabig et al., 2006) as the Green House model encourages a flattened hierarchy, professional growth, and staff autonomy. *Shahbazim* and Guides are encouraged to make their own work schedule, work as a team, and resolve conflicts.

Person-Centered Care (PCC) is a central tenet of culture change philosophy and culture change models of care. The definitions for PCC are varied and no single one captures PCC in its entirety (Morgan and Yoder, 2012). However, Morgan and Yoder (2012) proposed the following definition, which is more inclusive of the different aspects of PCC.

PCC is a holistic (bio-psychosocial-spiritual) approach to delivering care that is respectful and individualized, allowing negotiation of care, and offering choice through a therapeutic relationship where persons are empowered to be involved in health decisions at whatever level is desired by that individual who is receiving care (p. 8).

The above definition aligns with Kitwood's (1997) PCC precepts which are: (a) recognizing the resident as a person; (b) collaborating with the resident in order to accomplish activities of daily living (ADLs), such as bathing, dressing, eating along with instrumental activities of daily living (IADLs),such as phone calls, paying bills, housekeeping; (c) appropriately touching the resident; (d) relaxing and playing together; (e) negotiating with the resident to meet needs and wants, which places control back into the residents' hands; (f) celebrating with and for residents; (g) validating residents' personhood; and (h) facilitating the residents' ability to complete a task, not by doing for him/her, but through supportive action.

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Several research articles published regarding the efficacy of both PCC and culture change have been published in recent years (Fazio, 2008; Koren, 2010; Jones, 2011; Morgan & Yoder, 2011; Pope, 2012; Tellis-Nayak, 2007). Several questionnaires that measure the extent to which a nursing home organization has adopted culture change, or their readiness to adopt culture change are also available (Bott, Dunton, Gajewski, Lee, Boyle & Bonnel, 2009; Harris et al., 2006). Despite these resources, no published reports of nursing home staff members' attitudes toward culture change or person-centered care exist. In 2011, Ehlman and Jones (unpublished) developed the Person-Centered Care Attitude Tool (Per-CCat) to measure staff members' attitudes toward person-centered care. This survey has yet to be validated but will undergo validity testing during this study.

Statement of the Problem and Significance

The Green House project has been evaluated since its inception in 2002. Considerable evidence exists to support the efficacy of this model (Kane, Lum, Cutler, Degenholtz & Yu, 2007; Lavizzo-Mourey, 2011; Schilling, 2009; Sharkey, Hudak, Horn, James & Howes, 2011). Health indices, such as lower incidence of decline in late loss ADLs, maintenance of overall ADLs and IADLs, higher ratings on quality of life measures, higher satisfaction ratings and better scores on measures of emotional well-being have been reported (Burack, Weiner & Reinhardt, 2012; Burack, Weiner, Reinhardt & Annunziato, 2012; Hill, Kolanowski, Milone-Nuzzo & Yevchak, 2011), and resident quality indicators have been shown to be superior to comparison groups (Kane et al., 2007). Residents' families show greater satisfaction with the physical environment, privacy, autonomy, meals, housekeeping and amenities (Lum, Kane, Cutler & Yu, 2008-2009). Overall, families are more engaged in the residents' care than families in comparison groups (Lum et al., 2008-2009). What is not known is (a) how the key

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stakeholders (residents, family, and staff) understand Green House; (b) how they expect their living and working environment to change; (c) after the move, were their expectations about Green House met; and (d) in what ways is the working and living environment different from the previous environment.

The Green House model revolves around the concept of person-centered care. To date, there is no research examining staff members' attitudes toward person-centered care, creating a gulf in the culture change literature. It must not be assumed that all nursing home staff members embrace person-centered care as demonstrated by culture change initiatives that have failed because staff members were either inadequately prepared for the changes, the change process was inadequately implemented (Choi, 2008), or staff members did not fully understand the concept of culture change (Bellot, 2007).

There is no validated measure of attitudes toward person-centered care among nursing home staff. Researchers have published several culture change surveys which measure the level of an organization's culture change or the readiness of an organization to make culture change (Bott et al., 2009; Harris et al., 2006). Measuring attitudes toward person-centered care will enable nursing home administrators to understand individual staff members' readiness to embrace person-centered care, and to determine if a potential employee has the proper attitude toward caring for elders. This instrument may also help training and continuing education departments to identify areas that need to be stressed in training or reviewed with employees. Person-centered care is at the heart of all culture change initiatives; culture change cannot take place unless person-centered care is embraced by nursing home staff members.

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Purpose of the Study

Virginia Mennonite Retirement Community (VMRC) built three Green House homes. Beginning January 15, 2013, 30 residents and more than 30 staff members moved from Oak Lea, a standard nursing home, to Woodland Park, Green House homes. The objective of this study was twofold: (1) investigate key stakeholders perceptions of Green House; and (2) validate the person-centered care attitude tool (Per-CCat). The first goal was to understand (a) how stakeholders understood Green House, (b) what stakeholders were expecting from the move to Green House, (c) once moved, how stakeholders understood Green House, and (d) whether or not the stakeholders' expectations were met. This was achieved through pre-move and post-move focus groups. The second goal of this study was to establish the construct validity of the Per-CCat. This was achieved through a survey method that included approximately 120 staff members of VMRC.

Theoretical Framework

The philosophical foundation of this research was person-centered care. Person-centered care, is not a theory but rather a philosophy and model of care. Person-centered care was coined by Tom Kitwood in 1993 while working with people living with dementia (Kitwood, 1997). Kitwood's background in psychology and pastoral care naturally led to person-centered care. The foundation upon which person centered care rests is psychologist Carl Roger's theory of Client Centered Therapy and theologian Martin Buber's philosophy of I and Thou (Kitwood, 1997). Client Centered Therapy, like person-centered care, places the individual above the care provider. Interactions with clients require the care provider to practice genuineness, unconditional positive regard, empathy, and active listening (Rogers, 1980). I and Thou philosophy is, perhaps, best understood as a change in attitude toward another. Buber (1970)

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suggested that when one contemplates another, one enters into a relationship with the other. The other is "Thou," not "It." In other words, there is mutual respect for each other's personhood. Both Client Centered Therapy and I and Thou principles guided Kitwood's proposal that the primary psychological needs of people with dementia were comfort, attachment, inclusion, occupation, and identity. Love is at the center of these (Fazio, 2008; Kitwood, 1997). In his book, *Dementia Reconsidered: The Person Comes First* (1997), Kitwood states that person-centered care (PCC) is concerned with maintaining the individual's sense of self regardless of their cognitive abilities. Individuals with dementia, over time, lose the ability to advocate for themselves; therefore, it is incumbent upon the caregivers to advocate for the individual. Person-centered care is a philosophy of care that is appropriate for all nursing home environments and is even being explored as a philosophy of care in hospitals (Ekman, Swedberg, Taft, Lindseth, Norberg, Brink et al., 2011; Pope, 2012; Williams, 2010).

Research Questions

To appraise stakeholders' (residents, families and staff) perceptions about Green House and establish the construct validity of the Person-Centered Care Attitude Test (Per-CCat), this study answered the following questions:

- At one month prior to the move to Green House, what were stakeholders' (residents, family, and staff members) understanding of and expectations about Green House?
- At one month post move to Green House, what were stakeholders' understanding of Green House and had stakeholders' expectations about Green House been met?
- At three months post move to Green House, what were stakeholders' understanding of Green House and had stakeholders' expectations about Green House been met?
- Was the Person-Centered Attitude Test (Per-CCat) a valid attitude instrument?

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Analytical Strategies

Focus group recordings and field notes were transcribed and stored in Atlas.ti. Data was analyzed using the constant comparative method. Per-CCat data was entered, stored and analyzed using SPSS 21. Data were examined for outliers, multicolinearity and normalcy. Statistical testing included descriptive statistics, exploratory factor analysis, and reliability statistics.

Scope of the Study

This dissertation was an exploratory study of stakeholders' understanding of and expectations about Green House. It was designed to establish the validity of the Per-CCat. Two methodological approaches were taken: the first was a qualitative method using focus groups as the means for collecting data about stakeholders' knowledge of and expectations about Green House. Pre-move and post-move focus groups were conducted; and the second was a quantitative approach using a survey method.

Overview of Remaining Chapters

Chapter Two reviews the history of elder care in the United States, the culture of elder care, characteristics of the contemporary nursing home resident, nursing homes as organizations, nursing home culture change, culture change models, culture change and Green House outcomes, culture change measures, and the theoretical underpinnings of person-centered care.

Chapter Three contains the study design, design rationale, description of the study participants, source of the data, and the statistical analysis proposed to explore the hypotheses. In Chapter Four, results from the qualitative and quantitative analyses will be presented. Chapter Five will review and discuss the results of the analyses as they relate to the research questions and proposed hypotheses. Study limitations and implications will also be discussed.

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Chapter 2: Literature Review

Culture Change Care Philosophies

While many nursing homes adopting culture change do not subscribe to a particular culture change model, there are nursing homes that do have an allegiance to a singular model. There are several culture change models in the industry: Eden Alternative, Planetree, Wellspring, Pioneer Network, Green House, Household, & Live Oak Regenerative Community (see Table 1).

Table 1

Culture Change and Person-Centered Care Philosophies

Organization	Founder/ Year	Core Concepts	Vision/Mission	Classification
The Eden Alternative	William Thomas, MD 1991	"See places where elders live as habitats for human beings rather than facilities for the frail and elderly". -Principle-centered philosophy in that it provides people with a new way of thinking about elder care. Change vocabulary or language. For example, use word "Elder" and "Care Partner."	• Improve the lives of elders and their care partners by transforming the place where they live and work. • Deinstitutionalize nursing homes. • Place decision making in the hands of the elders.	A **model** of care and architecture. Space is organized into neighborhoods without a nursing station. Plants, animals, open spaces, and children are part of the environment.

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Table 1 – Continued

Organization	Founder/ Year	Core Concepts	Vision/Mission	Classification
The Planetree	Angelica Thieriot, 1978	It is patient-centered and holistic, promoting mental, emotional, spiritual, social, and physical health. There is a continuing care component to their model that recognizes the importance of human interaction, personal growth, and self-expression. In addition they promote independence, empowerment through education, and environments that are conducive to quality living.	"Planetree is a non-profit organization that provides education and information in a collaborative community of healthcare organizations, facilitating efforts to create patient centered care in healing environments."	This **model** is a philosophy of care for all ages, not just the elderly. It is classified by a psycho-social-spiritual approach to care and can be integrated into a hospital, hospice, or LTC facility.
Wellspring/ Brightview	Unknown	Specialize in providing a complete culture change environment for all elders along the care continuum. Most recently they have developed a program for residents living with Alzheimer's Disease (from the beginning stages to end stages).	"To create an atmosphere where residents and staff can celebrate life."	This is not a model. It is a continuing care retirement community that has adopted fully the principles of culture change. There are several Wellspring communities around the USA.
Pioneer Network	1997, long-term care (www.pioneer network.Net/A boutUs/ Values	Advocate for person-directed care in long-term care.	Provides education and support to long-term care facilities nationally and internationally that are making culture change.	An educational organization that provides support and education about culture change. They also support research in the field of culture change.

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Table 1 – Continued

Organization	Founder/ Year	Core Concepts	Vision/Mission	Classification
The Green House Project	William Thomas, MD, 2003	Create small, intentional communities (7-10 residents living in one house) for groups of elders and staff. • This model alters facility size and design. • Changes staffing • Alters delivery of care methods. • Vocabulary changes include calling CNAs Shahbazim. These staff members are cross trained and care for 7-10 elders in one home. The Guide, akin to a supervisor, is responsible for the overall operation and quality of service in the Green House. Guides are often responsible for several homes.	"…deinstitutionalized effort designed to restore individuals to a home environment, and at the same time provide them with personal and clinical care."	A model LTC community that was initially funded by the Robert Wood Johnson Foundation as a pilot project. The project was successful and there are now 126 Green House homes in the US. It is architecturally "culture change." This environment is designed for elders who need full-time assistance, but are not bed ridden or severely disabled.
Household Model	Unknown	Similar to the Green House, but specifically designed for elders living with dementia or Alzheimer's Disease.		

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Table 1 – Continued

Organization	Founder/ Year	Core Concepts	Vision/Mission	Classification
Live Oak Regenerative Community (Barkan, 2003)	Launched in 1977 at the Home for Jewish Parents in Oakland, CA, through the Live Oak Institute.	Core components of the Live Oak Regenerative Community are (a) values that keep the mission of the nursing home on course; (b) methodologies of care and living environment that fosters personal growth and fulfillment; and (c) creation of a role for individuals who are advocates for change and renewal.	To cultivate a community in which people connect with one another, develop a sense of self, and embrace aging.	This is not a replicable model per se. Rather, Live Oak aims to provide a culture in which elders can reach their full potential. Live Oak is described as a "living system formulated with the intention of creating a healthy culture of aging" (Barkan, 2003, p. 198) within the LTC environment and society.

Each offer a living environment and philosophy of care unique to its mission, but they all share a common value: to create a nurturing and caring environment that supports the individual's personhood.

The above philosophies espouse empowerment and autonomy for residents, patients, and staff alike. They advocate for smaller intimate care settings, when possible. The overarching goal of these approaches is to create a healthy and stable living, caring, and working environment, one that promotes quality of life and quality of work life. Consistent among the culture change models is the understanding that there are a cluster of needs that all humans have,

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and that “without the meeting of [these psychological needs] a human being cannot function, even minimally, as a person” (Kitwood, 1997, p. 81). Thus, implementing person-centered care, a key element of culture change, requires staff to place the person at the center of care by acknowledging that this person has five fundamental psychological needs that must be met: (1) to give and receive *comfort*; (2) to form special relationships and *attachments*; (3) to be *included* in a group; (4) to have an *occupation*, to be involved in living; and (5) to have an *identity* (Kitwood, 1997; Bellchambers & Penning, 2007). These psychological needs can be associated with the first four domains of culture change: (a) resident directed care and activities; (b) home environment; (c) relationship with staff, family, resident, and community; and (d) staff empowerment (Harris, Pouleson, & Vlangas, 2009).

Overview

The history of the contemporary nursing home is complex and varied and is influenced by societal, medical, and political factors that reach as far back as colonial times. While contemporary nursing homes are vastly different from the earliest elder care options, they still reflect many of the attitudes toward elders and elder care that were prevalent throughout the past centuries. However, a recent shift in these attitudes, termed “culture change”, is beginning to change the face of nursing homes, the culture of caring for elders, and the attitudes toward elders as a whole. This literature review examines this history of contemporary nursing homes, the evolution of the culture of caring for elders, and the characteristics of US elders today in order to understand how changing the culture is necessary and inevitable. This understanding would be incomplete without examining nursing homes as organizations, culture change principles, and culture change models of care, such as Green House project. While there is much evidence in support of culture change, there are significant gaps in the state of knowledge about culture

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change. In addition, there are still many barriers to its implementation. The chapter ends with a summary of both the culture change and person-centered care measurements and an overview of the philosophical and theoretical underpinnings of culture change.

The History of Institutional Elder Care

Nursing homes are a 20th century institution engendered by social, medical, and political needs; however, the roots of contemporary nursing homes can be traced to the almshouses of colonial times (Kaffenberger, 2001; Smith & Feng, 2010). During the 17th and 18th centuries, almshouses were established to care for people of all ages who were unable to achieve the level of self-sufficiency required in America (Cotter, 1996). While the majority of frail and ill elders were cared for by family members within the home, some were placed in almshouses along with the poor and mentally ill (Kaffenberger, 2001). This would soon change with the dawn of the Industrial Revolution and an increase of the United States' geographic size and population.

Between 1800 and 1900, the US population increased from 5.3 million to more than 76 million (U.S. Census Bureau, 2012); a dramatic increase of 1,335%. Contributing to this population boom were immigration and a decrease in mortality rates (Weitz, 2013). During this same time, young people migrated to cities searching for work, or they moved westward in search of arable land. This left many elders without family support, and by the mid to late 19th century, almshouses and settlement houses were being used with more frequency to house elders who had no family to care for them (Johnson & Grant, 1985). In response to this more urgent need to house elders, religious and ethnic-specific organizations began opening and operating homes for the aged. Their approach to elder care was more humanistic and a vast improvement over almshouses and poor farms (Johnson & Grant, 1985).

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Private citizens also contributed to the care and well-being of the poor and elderly by providing nursing services (Buhler-Wilkerson, 2001) and establishing settlement houses. Settlement houses were the precursor to present day community centers (Wade, 2004). Unlike community centers, staff and volunteers lived in the settlement house and were thus residing in the neighborhood in which they worked. Settlement houses provided daycare, healthcare, and education to underprivileged neighbors of all ages, religions, and races (Wade, 2004). At its peak (1913), the Settlement House movement had 413 houses in 32 states (Husock, 1993). Perhaps the most famous of these settlement houses is Hull-House, established in 1889 by Jane Addams. Her mission was to bring together poor and wealthy alike, so that they could live and work collectively to solve social problems (Addams, 1910). Hull-House was conceived of as a "broad social movement toward just living and working conditions for those who had the least" (Addams, 1910, p. xi). By the 1930's, the Settlement House movement was losing its momentum and was replaced by treatment professionals (e.g., social workers, psychiatrists, welfare) and community centers (Husock, 1993), which contributed to the medicalization of aging.

Until 1935, almshouses and poor farms were the last resort for elders without familial support or personal means. Almshouses, financed and managed by the state, were considered undesirable, a reputation the states were anxious to maintain in order to keep costs down. The Social Security Act of 1935 resulted in the decline of almshouses, because it provided enough income to elders to keep them from the almshouse (Smith & Feng, 2010). For-profit nursing homes took the place of almshouses while the federal government provided matching grants to each state to fund Old Age Assistance (OAA) programs. Individuals were not OAA eligible if

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they lived in an almshouse. This rule provided incentive for citizens to stay out of state-run facilities (Smith & Feng, 2010).

During this same period, business relationships between private nurses and businessmen resulted in the establishment of fee-for-service nursing homes. Eventually, this business model expanded to include non-profit, proprietary, and government-run nursing homes (Cotter, 1996).

After World War II, the federal government provided money through the Hospital Survey and Construction Act of 1946, commonly known as the Hill-Burton Act, to modernize US hospitals (Johnson & Grant, 1985; Shi & Singh, 2008). An amendment made in 1954 to the Hill-Burton Act authorized a distribution of funds to construct nursing homes (Smith & Feng, 2010; Vladeck, 1980), but the provision stipulated that nursing homes be operated "in conjunction with a hospital" (Vladek, 1980, p. 43). The natural result was that the architecture of long-term care facilities resembled hospitals (Vladek, 1980), and indeed, many nursing homes to this day are still institutional in feeling and appearance. Shortly after the Hill-Burton Act was passed, an amendment to Social Security mandated states to require licensing of all nursing homes (Weitz, 2013). Each state had its own licensing standards; there were no national standards (Walshe, 2001). That would not change until 1965 when President Johnson passed Title 18 (Medicare) and Title 19 (Medicaid) of the Social Security Act (Doty, 1996; Shi & Singh, 2008).

With the enactment of Medicare/Medicaid laws in 1965, long–term nursing care was paid for by Medicaid and short-term nursing care was paid for by Medicare (Eskildsen & Price, 2009; Smith & Feng, 2010). Between 1954 and 1965, the number of nursing home beds increased from 260,000 to 500,000, resulting in 449 million dollars in federal and state payments to nursing homes (Watson, 2010).

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Care in nursing homes, however, still needed improvement. In 1968, Congress took a step forward by passing the Moss Amendment, which required licensing of all nursing home administrators (Vladek, 1980) in addition to the organization itself. The Moss Amendment also mandated (a) full disclosure of ownership of the nursing home; (b) the identification of all people having a financial interest in the nursing home; (c) standards for record keeping, dietary services, sanitation, drug dispensing, and medical care; (d) transfer agreements between a nursing home and a hospital so that nursing home residents could receive acute care; (e) a system of medical and peer review of the medical care that nursing homes provided; and (f) employment of at least one full-time registered nurse (Vladek, 1980, p. 60). The Moss Amendment also gave state authorities permission to withhold Medicaid funds from nursing homes not meeting all licensing requirements. A provision in the Moss Amendment recommended that nursing homes have a similar reimbursement schedule resembling that of hospitals. This step was seen as necessary for improving the quality of care that elders received in LTC. However, Congress rejected the proposal (Vladek, 1980).

Despite some positive steps toward better care, the nursing home industry came under fire in the 1970s when financial and patient care abuses were unearthed. An investigation of nursing homes was launched by the Institute of Medicine (IOM) (Flesner, 2009; Smith and Feng, 2010); yet in spite of politicians' knowledge of these abuses, few policy changes were made to safeguard elders against abuse and fraud. In the meantime, the Miller Amendment (1970-1971) established a new level of care called intermediate care. Intermediate care facilities (ICF) were established to care for elders who did not require 24 hour care. ICFs were viewed as a way to lower the cost of care because the type of medical care needed was not complex and could be provided with fewer staff members. Rather than correcting the industry-wide problems of

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patient care, the Miller Amendment provided a substantial savings to the government and lowered standards of care (Vladeck, 1980). Perhaps a bright spot in the ’70s was the enactment of Public Law 92-603 (signed into law in 1972) which included a new policy stating that Medicaid would reimburse on a “reasonable cost-related basis” (Vladek, 1980). The hope was that nursing homes would provide better care knowing that they would be reimbursed at a minimum for such care.

In 1980, Bruce C. Vladeck published *Unloving Care: The Nursing Home Tragedy*, a scathing report of nursing home care in the United States. During the years following the publication of *Unloving Care*, the IOM investigated nursing home practices and made more than 100 recommendations to the federal government in its “Improving the Quality of Care in Nursing Homes” report. The Federal Nursing Home Reform Act, a part of the Omnibus Budget Reconciliation Act of 1987 (OBRA ’87), required nursing homes to meet a minimum set of standards in order to qualify for government reimbursement (Walshe, 2001). These standards included: (a) periodic assessment of each resident; (b) a comprehensive care plan for each resident; and (c) nursing, rehabilitation, pharmaceutical, and dietary services (Weiner, Freiman & Brown, 2007).

Under OBRA ’87, a bill of nursing home residents’ rights was created (42 CFR Part 483). The bill of rights stressed the rights to: (a) freedom from abuse, mistreatment, and neglect; (b) freedom from physical restraints; (c) privacy; (d) be treated with dignity; (e) exercise self-determination; (f) communicate freely; (g) participate in family and resident activities; (h) fully participate in one’s care planning; and (i) voice grievances without discrimination or reprisal (Wiener et al., 2007). Another positive outcome of OBRA ’87 included the creation of a uniform Resident Assessment Instrument that is completed upon admission to a nursing home

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and at least annually thereafter. These data, which include residents' medical, physical, functional, and affective status, are entered into the Minimum Data Set (MDS). From the MDS, quality indicators for nursing homes are developed (Weiner et al., 2007). OBRA '87 also provided for the development of Nursing Home Compare, a website that contains data about all Centers for Medicare and Medicaid (CMS) affiliated nursing homes. This website allows consumers to make an informed choice about which long-term care facility to use. All aforementioned OBRA '87 measures are still in effect today.

While many felt that OBRA '87 was groundbreaking, some advocates thought it was "mundane" noting that "so few of [OBRA 87's] 100-plus recommendations were either revolutionary or objectionable" (Willging, 2008, p. 12). Willging bemoaned the fact that Congress had to step in at all to tell the industry to do what was right (2008). He additionally stated that terms such as "penalties" overlooked the opportunity for "remedies," and that the "avoidance of harm" overlooked the opportunities for "enhancement of life." "Quality of care is more likely to be defined as the absence of bad events than the presence of good ones" (Willging, 2008, p. 14).

Throughout the late 1980s into the 1990s, changes to nursing home reimbursement schedules along with an increase in the number of elders requiring some form of LTC (not necessarily skilled nursing) due to chronic illness forced the LTC industry to create alternative modalities of care such as assisted living complexes and home health programs (Brown Wilson, 2007; Walshe, 2001; Wiener et al., 2007). While these new modalities of care filled a need, they opened up the LTC market to unregulated assisted living, senior housing, and home health organizations (Walshe, 2001; Weiner et al., 2007). The quality of care that elders received from these new facilities and services would be called into question.

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In the year 2000, new paradigms of care, collectively called culture change, began being implemented in nursing homes across the United States. The Pioneer Network, Eden Alternative, Green House Project, and Wellspring Model, to name a few examples, were created to bring empathic care into the nursing home. As of 2008, 56% of nursing homes across the US had either adopted culture change (31%) or were in the process (25%) of adopting changes (Doty et. al, 2008). Culture change will be discussed in greater detail in this literature review.

Table 2 provides a timeline of elder care in the US from colonial times to present day. The purpose of this timeline is to illustrate how nursing home care has been influenced by political climate, societal zeitgeist, and medical advances.

Table 2

Elder Care in the USA: From Almshouses to Culture Change

Time Period	Approach and/or Policy/Relevant Context
Colonial Period: late 1600s to late 1700s	Only two out of every 100 adults were elderly. Therefore, elders were revered and given a higher station in society. Men of means were usually respected and cared for in the home during their old age. Women of all economic classes were at the mercy of their family. Elders were cared for by their family, but those who were without family or means were sent to poorhouses to live out their lives.
Early to mid-1800s	Almshouses were still used to house poor and ill elders. However, religious and ethnic organizations established their own homes in an effort to keep "their own kind" out of the poor house.
Late 1800s	Settlement houses were established in large cities to help care for the poor of all ages, races, and creeds. The Industrial Revolution is largely responsible for the necessity of settlement houses. Immigrants enticed by the promise of work came to the big cities by the thousands. Underpaid and overworked, many immigrants could not make ends meet and were dependent upon settlement houses and other charitable organizations.

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Table 2 – Continued

Time Period	Approach and/or Policy/Relevant Context
Early 1900s	Care for the elderly became a state's responsibility. Many elders were sent to a state-run almshouse for care. The poorhouse was viewed as a shameful place to live and the states were only too glad to foster this image in order to keep costs down. Immigrant and religious organizations continued to open and operate their own establishments to prevent their people from living in almshouses.
1935: Advent of public institutional care	The Social Security Act was enacted and resulted in a decline in poorhouses. For-profit establishments took the place of poorhouses.
1946	The Hill-Burton Act improved the hospital system by providing funds to modernize them, thus making them more sterile and high tech.
1950	An amendment to the Social Security Act required nursing homes to be licensed.
1954	An amendment to the Hill-Burton Act provided grant money for the construction of nursing homes that had to be run in conjunction with hospitals. Nursing homes resembled hospitals in both look and feel.
1965	Medicare and Medicaid laws were signed by Lyndon Johnson. Medicaid is used to pay for long-term nursing care in a nursing home, whereas Medicare is used to pay for short-term rehabilitative care in a nursing home.
1968	The Moss Amendment was passed by Congress to improve the quality of care in nursing homes. Institutional standards were raised during this time.
1971	The Miller Amendment established a new level of care called intermediate care. Nursing homes were being reimbursed for providing less care using fewer resources and fewer skilled nurses. This designation saved the government millions of dollars and lowered the standard of care.
1972	Public Law 92-603 contained reforms for nursing homes, which allowed Medicaid to reimburse on a reasonable cost-related basis. Heretofore, states used arbitrary fee schedules.
1980	Unloving Care: The Nursing Home Tragedy by Bruce C. Vladeck was published.

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Table 2 – Continued

Time Period	Approach and/or Policy/Relevant Context
1987	The Omnibus Budget Reconciliation Act of 1987 (OBRA ’87) was signed into law as a result of the Institute of Medicine’s 1986 report “Improving the Quality of Care in Nursing Homes.” OBRA ’87 required nursing homes to meet a minimum set of standards in order to qualify for Medicare/Medicaid reimbursement.
Throughout 2000s	The focus on LTC has turned toward the quality of life of elders. Several organizations such as the Pioneer Network, The Eden Alternative, and Green House Project have been working at studying and advocating alternative care models.
2006	CMS endorses culture change by launching a program called Advancing Excellence in Nursing Homes. The aim is to improve the organizational culture in nursing homes and to implement person-directed care.
2008	The IOM published Retooling For An Aging America. This report outlined the ways in which the US health care system must improve in order to meet the needs of an aging population. They challenged health care institutes to “enhance the geriatric competence of the entire [health care] workforce; increase the recruitment and retention of geriatric specialists and care-givers; and improve the way care is delivered” (IOM, 2008, p. 1).

Evolution of Elder Care

In the previous section, the history of elder care in the United States was reviewed. This section aims to give insight into the medical model of care (which necessarily includes nursing and medical education) and its influence on the culture of nursing home care.

Despite an aging America and a projected shortage of professionals with a geriatric subspecialty, few students in health care are choosing geriatrics as a discipline (Mezey, Mitty, Burger, & McCallion, 2008; Varkey, Chutka, & Lesnick, 2006). Many health care students believe that geriatrics “is uninteresting, unrewarding and depressing” (Alfarah, Schunemann, & Akl, 2010, p. 1). These attitudes may be grounded in a lack of education about aging, a fear about one’s own aging and associated losses (Varkey et al., 2006), the U.S. society’s negative

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biases toward aging (Vicker, 1978, the negative experiences while training (Pursey & Luker, 1995), and the orientation of medical education to manage and cure acute disease (McVey, Davis, & Cohen, 1989). In addition, among agencies that provide services to older adults, there is a lack of financial support to educate their workforces; although it is widely acknowledged that more education is necessary (Maiden, Howrowitz, & Howe, 2010).

The Medical Model of Care

The lack of training in gerontology and geriatrics, or elder care, appears to stem from the medical model as the dominant philosophy of care. This model stresses cure, routines, efficiency, expediency, and technology over person-centered empathic care with an often dehumanizing effect. Dehumanization in nursing homes occurs, in part, because medical and nursing education and practice stress detachment and efficiency (Haque & Waytz, 2012). The result is that the individual is objectified and denied empathic care. It may be argued that these responses are necessary for expediency and emotional well-being of the practitioner; however, mechanization and emotional blunting unintentionally dehumanizes patients. De-individuation can be amplified for those people of minority or out-groups, such as elders or people of color (Haque & Waytz, 2012).

Emphasizing the medical model of care during training is only one possible explanation for the lack of empathic care in nursing home environments. Other contributing factors include: (a) nursing and medical school curriculum (didactic elements as well as clinical); (b) faculty knowledge and attitude; and (c) students' attitude. At one Midwestern nursing school, the majority of courses taught had less than 5% of gerontological content (Plonczynski, 2007). Additionally, faculty members were evenly divided between holding positive attitudes and neutral/negative attitudes toward older adults (Plonczynski, 2007).

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Koren and colleagues noted that student nurses hold neutral attitudes toward older people and low levels of gerontological knowledge; yet the further along the students were in their education, the greater their gerontological knowledge and the greater their comfort with and confidence in caring for elders (2008). Another study by Newell et al. found that the further along medical students were in their education, the greater their knowledge of geriatrics and competency in caring for ill elders (2004). Contrary to the previously mentioned studies, Ferrario, Freeman, Nellett, and Scheel (2008) found that senior nursing students (n = 117) had low aging knowledge scores and very negative attitudes toward aging.

Curriculum that focused strictly on the diseases of aging, the currency of the instructor's knowledge about gerontology, and witnessing insensitive behavior toward elders by acute care nurses contributed to nursing students' negative attitudes toward elders and caring for elders as a career (McLafferty & Morris, 2004). Geriatrics and gerontological curriculum may contribute to the traditional medically oriented, yet personally insensitive care, for which nursing homes have been criticized. Recognizing that the medical model of care was "falling short of the mark", the American Geriatric Society and the Institutes of Medicine published position papers recommending changes to the current medical education and health care practice paradigms.

The American Geriatric Society (AGS), in its position paper, "Education in Geriatric Medicine" (2001), recommended that geriatric medicine be integrated into the curriculum for all four years of medical school, and that faculty teaching geriatrics should have formal training. Subspecialties in geriatric medicine, such as geriatric psychiatry, should be formally recognized, and continuing medical education credits should be required for all physicians whose patient population is includes a majority of older adults.

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More recently, the IOM developed its own recommendations for elder care based on the results of its report, *Retooling for an Aging America* (Institutes of Medicine, 2008). Due to the projected increase in the elder population, and their need for health care the IOM recommended the following:

1. Enhance the geriatric competence of the entire health care workforce.
2. Increase the recruitment and retention of geriatric specialists and caregivers.
3. Improve the way care is delivered (IOM, 2008, p. 1).

While recommendations for enhancing geriatric competencies were made by the AGS more than a decade ago and reinforced by the IOM, academia has been slow to make appropriate changes.

Today, nearly 40.4 million people, or 13% of the US population, are over age 65 (Administration on Aging, 2011). These numbers are expected to increase over the next 15 years: it is estimated that by 2030 those who are 65 years and older will make up 19.3% of the US population (Administration on Aging, 2011). In 2009, 1.5 million adults 65 years and older lived in an institutional setting. This accounts for 4.1% of the population of elders (Administration on Aging, 2011). Need for LTC increases with age: 1.1% of people aged 65-74 are living in nursing homes, whereas 13.2% of those 85 and older live in nursing homes. The Pennsylvania Health Care Association (2010) predicts that nearly 70% of those who turned 65 in 2010 will require LTC at some point in their life.

The Virginia Department of Aging (2013) predicts that by 2025, 25% (2 million) of Virginia's population will be 60 years of age or older, with the fastest growing age group being among elders 85 years and older. Similar trends are reported in Western cultures around the globe (National Institute on Aging, 2011).

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Contemporary Nursing Home Residents: Who Are They?

The majority of residents living in nursing homes are female, white, non-Hispanic, widowed, and aged 75 or older. Most residents have graduated from high school, but fewer have a college education. Many LTC residents are suffering from three or more chronic conditions, including a decline in cognitive abilities (Kasper & O'Malley, 2007; Administration on Aging, 2011). More than half have spent down their savings on LTC so that their LTC is now paid for by Medicaid. In short, these elders, mostly women, are impoverished. Table 3 provides a profile of older adults living in long-term care.

Table 3

Profile of Older Adults Living in Long-Term Care

Living Arrangements	• 4.1% of older adults reside in nursing homes or other institutional settings. • The percent of those living in nursing homes increases with age: 0.9% of those 65-74 years of age reside in nursing homes; 3.5% of those 75-84 years of age live in nursing homes; and 14.3% of those 85+ live in nursing homes. • 19% of women are living in some arrangement other than independent living. • 9% of men are living in some living arrangment other than independent. • Older people represent about 88% of nursing home residents • 80.6% of those aged 65+ live in metropolitan areas. • 72% live outside cities • 19% live in the cities • 19% of those aged 65+ live in nonmetropolitan areas (AoA, 2011). • 80% of the elderly in nursing homes are considered long stay (90 days or more); more than half can be considered permanent residents with anticipated stays of one year or longer (Kasper & O'Malley, 2007).
Health Insurance Coverage	• 62% residing in nursing homes are covered by Medicaid.
Disability and Activity Limitations	• 83% of Medicare beneficiaries residing in a nursing home had difficulty with at least one ADL; 63% had difficulty with 3 or more (AoA, 2011; Kasper & O'Malley, 2007) • Prevalence of disease is higher with many comorbidities • 40% have both physical and mental conditions • 66.6% have multiple physical conditions (Kasper & O'Malley, 2007)

Nursing Home Culture Change

In the previous sections, the evolution of contemporary nursing homes and the characteristics of its residents have been discussed. Significant quality issues have been associated with nursing home care, and reform efforts at quality improvement have been a

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significant theme. Culture change is the most important industry wide initiative. Culture change is organizational change. In the following section, nursing homes as organizations and organizational change models are detailed. .

Nursing homes as organizations and organizational culture.

Before exploring nursing homes as organizations it is helpful to define what an organization is. Schein (1980) suggests that "an organization is the planned coordination of the activities of a number of people for the achievement of some common, explicit purpose or goal, through division of labor and function, and through a hierarchy of authority and responsibility" (p. 15).

Ramanujam, Keyser, and Sirio (2005) describe organizations as complex systems that "develop strategies to convert inputs to outputs" and must do so within certain parameters dictated by political climate, availability of resources, and its own history (p. 455). Organizations are dynamic environments made up of several interdependent subsystems (Schein, 2010; Schein, 1980) consisting of people, tasks, formal structures and procedures, and informal social structures and processes (Ramanujam et al., 2005). The interaction between people, the environment, and resources creates organizational culture (Schein, 1980).

Health care organizations are complex adaptive systems, but they are uniquely different from industrial organizations for several reasons (Shortell & Kalunzy, 2005; Weiner, Helfrich, & Hernandez, 2005): it is difficult to define and measure outputs; tasks vary across the organization and are often complex; work is often of an emergency nature and cannot be deferred; there is little tolerance for ambiguity or mistakes; subsystems are interdependent and require coordination; tasks require specialized skills; and members of the organization are loyal to their profession, not the organization. Furthermore, doctors, who generate the work and expenditures,

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are not effectively managed. Dual lines of authority make it difficult to coordinate work among subsystems, to determine accountability, and they contribute to role confusion.

Nursing homes, therefore, are complex open systems possessing many subsystems that are responsible for different outputs. Like other health care settings, work cannot be deferred and tasks require specialized skills. Subsystems in nursing homes are interdependent and require extensive coordination. Unlike other health care settings such as hospitals, nursing homes are people's homes; this adds another layer of complexity that is not present in other health care settings. The interaction between people (staff, residents, and family members), the physical environment, resources, and history (both organizational and professional) contribute to organizational culture in nursing homes.

Keup, Walker, Astin, & Lindholm's (2001) definition of organization culture is the "sum total of the assumptions, beliefs, and values that its members share" and is expressed through the way in which people communicate with each other, assign tasks, and mete out rewards (p. 1). Culture is a powerful force in the workplace and can either support organizational change or hinder it.

Organizational change.

Organizational changes are "departures from the status quo or from smooth trends" (Gibson and Barsade, 2003, p. 13) and are either first order or second order changes. In first order change, the emphasis is on continuing to "do what you do, but to do it better"better" (Scott, Mannion, Davies, & Marshall, 2003). Second order changes, on the other hand, are employed if an existing organizational culture is stagnant. Changes of this order are undertaken when the organization is in crisis, or when there is a deficiency in the current culture that cannot be remedied by "a change *in* culture, but rather demands a fundamental change of culture" (Scott et

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al., 2003, p. 113). Hoffman and Emanuel (2013) refer to this as reengineering. A business will undergo reengineering when it is at the top of its game and has an ambitious leader; when it wishes to maintain its lead; and when it is in deep trouble. "The U.S. health care system is in trouble, and rather than single reforms, it needs reengineering" (Hoffman and Emanuel, 2013, pp. 662).

The health care system in the United States has been pushed by political, economic, and social forces to change the way it delivers health care. These changes are a departure from the traditional medical model of care to population-based wellness which emphasizes public health, disease prevention, and health maintenance (Shortell & Kaluzny, 2005). Implementing cultural changes in health care settings presents a particular set of challenges due to professional domains and the subcultures that develop around them (Scott et al., 2003). Subcultures may share similar values and work together as a cohesive whole, or they may have disparate values and merely co-exist or clash (Scott et al., 2003). The interdependence of the subsystems makes it difficult to know with whom or where the immediate problem lies; or with whom or where to begin making corrections.

Systemic or organization-wide problems are not captured under current performance measures; these measures focus on individual failings rather than systemic flaws. Such measures offer very little information to the public or to clinicians regarding how the health care setting is performing (Fisher & Shortell, 2010) and, ultimately, what areas require correction. Fisher and Shortell (2010) suggest that with advances in health informatics and the "science of improvement" comprehensive, meaningful performance measures are on the horizon (p. 1715). Having a valid tool for defining the culture as well as identifying "broken systems" will enable

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health care organizations to strengthen weak areas and implement change in a fashion that is congruent with the unique culture of an organization.

One health care innovation introduced to reengineer U.S. health care is the patient-centered medical home (PCMH). This model, like organizational changes in nursing homes, is a departure from business as usual (Rittenhouse, Casalino, Shortell, McClellan, Gillies, Alexander, & Drum, 2011). The PCMH model aims to coordinate care for patients with chronic diseases by providing primary care (each patient has a primary care physician), new approaches to care (whole person orientation to care), and new payment models (more insurance choices) (Rittenhouse et al., 2011). Under this model, quality of care, patient satisfaction with care, access to care, and coordination of care were better than in health care settings not using the PCMH model (Shortell, Gillies, & Wu, 2010). In addition, there was less staff burnout, a reduction in ER visits and hospital admissions, and a reduction in costs (Medicaid and State Children Health Insurance Program). In spite of the efficacy of PCMH, few practices in the US have adopted the model. This may be due in part to a lack of education and support staff; the practices that adopted PCMH were large physician organizations (PO). Other efforts at culture change have been successful when health care organizations had current clinical information technology (for example, electronic medical records), external incentives to improve quality of care (bonus from health plan, public recognition, and better contracts with health plans) (Casalino et al, 2003), accurate and valid outcome measurement tools (Fisher & Shortell, 2010), support staff and practice extenders, and strong leadership (Shortell, Gillies, & Wu, 2010). "A culture that emphasizes learning, teamwork, and customer focus may be a 'core property' that health care organizations [in the United States] will need to adopt if significant progress in quality improvement is to be made" (Ferlie & Shortell, 2001).

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In addition to policy forces, internal forces, specifically the culture *of* nursing homes, have also influenced change. A lack of humanistic management theory, and thus management style, has contributed to a work climate that feels cold, impersonal, and demoralizing (Slocombe, 2003). More recently, postmodern organizational theories (such as culture change) warn against the depersonalization and de-professionalization of health care employees. This is a move away from a prevailing attitude that is attributed to bureaucratic interference to protect the patient (Mick & Mark, 2005). Through organizational culture change, the nursing home industry has been making efforts to improve both the quality of care that it provides to its residents and the work life of its employees.

Nursing home culture change.

Nursing home culture change "encompasses almost three decades of consumer advocacy coupled with legal, legislative, and policy work aimed at improving both the quality of care and the quality of life in nursing homes" (Koren, 2010, p. 312). Culture change espouses person-centered care, resident autonomy, and a homelike environment (Bott, Dunton, Gajewski, Lee, Boyle, Bonnel, et al., 2009; Doty, Koren, & Sturla, 2008; Fazio, 2008; Koren, 2010; Miller et al., 2010; Scalzi, Evans, Barstow, & Hostvedt, 2006; Rahman & Schnell, 2008; White-Chu, Graves, Godfrey, Bonner, & Sloane, 2009). It encourages staff autonomy and empowerment, a flattened hierarchy, and consistent assignment to the same residents (Kostiwa & Meeks, 2009; Miller et al., 2010; Mitty, 2005; Stone & Dawson, 2008; Tellis-Nayak, 2007a; Yeatts & Cready, 2007). In essence, culture change implies a shift in power from the health care provider to the consumer (Martin & Border, 2003).

For many years nursing home culture change lacked a formal definition (Cassie & Cassie, 2012; Rahman and Schnell, 2008), and therefore had many interpretations. However, in order to

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formalize a definition of culture change, a panel of nursing home experts created a consensus document that identified six culture change constructs or domains. These domains, listed in Table 4, include: (1) resident–directed care and activities; (2) a living environment designed to be a home rather than an institution; (3) close relationships between residents, family members, staff, and the institution; (4) work organized to support and empower all staff to respond to residents' needs and desires; (5) management enabling collaborative and decentralized decision making; and (6) systematic processes that are comprehensive and measurement-based and that are used for continuous quality improvement (Harris, Pouleson, & Vlangas, 2006; Miller et al., 2010).

Table 4

Culture Change Constructs and Definitions

Culture Change Construct	**Definition of Construct**	**Examples of the Construct** *(not an exhaustive list)*
1. Resident directed care and activities.	Care and all resident-related activities that are directed by the resident.	Resident and family are included in care planning meetings. They are included in planning the activities that are offered. Resident decides what time to awaken and when to sleep. Bathing is done when and how the resident prefers.
2. Home environment.	A living environment that is designed to be a home rather than an institution.	The living environment has plants, pets, and comfortable seating. Residents are encouraged to bring their own furniture and decorations. Residents have flexibility in when to eat meals; snacks and drinks are available at all times. Residents can smell food cooking and may, if able, participate in food preparation. There is no overhead intercom system.

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Table 4 - Continued

Culture Change Construct	Definition of Construct	Examples of the Construct *(not an exhaustive list)*
3. Relationships with staff, family, resident and community	Close relationships existing between residents, family members, staff, and community.	Staff, family, and residents celebrate birthdays and holidays together. Staff members keep family informed of changes to their loved one's mental or physical status. Special programs are scheduled so that children from the community can interact with the residents. Community wide meetings (to include all stakeholders) are scheduled at regular intervals.
4. Staff empowerment	Work organized to support and empower all staff to respond to residents' needs and desires.	Staff members make their own work schedule and are cross trained to do other tasks related to resident care. Other options for continuing education are offered to all staff members.
5. Collaborative and decentralized management	Management enabling collaborative and decentralized decision- making	CNAs, LPNs are included in care planning meetings. They are also responsible for working out scheduling conflicts and other work related conflicts.
6. Measurement-based continuous quality improvement (CQI) process	Systematic processes that are comprehensive and measurement-based, and that are utilized for continuous quality improvement.	Improvements and changes to the nursing home facility or organizational structure are ongoing and formally measured at regular intervals.

Note. Taken from Harris Y., Pouleson, R. & Vlangas, G. (2006); Kissam, Gifford, Parks, Patry, Palmer, Wilkes, Fitzgerald, et al., 2003)

Person-centered care.

Person-Centered Care (PCC) is the central tenet in the nursing home culture change paradigm (Crandall, White, Schuldheis, & Talerico, 2007; Dilly & Geboy, 2010). Indeed, the term PCC is often used alongside or instead of culture change (Fazio, 2008; Tellis-Nayak, 2007b). However, for this research study, PCC is operationalized as a tenet of culture change. Culture change can best be understood as an umbrella with each of the above mentioned

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attributes serving as a panel on the umbrella. PCC is one panel that has its own definition. Appendix A provides an illustration of how PCC fits into the culture change paradigm.

Person Centered-Care was proposed by the gerontologist Tom Kitwood (1993) as a humane way to provide care to patients living with dementia. PCC emphasizes the individual as the center of care rather than the tasks necessary to care for the person (Kitwood, 1993; Kemeny, Boettcher, DeShon, & Stevens, 2006). The PCC philosophy affirms the dignity of residents and encourages staff to provide care *with* the individual's involvement rather than doing *to* or *for* the person (Tellis-Nayak, 2007a; Kitwood, 1997). A key goal in person-centered care is to maintain the individual's personhood regardless of cognitive and physical abilities. Morgan and Yoder (2012) have provided a succinct holistic definition of PCC that is in keeping with Kitwood's vision of PCC:

> PCC is a holistic (bio-psychosocial-spiritual) approach to delivering care that is respectful and individualized, allowing negotiation of care, and offering choice through a therapeutic relationship where persons are empowered to be involved in health decisions at whatever level is desired by the individual who is receiving the care (p. 8).

The PCC model of care is anchored in the teachings of Martin Buber and Carl Rogers, a theologian and psychologist, respectively. Martin Buber proposed that human relations consist of two relationships: *I - It* and *I – Thou*. *I - It* relationships are ego-centered and are not experienced outside the self (Buber, trans. 1970). By contrast, the *I – Thou* relationship includes another person: it is *I-Thou* that creates the world of relation (Buber, trans. 1970, p. 56). Kitwood was greatly influenced by Buber's theological position, which is evident in his

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proposition that elders living with dementia need to have access to nature, other people of all ages and cognitive abilities, and music and art (1997).

Carl Rogers coined the term Person-Centered to describe his approach to psychotherapy. The primary aim of Person-Centered Therapy is to help the individual develop as a person, to become him/herself (Rogers, 1980; Rogers, 1961). Rogers (1980) proposed that all organisms have an “actualizing tendency” (p.117); that is, every organism strives to reach its full potential, to realize its “inherent possibilities” (p. 117). Rogers (1980) believed that all people possess the resources for self-understanding, for changing basic attitudes and behaviors, and for altering their self-concept. In order for these resources to be accessible to the individual, there must be a climate of “defined facilitative psychological attitudes” (Rogers, 1980, p. 115). Rogers’ influence is evident through the PCC principles of recognition, collaboration, holding, and validation.

Person-Centered Care (PCC) has been described as an attitude (Collins, 2009; Dilley & Geboy, 2010), model (Dilley & Geboy, 2010), philosophy (Collins, 2009; Dilley & Geboy, 2010; Manley, 2011), roadmap or operational system (Collins, 2009; Love & Kelly, 2011), and a process (Collins, 2009; Crandall et al., 2007). However, researchers agree that PCC has the following characteristics: (a) focuses on getting to know the resident as an individual, not simply as a set of medical conditions; (b) promotes the resident’s autonomy and independence by allowing the resident to make informed choices and to take risks; (c) includes the resident in his or her health care decision making; (d) tailors health and social care and health messages based on best evidence and best practices and with the individual resident in mind; (e) provides ample support to the resident so that he or she can make their own choice; and (f) provides ongoing evaluation of the appropriateness of the care that each resident is receiving (Manley, 2011).

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PCC is being implemented in nursing homes, hospitals, assisted living facilities, day centers, and home health (Love & Kelly, 2011). It is a key element of nursing home culture change (Flesner, 2009; Crandall et al., 2007) and is considered to be, among geriatrics nurses, the gold standard of care (Crandall et al, 2007; Love & Kelly, 2011). While PCC was originally developed with dementia care settings in mind, it is an equally appropriate approach for those who are cognitively intact (Boise & White, 2004).

Nursing Home Culture Change Outcomes

One of the first large scale studies of culture change was conducted by Doty, Koren, and Sturla (2008) for The Commonwealth Fund. Their report, *Culture Change in Nursing Homes: How Far Have We Come?* (Doty et al., 2008), summarized findings from a national survey that had been conducted between February and June of 2007 of 1,435 nursing homes. Nursing homes that were located within hospitals and Medicare-only facilities were excluded (as these facilities usually provide care for short-stay patients only). Approximately one quarter (23%) of the nursing homes were non-profit. Geographical settings included urban (27%), suburban (41%) and rural (32%) areas. There was nearly an even split between bed capacity, with 45% having 99 or fewer beds and 48% having 100 to 199 beds.

Directors of nursing (DONs) were asked to complete a paper-and-pencil questionnaire that focused on "three domains of culture change: resident care, staff culture and work environment, and physical environment" (Doty et al, 2008, p. vi). Findings from the survey demonstrated that 31% of the nursing homes surveyed have adopted all or most of the culture change principles (termed culture change adopters). However, only 5% of the culture change adopters indicated that their facility met the definition of culture change completely. The remainder indicated that their nursing home met the definition "for the most part" (p. 3). Culture

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change strivers, defined as nursing homes that have adopted only a few aspects of culture change, represented 25% of the sample. The remaining sample (43%) was still adhering to the traditional model of care (termed traditional). Traditional nursing homes had adopted neither the aspects of culture change nor a leadership commitment to culture change.

Interestingly, even among the culture change adopters (31%), only one quarter allowed residents to determine all aspects of their daily schedule (this included eating, bathing, and decisions regarding their neighborhood). Doty and colleagues (2008) surmised that this aspect of culture change is difficult to implement because it affects staffing, timing, and preparation and delivery of food.

With regard to resident autonomy (that includes meal planning, decorating common areas, planning social events, developing a care plan, and staffing), (2008) found variability between culture change adopters and traditional nursing homes. For example, 58% of the culture change adopters reported that their residents are involved in all aspects of daily living as compared to 25% of the traditional nursing homes. However, few nursing homes (only 3%) involved residents in the operational decisions about the nursing home (e.g., which staff works in which neighborhood).

An important domain of culture change is providing an environment that fosters staff autonomy and opportunities to develop relationships with the residents. One way in which this can be achieved is by assigning staff to the same neighborhood (unit) when on duty. Seventy-four percent of all nursing homes surveyed consistently assigned staff to the same group of residents. When staff members are assigned consistently to the same residents, staff—if given the opportunity—can make meaningful contributions during care team meetings. These opportunities can be achieved through flattening the nursing home organizational hierarchy. As

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Doty and colleagues reported (2008), culture change benchmarks are hard to achieve because it requires dismantling the traditional hierarchy, which many leaders are reluctant to do. For example, only 15% of nursing homes allowed staff (CNAs and LPNs) to create self-managed work teams; 32% permitted residents and staff (CNAs and LPNs) on the senior management team; and 53% provided staff (all staff) with leadership training opportunities. Again, there was variability in staff autonomy between culture change adopters and traditional nursing homes: 69% percent of culture change adopters included CNAs in resident care planning meetings, and only 37% of traditional nursing homes did so. Across the board, only 14% of nursing homes cross-trained their staff to assume different responsibilities. And, few culture change adopters included CNAs in decision making about hiring new staff (9%) or budget allocations (5%).

With regard to physical changes to nursing homes, the researchers (Doty et al., 2008) found that few homes made major structural changes, and surmised that making structural change is perhaps the most difficult for nursing homes because of the age and/or layout of the facility, available funding, and state regulations. Of the homes surveyed, only 8% of residents reside in neighborhoods and 1% live in households. Nearly all of the nursing homes still have a nurses' station (97%) and a paging system (72%), with only five nursing homes using them for emergencies only.

Overall, culture change has had a positive impact on the business operations and staffing in those nursing homes that have adopted culture change. While Doty and colleagues (2008, p. 16) did not report specific financial figures, they did report DONs' perceptions about whether or not culture change improved particular business operations. Specifically, DONs were asked if culture change (1) improved their nursing homes' competitive position in the market area (78% agreed), (2) improved occupancy rate (60% agreed), and (3) improved operational costs (60%

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agreed). With regard to staffing, DONs were asked if culture change (1) improved staff retention (59% agreed), (2) improved absenteeism (50% agreed), and (3) improved use of agency staff (23% agreed). Understandably, the more engaged in culture change a nursing home was, the more likely they were to report improvements in business operations and staff retention.

Doty et al. (2008) noted that in spite of a mandate that nursing homes adopt culture change, few nursing homes are doing so. Some of the problems with making changes can be attributed to staff resistance (61%) and cost (59%) and other barriers such as regulations (56%) and facility size (49%). Nursing homes that have implemented or have been striving to implement culture change have one thing in common: a leadership committed to culture change. Those nursing homes that have not implemented culture change do not have leadership commitment.

Another large scale study of culture change outcomes in Kansas nursing homes was undertaken by the Kansas Department on Aging (Bott et al., 2009). This research study focused on residents' health outcomes, staff turnover, nursing home deficiencies, quality indicators, and the extent to which a nursing home had adopted culture change.

All free standing nursing homes (n = 351) located in Kansas were invited to participate in this study. Of the two hundred twenty-three nursing homes that agreed to participate, which were stratified by regional population, 100 were selected to complete the research survey. Seventy two surveys were returned.

Bott and colleagues (2009) reported that across the state of Kansas, nursing homes reported turnover rates between 3% and 319% with an average rate of 67%. In addition, 31% of nursing homes were not meeting the requirement that residents receive the necessary care and services to maintain the highest physical, mental, and psychosocial status in accordance with the

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care plan (Bott et al., 2009). Additionally, average rates of Quality Indicators (such as fractures, depression, and the use of antipsychotic drugs) were no different across nursing homes. However, "the prevalence rates were highest for symptoms of depression and the use of antipsychotics in the absence of psychotic or related conditions" (p. 18). Not surprisingly, nursing homes with the most culture changes had the lowest quit rates, incidence reports, and antipsychotic drug use among their residents. However, the proportion of residents suffering from depression was lowest among nursing homes that had made limited culture change. This finding may be due to the fact that some of these residents were medicated.

Additional support for culture change was provided by Burack and colleagues (Burack et al., 2012b) and Annunziato and colleagues (Annunziato, Burack, Barsade, & Weiner, 2007), who conducted a longitudinal case-control research study of nursing homes in the New York area. Their research outcomes suggested that culture change positively affected residents' behavioral symptoms, thus reducing the need for pharmacological interventions (2012a) and improved residents' quality of life (2012b). Furthermore, staff burnout was reduced in nursing homes that had made culture change and family members were more satisfied with their loved ones' care (Annunziato et al., 2007).

Like Doty et al. (2008), Sterns, Miller, and Allen (2010) found that among nursing homes (total sample n = 291) that had adopted all elements of culture change, staff turnover was lower (3% to 24%) than the national average turnover rate (as of 2004, according to the Health Resources and Services Administration, 46.1% for RNs; 42% for LPNs; and 64.4% for CNAs). Successful implementation of the easier changes (e.g., changing to colored bath towels, placing scented candles in the bathroom, putting plants in common areas, painting hallways, referring to units as neighborhoods, etc.) may have catalyzed the more complicated culture changes (e.g.,

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removing nursing stations, open meal times, etc.). Sterns and colleagues (2010) noted that the more committed a nursing home was to the ethos of culture change, the more likely they were to have adopted all domains of culture change. Nursing homes that were not fully committed from the start may have felt that the minor culture changes were good enough and that more changes were not necessary (Sterns et al., 2010).

Research outcomes have demonstrated that culture change improves residents' QOL, nursing home quality indicators, families' satisfaction with care, and staff's quality of work life. They have also revealed that in spite of the benefits of making culture change, many nursing homes across the US have not done so; this may be due to lack of strong leadership commitment to culture change.

Green House Project

One of the most dynamic demonstrations of culture change is the Green House Project. The Green House Project, developed by geriatrician Dr. Bill Thomas in 2003, aims to deinstitutionalize LTC and create a supportive and homelike environment for elders (Sharkey et al., 2011). Green House is both an architectural and philosophical departure from standard nursing home care. Green House homes are designed to be small-house nursing homes that accommodate 8-10 residents. Residents share all the common living areas such as the living room (hearth room), kitchen, dining room, sun room, and patio; however, bedrooms and bathrooms are private. The physical arrangement of the house fosters greater autonomy among residents. In the Green House paradigm, CNAs are called *Shahbazim*. *Shahbaz* (singular), a Persian word that means royal falcon. In Persian folklore, the Shahbaz helped and guided the Iranian people. In the Green House model, *Shahbazim* are not viewed as part of a nursing department. Thomas (n.d.) argued that the hands-on-care that the *Shahbazim* provide is

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important enough to warrant its own professional standing. *Shahbazim* work as a team in the Green House home and provide care to all of the residents, rather than being assigned to particular residents. They are cross-trained to assist with activities of daily living (ADLs), instrumental activities of daily living (IADLs), cooking, and cleaning. Nurses (RNs) and administrators, called Guides, serve as mentors to the *Shahbaz* and provide medical care to the residents. These changes are a radical departure from the typical nursing home structure.

Green House is a relatively new concept in elder care and as such has not yet been extensively studied. However, it is gaining a foothold in the nursing home industry. Currently there are 126 Green House homes on 30 campuses across the US (Jenkens, Thomas, & Barber, 2012) and over 100 more facilities in development (Jenkens, Sult, Lessell, Hammer, & Ortigara, 2011). Research suggests that the Green House model of care is a promising alternative to standard nursing home environments and care (Ragsdale & McDougall, 2008). For this literature review, Green House outcomes have been placed into five broad categories: (1) residents' health, (2) quality of life, (3) quality indicators, (4) stakeholder satisfaction, and (5) financial implications.

The first Green House homes were built in 2003, on the campus of Mississippi Methodist Senior Services (MMSS), in Tupelo, Mississippi (Rabig et al., 2006). Rabig and colleagues monitored the progress of construction as well as the transition of residents from standard nursing homes to one of the four Green House homes. Residents were transitioned to their new homes every week or two.

Rabig and colleagues (2006) reported that residents who previously needed wheelchairs no longer needed them because the distances in the Green House were shorter. Overall, residents and family were satisfied with the layout of the Green House; they were especially pleased with

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the private bedrooms. Staff initially had concerns about the safety of their residents and the loss of power that is inherent to this model. However, over time the staff adjusted and came to "own the model and be enthusiastic proponents" (p. 538). Withdrawal behaviors (absenteeism, lateness, and resignation) of staff members were much improved in the Green House compared to other facilities on the campus. In addition, no injuries related to transferring residents were reported during the observation period.

Two additional studies, conducted at MMSS, examined the effects of Green House nursing homes on residents' health, quality of life, satisfaction (Kane et al., 2007), and families (Lum et al., 2008). In the first study, Kane and colleagues (2007) hypothesized that Green House residents' quality of life and satisfaction would be greater than the residents living in two traditional nursing homes, Cedar and Trinity. The research was designed as a longitudinal quasi-experimental study. Two standard care nursing homes (n = 40 residents per site) and four Green House homes (n = 40 residents) participated. The researchers were interested in knowing about residents' perceptions of their health (excellent, very good, good, fair, or poor) and their ability to perform ADLs and IADLs. Eleven domains of QOL were also measured: "physical comfort, functional competence, privacy, dignity, meaningful activity, relationship, autonomy, food enjoyment, spiritual well-being, security, and individuality" (Kane et al., 2007, p. 834).

Kane and colleagues (2007) reported that residents living in Green House had a lower incidence of decline in late loss ADLs. However, there were not significant differences between Green House and the comparison groups with regard to health and overall ADLs and IADLs. Green House residents reported higher quality of life than the comparison residents on four indicators: privacy, dignity, autonomy, and food enjoyment. Overall, Green House residents reported significantly higher satisfaction with their living arrangements than did the comparison

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groups and were more likely to recommend the Green House to others. With regard to quality of care, residents living in Green House had a lower prevalence of bed rest and fewer residents remaining sedentary. However, Green House residents had a higher rate of incontinence than one of the other nursing homes.

The second study (Lum et al., 2008) focused on the effects of Green House on residents' families. Again, the same group of nursing homes was used: two standard care nursing homes (Cedar and Trinity, n = 39 residents each) and four Green House homes (n = 39 total residents). The researchers measured families' satisfaction with care, experience as consumers, involvement with resident, subjective and objective burden, and global satisfaction. Analysis revealed that three quarters of the respondents were female and more than half were adult daughters or daughters-in-law. Green House family members were more engaged in their resident's care than family from the other nursing homes. Qualitative interviews revealed that Green House family members were pleased to have the responsibility of laundry shifted to the *Shahbazim*; before the move to Green House, family members would do their loved one's laundry to avoid ruin or loss. Compared with families from Cedars and Trinity, Green House families reported higher satisfaction with the physical environment, health care, privacy, and autonomy. Global satisfaction with the living environment was higher among Green House families, but was not significantly different from the other two nursing homes.

Empowerment, a key domain in Green House, was examined by Bowers and Nolet (2011). Their sample was comprised of *Shahbazim* (most of whom were trained as CNAs) working in 11 Green House settings. Overall, *Shahbazim* appreciated the opportunity to make decisions about daily routines, prioritizing tasks, and schedules. They felt comfortable talking directly or over the phone with family about changes in residents' health status, end-of-life care,

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relationships with other residents, likes and dislikes, etc. However, *Shahbazim* did not initiate contact with doctors or families to discuss medication; this they viewed as the nurses' purview.

Perhaps the most challenging aspect of empowerment for the *Shahbazim* was addressing conflicts that occurred among staff (Bowers & Nolet, 2011). Many of the *Shahbazim* did not feel prepared to deal with conflicts. Working as a team was the most common cause of conflict. For some, working as a team member was difficult after years of working in standard care nursing homes where CNAs worked independently to care for a prescribed number of people. *Shahbazim* had difficulty adjusting when work spilled across shifts; it took time for them to see multiple shifts as teams striving for the same goal.

Overall, *Shahbazim* embraced empowerment. It gave them opportunities for personal development by learning new skills, using talents they already possessed, and serving as mentors to newer staff. Nevertheless, education concerning conflict resolution and team building will be a necessary part of Green House training (Bowers & Nolet, 2011).

At first glance, it would seem that the Green House model would be too expensive to be considered an option for many organizations. However, the Green House Project celebrated the opening of its 100th Green House in September, 2011 (Lavizzo-Mourey, 2011). There are an additional 130 homes in development across the US (Jenkens et al., 2011). Thus, the initial outlay is seemingly worth the cost to many organizations. Given the organizational and environmental redesign that comes with Green House, questions about staff and environmental costs are relevant.

Jenkens and colleagues (2011) examined costs related to maintaining Green House homes. Their first study focused on administrative and staffing costs. Five Green Houses and two traditional nursing homes were evaluated. The Green Houses included in this study ranged

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in size from 4 homes serving 40 residents to 16 homes serving 192 residents. The two traditional nursing homes had 99 and 59 beds, respectively. All Green House facilities but one were non-profit.

Overall operating costs for the five Green Houses® (excluding interest and depreciation) were found to be between $161.00 and $237.00 per resident day with an unweighted mean of $199.00 (Jenkens et. al, 2011). The national median value for nursing homes is $197.51. *Shahbazim* salaries were the greatest expense for the Green Houses®; however, *Shahbazim* perform the other tasks that are usually taken care of by other cost centers (e.g. dietary, laundry, etc.) in traditional nursing homes. Food cost per resident were lower in some homes and higher in others: the average was $7.48 per day. Plant operations (utilities and maintenance) tended to be higher in Green House compared to traditional nursing homes ($5.28 versus $5.17) due to the higher square footage per resident that a Green House facility provides. Capital costs are much greater for Green House than for standard nursing homes. It is recommended that Green Houses® provide 650 square feet per resident. Using the national average of $128.00 per square foot, the cost of Green House per resident is $83,200.00. Standard nursing homes provide between 239 square feet and 318 square feet, which costs between $30,592.00 and $40,704.00. These figures are based upon costs per bed. “If the environmental culture change undertaken can reasonably be expected to impact occupancy, projecting cost on a per resident day basis may be a more meaningful measure than the commonly used cost per bed” (Jenkens et al., 2011, p. 17). Thus, if 100% of the capital costs are financed with a loan to be repaid over a 30 year period at an interest rate of 6%, and the occupancy rate is at the average rate (based upon the average occupancy rate of the five Green Houses in this study) of 96.2% (and 650 sq ft x $128), the costs per resident day is $18.82. This is $8.69 more than a facility with the same capital costs per

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resident and occupancy rate that offers only 350 square feet per resident (Jenkens et al., 2011, p. 17).

Stakeholder Attitudes Toward and Expectations for Culture Change and Person-Centered Care

The aim of this research is to understand stakeholders' attitudes toward person-centered care and their expectations for Green House living. Up to this point, culture change outcomes (which include person-centered care and Green House) have been reviewed. In this section the literature addressing attitudes and expectations is reviewed.

Before a review of the literature was undertaken, a definition of the word expectations was settled upon to aid in the literature search. The word expect (expectation) means "to look forward to" or "to consider reasonable, due, or necessary", or "to consider bound in duty or obligated". Thus, any one of the three meanings was assigned to the word expectations. Having a clear meaning of the word allowed for the culling of irrelevant research.

There is a large body of research focusing on culture change models and resident outcomes. However, the search of the extant culture change literature revealed that there is a paucity of research focusing on attitudes and expectations toward culture change models of care, and person-centered care. Key words (such as attitude, expectation, beliefs, perception, perspective, culture change, Green House living, small-house living, small house nursing care, residents, elders, older adults, staff, family, stakeholders, and LTC) were entered into EBSCOhost, Medline, and Google Scholar search engines in various combinations.

Only three new articles (beyond those reported in this literature review) appeared that were relevant to small-house living, person-centered care, and culture change. All three were literature reviews of both quantitative and qualitative studies; two articles were literature reviews

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of the extant literature about small-house nursing care (Fancey, Keefe, Stadnyk, Gardiner, & Aubrecht, 2012; Verbeek, Rossum, Zwakhalen, Kempen & Hamers, 2009) and one was a literature review examining the research related to consumer decision making about and expectations for residential care (Edwards, Courtney, & Spencer, 2003). Both Fancey et al. (2012) and Verbeek et al. (2009) summarized research about the physical setting, resident quality of life and care, residents' quality of life as it relates to the physical design of the building, and family involvement. Nothing was directly mentioned about stakeholders' expectations. Moreover, all of the research cited in those reports has been reviewed in this literature review. Edwards and colleagues' (2003) review of the literature did not reveal new research relevant to expectations or attitudes. However, their conclusion was quite relevant to this research proposal: "The deficiency [in the literature] extends to an understanding of consumer expectation about the quality of services they encounter once admission has been obtained" (Edwards et al., 2003, p. 70). It can also be concluded that the deficiency in the literature extends to consumer (stakeholder) expectations for small house living before they enter into the Green House or LTC environment. Thus there is a gap in the culture change literature with regard to expectations that stakeholders have before and after entering long-term care of any kind.

Summary

Several conclusions can be drawn from the research about nursing home culture change, PCC, and Green House. First, staff job satisfaction is directly related to residents' satisfaction with care (Liu, 2007). Expanding the role of staff members will contribute to employees' commitment to and satisfaction with their work (Doty et al, 2008; Miller et al, 2010). Second, maintaining residents' dignity is likely to result in greater satisfaction with the facility and the staff (Burack et al., 2012b). Third, having good food to nourish the body and engaging activities

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to nourish the mind contributes to satisfaction with the nursing home (Burack et al., 2012b). Fourth, implementing culture change values has a positive effect on elders' behavioral function thus reducing a need for psychotropic drugs (Burack et al., 2012b). Fifth, implementing culture change may increase the bottom line (Jenkens et al., 2011). For example, nursing homes that have implemented culture changes have shown improvements in occupancy rates of 3%, whereas Green House occupancy rates are about 95%. Operational costs of Green House are not significantly different from standard nursing homes and capital costs demonstrate that residents get more value for their money (Jenkens et al., 2011). Sixth, a nursing home with leaders and staff committed to culture change is more likely to successfully make culture change (Doty et al., 2008). Finally, there is a rich body of research regarding culture change outcomes. However, as the Green House model is a relatively new concept, it does not yet possess a wide range of outcomes research. Notable exclusions, in both the qualitative and quantitative research literature, are questions related to stakeholders' attitudes toward and expectations for culture change, Green House, and person-centered care.

Barriers to Culture Change

Organizational culture change is a process (Gibson & Barsade, 2003) that requires cooperation from all stakeholders, not just the change leaders. Choi (2011) suggested that change fails because "leaders have underestimated the central role individuals play in the change process" (p. 480). Nursing home culture change, in order to be successful, must include the support of all the key stakeholders, which includes administrators, leaders, staff members, residents, and family members. When one of these stakeholders is absent from the change discussion and change process, the change process does not go as smoothly as planned (Norton, 2010).

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When an employee feels involved in the organizational change process through communication and educational initiatives, then the employee is open to change (Choi, 2011). Furthermore, if employees believe that the change is likely to benefit them individually, that it will be easy to cope with, and that it is congruent with the mission and values of the organization, then employees are more likely to be committed to the change (Choi, 2011). An important domain of culture change is flattening the organizational hierarchy so that all staff are part of the decision making process.

Flattening the hierarchy—which requires including direct care staff in discussions about matters related to resident care and operation of the nursing home as well as work autonomy was difficult for nursing homes to embrace because it required dismantling a long-held belief in the medical model (Doty et al., 2008; Norton, 2010). Indeed, only 32% of culture change nursing homes reported culture change values congruent with a flattened hierarchy (Doty et al., 2008). Culture change values may contradict the care practices that nurses and doctors were taught and may cause confusion about whether or not professional or regulatory requirements have been violated (Burger et al., 2009; Haidet, 2010). For example, when nursing and non-nursing staff alike are providing care for residents, the lines of accountability for clinical care are blurred (Bellot, 2007; Burger et al., 2009).

The lack of familiarity with nursing home culture change may be another barrier to adopting culture change (Bellot, 2007; Miller et al., 2010). Miller and colleagues (2010) found that knowledge about culture change varied among LTC professionals. Of the 1,147 LTC professionals surveyed, 66% were familiar with the term culture change, with only 7% reporting not being at all familiar with the term culture change. Nursing home providers and consumer advocates were the most knowledgeable about culture change (90.5% and 76.1% were either

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"familiar" or "extremely familiar" with culture change values, respectively). Interestingly, academics were the least familiar with culture change terms (only 58% rated themselves as either "familiar" or extremely familiar"). In another study, Bellot (2007) found that registered nurses (n= 47) working in two Wellspring Model nursing homes (n = 20 and 27) were uncertain about the meaning of culture change. Only one nurse understood that the nursing home in which she worked had implemented a culture change model.

Barriers to implementing culture change include a lack of knowledge about the terms and their meanings, a belief that culture change initiatives are expensive, and a lack of strong leadership.

Future of the Culture Change Movement

In recent years, The Center for Medicare and Medicaid Services (CMS) has endorsed the culture change movement by mandating that individual state's Quality Improvement Organizations (QIOs) work with nursing homes to "improve organizational culture" (CMS, 2012). QIOs—for which there is one per state, the District of Columbia, and each territory—work with consumers, hospitals, doctors, and other care providers to ensure that patients receive the right care at the right time (Shi & Singh, 2008). The program protects the integrity of the Medicare Trust Fund by making sure that payment is made for only medically necessary treatment. QIOs are also responsible for investigating complaints about quality of care (Shi & Singh, 2008).

In 2006 the CMS further endorsed culture change by launching a program called "Advancing Excellence in America's Nursing Homes," a quality improvement effort to implement person-directed care. However, Rahman and Schnell (2008) caution that an industry-wide adoption of culture change, without supporting research, may be premature. Rahman and

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Schnell (2008) conducted a retrospective analysis of nursing home culture change research published between 1995 and 2005. While there is a wide body of literature on how to implement nursing home culture change, very little research focused on its efficacy. The culture change movement message is largely published in books, conference reports, and on the internet, not in peer reviewed journals. "Instead, case studies and anecdotal reports are often presented as evidence of success, typically with no mention of the caution needed when one is attempting to generalize from this information" (Rahman & Schnell, p. 144). The fear is that serious consequences may result from adopting an understudied intervention, such as wasted time, money, and a failure to produce the desired outcomes.

More recently, Hill and colleagues (2011) examined the extant literature on culture change models and health outcomes. They concluded that "residents' health outcomes after comprehensive culture change model implementation is inconsistent" and making practice recommendations at this time unadvisable (Hill et al., 2011, p. 30).

Measuring Nursing Home Culture Change & Person-Centered Care

Harris et al. (2006) prepared a literature review summarizing eight culture change surveys used to study the effects of culture change including a thorough evaluation of each survey and a working definition of culture change (refer to Table 4). Table 5 provides a list of the culture change measurements.

Each of the eight surveys was evaluated for culture change practices; 25 practices were identified and categorized under the appropriate construct. The authors' (Harris et al., 2006) study resulted in six conclusions. First, six core constructs and 25 culture change practices were identified (Table 6) which suggests that there are more similarities among the surveys than differences.

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Table 5

Culture Change Measurements

Measurement Tool	Created By	Validity/Reliability
1. Artifacts of Culture Change	CMS and Edu-Catering	Not provided in literature.
2. CARF International Person-Centered Long-Term Care Community Standards	Commission on Accreditation of Rehabilitation Facilities	Not provided in literature.
3. Culture Change Indicators Survey	Institute for Caregiver Education	Not provided in literature.
4. Culture Change Staging Tool	Grant, Zupan, Norton	Not provided in literature.
5. Eden Warmth Survey for Elders, Families and Employees	Eden Alternative	Not provided in literature.
6. Kansas Culture Change Organizational Self-Assessment	Kansas Foundation for Medical Care	Has been validated.
7. Long-Term Care Leadership Self-Assessment	American College of Health Care Administrators	Not provided in literature.
8. Wellspring Alliance Staff Survey	Grant	Not provided in literature.

Note. Taken from Harris, Poulsen, and Vlangas (2006). *Measuring culture change: Literature review*. Colorado Foundation for Medical Care.

Table 6

Culture Change Construct and Related Practices

Culture Change Construct	Culture Change Practices
1. Resident directed care and Activities	• Restoring dining choices. • Providing bathing options. • Assisting residents in determining their own daily schedules and care plans. • Promoting all remaining capacities for self-care and mobility.

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Table 6 – Continued

Culture Change Construct	Culture Change Practices
2. Home environment	• Redesigning resident rooms for privacy, personalization and individual needs. • Introducing plants, pets, children and surroundings that are reminiscent of past lives. • Redesigning public and outdoor living spaces for stimulation and activity. • Developing neighborhoods or households with dedicated areas for dining and living.
3. Relationships with staff, family, resident, and community	• Committing to consistent staffing. • Promoting a sense of community. • Including family members in decision making. • Providing intergenerational/volunteer programs and activities. • Honoring death and dying with dignity.
4. Staff empowerment	• Involving staff in care planning and care conferences. • Enabling staff to handle scheduling. • Implementing cross-training for all staff levels. • Promoting staff development and empowerment.
5. Collaborative and decentralized management	• Developing self-managed work teams and encouraging teamwork. • Modifying hiring and retention practices to promote staff satisfaction. • Promoting strong leadership qualities among management. • Promoting open communication at all levels. • Conveying the mission, vision, and direction of culture change.
6. Measurement-based CQI Process	• Monitoring and evaluating quality of care and services. • Monitoring staff turnover and longevity. • Monitoring financial information.

Note. Taken from: Harris Y., Pouleson, R. & Vlangas, G. (2006). *Measuring culture change: Literature review*. Colorado Foundation for Medical Care, pp. 17-23.

Second, all but five of the 25 practices have documented evidence in the research literature for improving outcomes (Table 7). Third, it may be necessary to study different audiences (stakeholders) because attitudes, beliefs, experiences, and expectations differ from one

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Table 7

Lack of Evidence for the Effectiveness of Culture Change Practices on Selected Outcomes

Culture Change Practice	Selected Outcomes
1. Enabling staff to handle scheduling. 2. Implementing cross-training for all staff levels. 3. Conveying the mission, vision, and direction of culture change. 4. Monitoring staff turnover and longevity. 5. Monitoring financial information.	Pressure ulcers, physical restraints, depression, pain, incontinence, rate of transfer to acute care, medication safety and adverse events, workforce outcomes.

Note. Taken from Harris Y., Pouleson, R. & Vlangas, G. (2006). *Measuring culture change: Literature review*. Colorado Foundation for Medical Care, pp. 17-23.

group of stakeholders to the next. Fourth, measuring culture change will require a mixed methods approach in order to arrive at the most comprehensive picture of culture change. Fifth, the majority of culture change measurement tools have not been validated (or their validation procedures and outcomes have not been published) or cross validated. Finally, further research is needed to determine the effect that culture change has on clinical practice and workforce outcomes.

Edvardsson & Inness (2010) reviewed nine surveys measuring person-centered, patient-centered and individualized care. Table 8 provides a summary of the PCC instrument, what it measures, and its validity and reliability estimates. The first four surveys in Table 8 are specific to long-term care and dementia settings and will be described next; the final five surveys are

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Table 8

Person-Centered Care Measures

Name of Tool	Aim	Validity/Reliability
Dementia Care Mapping, 8th edition (Edvardsson & Innes, 2010).	Observation of individuals living with dementia. Based upon Kitwood's Person-Centered Care	No data about the 8th edition.
The Person-Directed Care Measure (Edvardsson & Innes, 2010).	Evaluates the care setting and to what extent it is congruent with PCC	• Cronbach's α = 0.85. • "Construct validity estimated in five factors explaining 61% of total variance" (p. 837)
The Person-Centered Care Assessment Tool (Edvardsson, Fetherstonhaugh, Nay, & Gibson, 2010)	Evaluates to what extent staff members rate the care they give as being person-centered.	• Cronbach's α = .84 for total scale. • Test-retest Reliability = correlation coefficients between 0.70 -0.90 • Construct validity = satisfactory. "PCA separated the items into stable three- factor solutions explaining nearly 56% of the total variance in the sample" (p. 104).
Measure of Individualized Care (Chappell, Reid, & Gish, 2007)	Used to measure individualized care given to people with dementia. Three domains of care were created into three independent tools: knowing the person, autonomy, and communication.	For each of the three domains, construct validity was estimated and explained 29%, 31%, and 33% of the variance respectively. Cronbach's α = 0.77, 0.80, and 0.64 respectively. Test-retest reliability (Pearson's r) = 0.60, 0.88, and 0.77 respectively.
Family Involvement in Care (Edvardsson & Innes, 2010).	Measures family's perceived involvement with care for their loved ones living with dementia in long-term care. Two domains of family involvement were created into two independent tools: (1) family perceived involvement, and (2) importance attached to family involvement.	For the two independent tools, construct validity was estimated. For the first tool "one interpretable factor explained 44% of the total variance; for the second tool, two interpretable factors explained 30% of the total variance" (p. 839) Cronbach's α = 0.93 and 0.85 respectively.

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Table 8 – Continued

Name of Tool	Aim	Validity/Reliability
The English Language Person-Centered Climate Questionnaire-Patient Version (Edvardsson, Koch, & Nay, 2008)	Measures patients' perceptions of the extent to which the health care environment is person-centered.	Cronbach's α = 0.90 Test-retest reliability = intra-class correlation coefficient of 0.70; 95% confidence interval ranging between 0.63-0.77
The English Language Person-Centered Climate Questionnaire-Staff Version (Edvardsson & Innes, 2010)	Measures staff members' perceptions of the extent to which the health care environment is person-centered.	• Construct validity estimated 72% of the total variance for four factors. • Cronbach's α of the total scale = 0.89 • Item total correlations = 0.24-0.71 • Test-retest reliability = Intra-class correlation of 0.80
The Person-Centered Inpatient Scale (Edvardsson & Innes, 2010)	Measures patients' perceptions of person-centered care.	Unknown
The Client-Centered Care Questionnaire	Measures the patients' evaluation of the extent to which home health nurses are client-centered	• Construct validity estimated in one factor explained 58% of the total variance. • Cronbach's α = 0.94 for the total scale.

specific to hospital care or home health care and will not be described in this chapter, although they are presented in Table 8.

The first survey, Dementia Care Mapping 8 (DCM 8), is an observational tool that is used to help care givers see the world from the residents' perspective (Ervin & Koschel, 2012). One staff member observes five residents who are in a common area of the facility for a certain period of time. Every five minutes, the observer uses specific codes to record what has been observed (e.g., behavior, well-being, social interaction, staff interactions, etc.). The staff members receive feedback about the observations that were made during the time they interacted

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with residents. Feedback contains both positive and negative information about interactions with residents and is aimed at improving staff members' competencies and performance (Ervin & Koschel, 2012). DCM 8 is a commercial instrument that requires training. It has shown satisfactory construct validity estimates and internal consistency reliability (Edvardsson & Innes, 2010).

The second tool, The Person-Directed Care Measure, is a 50 item survey completed by nursing home care staff. This tool measures staff members' perceptions of the extent to which PCC is practiced in their care setting. The tool showed satisfactory construct validity (Edvarddson & Innes, 2010).

The third instrument, the Person-Centered Care Assessment Tool (P-CAT), is a 13 item questionnaire containing three subscales: personalizing care, organizational support, and environmental climate (e.g., chaotic work environment, too much emphasis on getting work done, and residents having a hard time finding their way around the nursing home) (Edvardsson, Fetherstonhaugh, Nay, & Gibson, 2010). The P-CAT was developed to assess staff members' perception of the level of PCC in their workplace. The survey has satisfactory internal consistency validity for the total scale (Cronbach's Alpha = .84) and satisfactory test/re-test reliability (Edvardsson, et al., 2010).

The final survey under the LTC and dementia care heading is the Measures of Individualized Care. This survey consists of three scales "measuring three domains of individualized care" (Chappel, Reid & Gish, 2007, p. 528): (a) knowledge of the resident; (b) resident autonomy; and (c) communication between the staff members and between staff members and residents. The survey has minimally acceptable internal consistency reliability

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(Cronbach's Alpha =.67); however, the researchers noted that further testing is required (Chappel et. al, 2007).

The above mentioned surveys measure the extent to which PCC has been delivered or received. None of the PCC surveys measure the givers' or the receivers' attitude toward PCC. It must not be assumed that all nursing home care givers have a positive attitude toward PCC. PCC is a relational process that challenges prevailing medical and nursing professional norms (Haidet, 2010) and may make some care givers uncomfortable. PCC requires nursing home staff members to either possess or develop the skill to enter into a "therapeutic relationship" where the resident is empowered to make choices about their care (Morgan & Yoder, 2012). It is worth knowing and understanding what care providers believe about PCC in order to have a fuller sense of PCC as a model of care.

Chapter Two Summary

This literature review covered nursing home history, the culture of elder care, characteristics of nursing home residents, and nursing homes as organizations, nursing home culture change, culture change models, culture change outcomes, Green House outcomes, staff empowerment, culture change measures, and theory. The following are observations that can be made about the literature and research pertaining to culture change. First, caring for elders has come a long way since the days of almshouses. Beginning in the early 1990s, new paradigms of nursing home care, collectively called culture change, were instituted, making vast improvements in the care that elders received. However, in spite of its demonstrated benefits, culture change is embraced by only half of LTC facilities in the US. Second, culture change and Green House improves residents' quality of life, staff's work life, and families' satisfaction with care. Third, Culture Change models, including Green House, are cost effective, reduce turnover,

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and improve residents' satisfaction with care. Fourth, medical and nursing education is being pulled along by culture change and PCC models. These paradigms of care are challenging nurses and doctors to change the way they practice their craft, which naturally means changing nursing and medical school curricula. Fifth, conspicuously absent from the research is an evaluation of how frontline staff and other stakeholders understand nursing home culture change. Indeed, Belott (2007) demonstrated that even staff working in culture change environments could not define culture change. Sixth, there are no surveys measuring staff attitudes toward culture change or PCC. Seventh, no outcomes research has been published examining stakeholders' understanding of Green House, what their expectations are, and whether their expectations were met once living or working in Green House. Finally, researchers agree that more studies about culture change outcomes are necessary in order to provide a solid, research based intervention (Hill et al., 2011). As Rahman and Schnell (2008) pointed out, serious consequences may result from adopting an understudied intervention, such as wasted time, money, and a failure to produce the desired outcomes.

Therefore, this research study explored the implementation of the first Green House in the state of Virginia. This study focused on resident, family, and staff expectations about Green House before and after the move to Green House, and looked at staff attitudes toward PCC.

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Chapter 3: Research Methods

Overview of Research Design and Methodology

This chapter presents the research methods and analytic techniques used for this exploration of stakeholders' transition from a nursing home environment to a small house care environment (Green House). Because of the nature of the research questions, this dissertation research was designed as both qualitative and quantitative research conducted in multiple phases. For consistency, the research methods are presented as two separate research studies. The qualitative research study is presented first in its entirety followed by the quantitative study.

The changing organizational culture in nursing homes emphasizes transitions from traditional nursing home care to new ways to care that focus on the various aspects of culture change, especially person-centered care. Little culture change outcomes research is available describing stakeholders' expectations for Green House living or attitudes toward person-centered care (PCC). Therefore, the purpose of this dissertation research was to examine stakeholders' expectations about small-house nursing care and attitudes toward PCC. Additionally, this dissertation research aimed to explore the validation potential of the Person-Centered Care Attitude Test (Per-CCat), a new survey designed to measure nursing home staff attitudes toward person-centered care. Under the qualitative heading, the focus group format, grounded theory, and symbolic interactionism will be reviewed. Under the quantitative heading, the Person-Centered Care Attitude Tool (Per-CCat) and analytic strategies will be reviewed.

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Background

This research was conducted at Virginia Mennonite Retirement Community (VMRC), a continuing care retirement community located in Harrisonburg, Virginia. VMRC offers older adults a variety of housing choices based upon need and finances. The focus group for this study was derived from Oak Lea, VMRC's traditional skilled, long-term care nursing home, and Woodland Park – Green House, a culture change innovation, which consists of three separate houses with 10 residents each. Woodland Park – Green House is a residence designed for older adults who require nursing home services.

In January 2013, one unit (neighborhood) in Oak Lea was closed permanently. The 30 residents residing in the neighborhood were given the options of remaining at Oak Lea (living in another neighborhood) or moving to Woodland Park. Likewise, staff members working at the closing neighborhood were also given the options of transferring to Woodland Park, being reassigned to another neighborhood in Oak Lea, or transfering to another campus facility. Thus, everyone making the move to Woodland Park was given the opportunity to make their own choice.

VMRC prepared residents and family for the move through educational meetings conducted by VMRC staff members. Staff members making the transition to Woodland Park participated in a six day training program conducted by educators trained in the Green House model of care. Staff member teams (one team for each house) rotated through educational sessions between November 1, 2012 and December 18, 2012. The curriculum consisted of the following: (a) person-directed care and Green House care; (b) communication; (c) roles' responsibilities; (d) care and clinical decision making; (e) dementia care and knowing the elder; and (f) rhythms of the day (Mathews-Ailsworth, 2012).

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Qualitative Study Design & Rationale

Study design. This qualitative research is a non-experimental prospective correlational study employing a pre-move/post-move focus group method of data collection; data collection occurred over a period of five months. Table 9 provides a visual of the study design. Focus groups with residents, family, and staff members (stakeholders) were held in mid-December 2012 one month prior to the move to Green House (Woodland Park). Follow-up focus groups were scheduled for mid-March 2013, one month post move, and again in mid-May 2013, three months post-move. Symbolic Interactionism (SI) and Ground Theory (GT) were guiding data management and analytic techniques.

Table 9

Study Design

Qualitative: Focus Groups	Observation December 2012	Intervention	Observation March 2013	Observation May 2013
Residents	O_1	X_{Move}	O_2	O_3
Family	O_1	X_{Move}	O_2	O_3
Staff Members	O_1	X_{Move}	O_2	O_3

Study design rational and operational definition of symbolic interactionism and grounded theory.

Since little research has focused on stakeholders' understanding of, expectations for, and attitudes toward the Green House model of care, this research study aimed to explore these concepts. Expectations and attitudes are difficult to measure through survey methods (Morgan, 1997; Ritchie & Lewis, 2010; Sharken Simon, 1999). Focus groups or interviews, on the other hand, are a better means of investigating thoughts, opinions, attitudes, and feelings (Morgan, 1997; Ritchie & Lewis, 2010; Sharken Simon, 1999). Thus the qualitative method was deemed the most desirable approach to data collection and analysis.

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Symbolic Interactionism (SI) and Grounded Theory (GT) were employed for this study; the following paragraphs describe SI and GT and the rationale for their use in this study.

Symbolic Interactionism (SI). Symbolic Interactionism, a term coined by Herbert Blumer in 1937, grew out of the fields of sociology and social psychology (Blumer, 1969; Ritchie & Lewis, 2010). In this tradition, researchers explore "behavior and social roles to understand how people interpret and react to their environment" (Ritchie & Lewis, 2010, p. 12). Symbolic Interactionism is a distinctive approach to examining "human group life and human conduct" (Blumer, 1969, p. 1).

Blumer (1969) suggested that Symbolic Interactionism is based upon three assumptions: (a) individuals interact in and with their environment based upon a symbolic meaning that they have placed upon the object or things in their world; (b) meaning about the world, oneself, or others comes from interactions with others; and (c) meaning continually adjusts through interactions with others and objects in the world. Thus, meaning is always fluid and never static because of exposure to others and objects in the world.

Symbolic Interactionism was adopted for this study because of its focus on groups of individuals rather than society, the influence of the interaction between individuals, the meaning that events have for individuals, and the symbols individuals use to describe an event's meaning.

Using Symbolic Interactionism as a framework with which to interpret the data, the *a priori* assumption is that stakeholders' perspectives of Green House were informed by their interactions with each other and the environment, and by the "embeddedness" of the individual stakeholder in the social network of the Green House (Charon, 2010).

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For this research study, the symbolic interaction can be visualized in this way: Group ↔ Event ↔ Symbol, where Group = residents, family, and staff members; Event = move to Green House (subsequently living in Green House); and Symbol = meaning (descriptions, expectations, attitudes) that individuals place on their move to Green House.

***Grounded Theory (GI) Methodology*.** Grounded Theory (GT) was developed by Glaser and Straus in 1967 (Charmaz, 2006) and is the most widely used method for collecting and analyzing interview-type data (Bernard & Ryan, 2010). Grounded theory is a research method by which theories are generated rather than tested (Corbin, 1986a). Data can be derived from interviews, either in-depth or focus group, about people and their lived experience (Bernard & Ryan, 2010). The term grounded theory is often used in a broad, nonspecific way to describe a method of analyzing qualitative data and developing theory (Schwandt, 2007). However, GT methodology is specific, well developed, and is imbued with empiricism and rigorous coding methods (Charmaz, 2006).

Grounded theory (GT) methodology is an appropriate strategy for the analysis of the focus group interviews; human experiences of an event are unique to each individual; however, there are usually similarities in perspective among people who have a shared experience (Bernard & Ryan, 2010). Grounded theory methodology allows the researcher to record and interpret the unique experience of each individual and yet identify patterns among individuals that may help in defining the phenomenon of interest (Creswell, 2009; Spencer, Ritchie & O'Conner, 2010). The intent of this analysis is to understand the nature or meaning that individuals have assigned to the transition to a new living (or working) environment (Saldana, 2009, Schwandt, 2007).

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Sampling Procedures

Sample.

The sample for the qualitative study is a convenience sample. After receiving VCU's Office of Human Subjects Protection approval (described later in this chapter), research began with all residents and staff receiving a letter from VMRC describing the research collaboration that was developed between the retirement community and VCU, Department of Gerontology. Ten residents, 10 staff members, and 10 family members of residents were chosen by VMRC to participate in the focus groups. VMRC acquired consent to participate from residents, staff, and family members. VCU, Department of Gerontology prepared focus group invitations using VCU, Department of Gerontology letterhead. Invitations were distributed by VMRC approximately two weeks prior to the focus group. Follow-up focus group members were chosen in similar fashion. The individuals who participated in the post-move focus groups were not always the same individuals as those who participated in the pre-move focus group.

For this research, the aim was to recruit at least six individuals per cohort for each time point. Thus, at least 18 residents, 18 staff members, and 18 family members were required over the course of the study. Table 10 summarizes the estimated number of participants for each focus group.

Table 10

Focus Group Recruitment Estimates

Cohort	Pre-move Focus Group	One-month Post-move	Three-months Post-Move
Residents	6	6	6
Family Members	6	6	6
Staff Members	6	6	6

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Sample inclusion criteria.

There are four selection criteria for residents: the resident must (a) be moving into the Green House, (b) have a BIMS score of 10 or greater[1], (c) speak fluent English, and (d) give voluntary consent.

The criteria for family include the following: family members must (a) be family of residents moving to Green House (only one family member per resident, and must be considered the primary caregiver), (b) speak fluent English, and (c) give voluntary consent. The criteria for staff included the following: staff must (a) be making the transfer to Green House, (b) not be in a supervisory role, (c) speak fluent English, and (d) give voluntary consent.

Measurements

Focus Groups: The focus group method was the method of inquiry for this qualitative study; it was chosen over the interview method for four reasons. First, the focus group method is efficient (Morgan, 1997) and cost effective (Sharken Simon, 1999). Fern (1982) pointed out that conducting two focus groups consisting of eight people each produced as much information as 10 individual interviews. Second, the focus group method is the best means for gathering information about the opinions, attitudes, beliefs, and meanings of an experience—in this case, the move from a nursing home to Green House (Morgan, 1997; Finch & Lewis, 2003; Sharken Simon, 1999). Finally, focus groups allow the researcher to observe and record the interaction between participants, to see body language, facial expressions, and so on (Morgan, 1997; Sharken Simon, 1999). Observation data was recorded through field notes and memos.

[1] BIMS (Brief Interview for Mental Status) scores are based on three skill sets: (a) repeating three words; (b) correctly orienting in time (month, day, and year); and (c) recalling the three words from the first exercise. The BIMS score ranges from 0-15 with 13-15 = cognitively intact, 08-12 = moderately impaired, and 00-07 = severely impaired (Department of Health & Mental Hygiene Maryland, n.d.).

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The list of focus group questions can be found in Appendix C. The questions are open-ended and specific to the expectations for the move to, satisfaction with, thoughts about, feelings toward, and understanding of Green House.

All data for the qualitative research was collected using an audio recorder and then transcribed. During the focus groups, another member of the research team was present to take field notes and memos (qualifications of the research team are discussed later in this section). Transcriptions, memos, and field notes are considered data sources. Demographic information was collected from the residents, staff, and family members via a brief survey that was distributed at the beginning of the focus groups (see Appendix C). No identifying information was required on the questionnaire. Video recordings were not used to further protect the privacy of those who participated in the focus groups.

Variables of interest.

The independent variable (IV) is the lived experience of Green House. The dependent variables (DVs) are related to the meaning that the individual assigns to his/her experience of the phenomenon, such as anticipating the move to Green House and understanding Green House, the experience of living in Green House, and satisfaction with and attitude towards the new environment. Appendix C, pages 5-7 provide a description of the focus group questions.

Analytical strategies specific to Grounded Theory.

***Data management and analysis*.**

Grounded Theory for qualitative analysis consists of three specific tasks: coding, memoing, and refining theories. The process is not linear, but rather iterative and overlapping. At all stages of analysis, the search for theory was taking place. In the following paragraphs each task is defined, and its use in this study is explained.

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A *code* is a "word or short phrase that symbolically assigns a summative, salient, essence-capturing attribute to a portion of language-based or visual data" (Saldana, 2007, p. 3). Codes help clarify how each piece of data was selected, separated, and sorted; it is the first step to making "analytic interpretations" (Charmaz, 2006, p. 43). Coding is performed in cycles. For example, the first cycle of coding, or initial coding, may include one word, a sentence, or an entire paragraph from the data (Saldana, 2007). Following suggestions for coding made by Charmaz (2006), initial coding of these data was grounded in the data and was worded in such a way as to describe the action in the setting. This approach is suggested because it stifles the researcher's tendency to draw upon extant theory or preconceived ideas (Charmaz, 2006). There are three approaches to initial coding: word-by-word coding, line-by-line coding, and incident-to-incident coding. Word-by-word coding is most appropriate for documents, ephemera, and internet data; line-by-line coding is appropriate for interview data; and incident-to-incident coding, while closely related to line-by-line coding, is best suited for observational data (Charmaz, 2006). Line-by-line coding was the primary coding strategy for this study with incident-to-incident coding being used when appropriate.

A coding schema (or list) was developed using data from the first transcript. All subsequent transcripts were coded by drawing upon codes assigned during the initial coding; new codes were assigned if the data did not fit pre-existing codes and existing codes were revised as necessary.

Codes that are participants' special terms or words, *in vivo* codes, also served as codes in this analysis. Words or statements made by the participants that are specific to their experience of Green House were quoted. In fact, the Green House model of care has its own vocabulary that may make its way into the stakeholders' vernacular. Examples of such terms include "Green

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House", "*Shahbaz*", "Guide", "resident-centered" or "person-centered care", and "autonomy". *In vivo* codes are useful for flagging important data, capturing the essence of an individual's or group's experience, and helping to identify terms that are specific to the group's perception of the experience (Charmaz, 2006).

The second cycle coding method, *focused coding*, is more "directed, selective, and conceptual" than the coding in the first cycle (Charmaz, 2006, p. 57). During second cycle coding, the researcher reorganizes codes or reanalyzes the data that has already been coded (Saldana, 2007). Categories are developed by breaking the data into smaller segments, with each segment representing a concept or abstraction of the data (Corbin, 1986b). It is during this exercise that the list of codes may be condensed to a smaller and more salient list of categories, themes, and/or concepts (Saldana, 2007). Focused coding can be extended to include axial coding, which is a means of bringing data that has been fractured, due to initial coding, back together to form a coherent whole (Charmaz, 2006). In order to keep track of the codes and memos, a codebook was developed.

The codebook contains a column for facts/incidents, categories, codes, and definitions (Corbin, 1986a; Saldana, 2009). Once themes and codes had been identified, the data were entered into Atlas/ti®, a full featured text management system developed specifically for qualitative analysis and data storage. Through the use of Atlas/ti®, links were made between the text, codes, and memos. Comparisons will be made between groups, within groups, and over time will be made using the thematic and coded data.

A critical step in grounded theory is *memoing,* which serves as a prompt for thoughtfully examining the assigned codes. "Writing memos throughout the coding process keeps the researcher engaged in the analysis and helps to increase the level of abstraction of [your] ideas"

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(Charmaz, 2006, p. 72). Memos consisted of notes taken during the focus group, during debriefing following the focus group, while coding, making categories, and recoding. Memos were recorded in notebooks, the margins of the transcripts, and in Atlas/ti®. Indeed, all data was ultimately be stored in Atlas/ti®.

Building and refining theories. The constant comparative method was used until a conceptual framework became evident; "[a]s coding categories emerge, the next step [will be] to link them together in theoretical models around a central category that holds everything together" (Bernard & Ryan, 2010, p. 275). Using the constant comparative method, the emerging theory is tested against new cases, modified, retested, and so on until no new categories can be developed from the data (Bernard & Ryan, 2010; Glaser & Strauss, 1999). Appendix B illustrates the constant comparative method concept. Stage 1 (initial coding) analysis through Stage 4 (focused coding or second cycle coding) overlap; stage 1 analysis sets the "stage" for the emerging categories and theory; and the final three stages of analysis can take place because of careful coding during initial coding. Each of the tasks located on the right of the diagram is iterative; that is, the process does not occur in a linear fashion. The data are constantly compared to each other and to new cases until the researcher is satisfied that nothing more can be derived from the data, when the data have reached a point of saturation. The data are never forced to fit a concept or theory.

Trustworthiness criteria. It is difficult to apply quantitative vocabulary and related definitions to qualitative research because of the vast differences in the research methods and philosophical underpinnings (Guba & Lincoln, 1994; Shenton, 2003). Even within qualitative research there are competing paradigms (Guba & Lincoln, 1994). Nevertheless, practitioners of each discipline strive for rigor and truth in their research. The term trustworthiness, in a broad

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sense, refers to the positivist terms validity and reliability (Davies & Dodd, 2002). One criticism of qualitative research is that there are no quality standards by which to measure the "goodness" of research methods and findings. In an effort to bring rigor to qualitative research, Lincoln and Guba (1985) suggested the following five criteria be followed for establishing trustworthiness in qualitative research: credibility, dependability, confirmability, transferability, and authenticity (Lincoln & Guba, 1985; Polit & Beck, 2008; Shenton, 2004). These criteria have been widely used in qualitative research (Beck, 1993; Bowen, 2009; Chiovitti & Piran, 2003; Shenton, 2004; Tuckett, 2005). The credibility of a qualitative study hinges upon the believability of the findings. The question is: given this study design, are the interpretations and findings believable?

The dependability of the study refers to the ability to replicate the study. In other words, would the findings be similar if the study were repeated in a similar context with similar participants? Confirmability, on the other hand, refers to the objectivity of the findings: do the findings represent the participants' voices, not the "biases, motivation, or perspectives of the researcher" (Polit & Beck, 2008, p. 539). Transferability refers to the extent to which the findings can be generalized to other groups in other settings. The final criteria, *authenticity* refers to the extent to which the researcher can bring the reader into the lived experience of the participants. The credibility of a study cannot be attained in the absence of dependability (Polit & Beck, 2008). Table 11 provides the trustworthiness criteria, its parallel in quantitative research, definitions of both, and the research strategy that is being used in this study to ensure trustworthiness. In the next section, threats to trustworthiness are examined.

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Table 11

Trustworthiness Criteria, Parallel Terms, and Associated Research Methods

Trustworthiness Criteria / **Parallel Quantitative Term**	**Definition**	**Research Method to Address Criteria**
Credibility	Measures how faithful the researcher was to the description of the phenomenon (Beck, 1993); refers to the believability of the research findings and demonstrating the credibility of the research to readers/evaluators (Polit and Beck, 2008).	• Use of grounded theory, a well established research method. • Ongoing relationship with VMRC. • Constant comparative method • Triangulation • Field notes • Tape recordings • Transcriptions • Memoing • Debriefing with supervisor • Negative case analysis • Peer review (Shenton, 2004; Tuckett, 2005)
Internal Validity	The extent to which it can be concluded that the independent variable rather than moderating or control variables "caused" the observed change (Polit & Beck, 2008).	
Dependability/ Auditability	Refers to the stability of the findings over time and conditions. In other words, will the same results be found when using the same or similar subjects in the same or similar conditions (Polit & Beck, 2008).	• Scripted questions for the focus groups. • Audit trail (field notes, transcripts, memoing journals to include thoughts about emerging theories) • In depth description of the procedures.
Reliability	Similar to dependability in that the aim is to achieve the same results when study methods have been repeated exactly as the original study.	
Confirmability	Refers to the extent to which the data reflect the experiences and opinions of the subject and not the preferences of the researcher (Shenton, 2004; Polit & Beck, 2008).	• Member checking • Triangulation • Bracketing • Theoretical audit trail
Objectivity	The extent to which two researchers would draw the same conclusion concerning the data (Polit & Beck, 2008)	
Transferability/ Fittingness	Refers specifically to how detailed a description of the research procedures was provided so that a generalization of the findings can be applied to a similar population at a different site (Polit and Beck, 2008).	• Literature review—"Thick" description of the populations under study • Detailed description of the research procedures as they occur in the field.
External Validity	The extent to which the results of the study can be generalized to populations other than the one studied (Beck, 1993; Polit and Beck, 2008).	

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Table 11 – Continued

Authenticity	A distinctly qualitative criteria, authenticity refers to the extent to which the reader is drawn into the world of the people being described. The aim is to invoke in the reader a sense of the mood or the experience of the individual (Polit & Beck, 2008).	• Tape recordings • Field notes • Transcriptions • Peer review
No counterpart in quantitative research.		

Threats to trustworthiness.

There are several threats to the trustworthiness of qualitative data, such as inadequate or inappropriate data, researcher bias, and reactivity. First, trustworthiness can be undermined if there is too little or inadequate data (Charmaz, 2006).

Ideally data should be substantial, rich, and relevant. To ensure that the data collected were appropriate and adequate, the following questions were asked (Charmaz, 2006, p. 18):

(a) Have I collected enough background data about the persons, processes, and settings to have ready recall and to understand and portray the full range of contexts of the study?

(b) Have I gained detailed descriptions of the range of participants' views and actions?

(c) Do the data reveal what lies beneath the surface?

(d) Are the data sufficient to reveal changes over time?

(e) Have I gained multiple views of the participants' range of actions?

(f) Have I gathered data that enable me to develop analytic categories?

(g) What kinds of comparisons can I make between data? How do these comparisons generate and inform my ideas?

Second*, bias* refers to the researcher's own knowledge, expectations, experiences, and attitudes toward the subject matter, or the individual. One way to reduce bias is to bracket (set aside) assumptions that one has about everyday life (such as knowledge, attitudes, and beliefs

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that the researcher holds about a topic). Chenitz and Swanson (1986) recommend that the researcher be self-aware while they are in the field in order to diminish their effect upon the participants; "to exploit their subjectivity to the advantage of the research" (p.56); and to increase the objectivity of the findings. Shenton (2004) suggested using a technique called reflective commentary, writing down biases, in order to identify preconceived ideas about the topic under research. By bracketing, it becomes possible to focus on the intrinsic nature of the concept of interest (Schwandt, 2007). Due in part to a literature review, it was necessary for the researcher of this dissertation to bracket her opinions about the Green House model of care, nursing home culture change, and the quality of elder care in the US. Some qualitative researchers believe that a literature review is contrary to grounded theory methodology (using its strictest definition) (Elliot & Higgins, 2012); however, Chenitz (1986) suggested using the literature as a form of data to investigate the type, scope, and range of the research. Indeed, it was through an extensive review of the literature that gaps in research about stakeholders' expectations regarding Green House were identified.

Another means to reducing bias (and enhancing confirmability and authenticity) is *member checking*, a method used to confirm the interpretation of the data. Member checking entails contacting the participants of a study and asking them to confirm the accuracy of the interpretations that the researcher has made (Bernard & Ryan, 2010; Charmaz, 2006). Member checking reduces bias by removing the values or preconceived notions that the researcher may have had. Member checking, in the strictest sense, was not conducted during the analysis phases of the study because the researcher did not have access to the participants' contact information following the completion of the focus groups. However, during the focus group, the researcher

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paraphrased (repeated back in her own words) the ideas the participants expressed and asked if her interpretation was accurate.

Another way in which researcher bias was checked is through peer review of the coding schema (Shenton, 2004). The coding schemes were reviewed by two gerontologists in VCU's department of gerontology. The researcher initially evaluated the data and developed the coding scheme. Then the data was given to the two gerontologists for their review. The aim of this exercise was to reach agreement among coders. This process enhanced the credibility and dependability of the findings.

Another potential threat to trustworthiness, *reactivity*, refers to the influence of the researcher on the individual subject: "[W]hat the informant says is *always* influenced by the interviewer and the interview situation" (Maxwell, 2005, p. 109). Reducing reactivity required the researcher to be self-aware (Chentiz & Swanson, 1986). The researcher recorded reflections of the focus groups that also included the researcher's feelings and reactions to the information. Getting feedback from the note taker, who was present during the focus groups, also helped identify ways in which the researcher may have been biased. In quantitative research, questionnaires help support researcher-participant objectivity by creating distance between the participant and the researcher (Davies & Dodd, 2002). In qualitative research, interactions with the group or individuals under study are unavoidable because the interviewer is the instrument (Chentiz & Swanson, 1986). Building rapport with the focus group participants was one of this researcher's goals since a degree of connectedness and empathy is necessary (Davies & Dodd, 2002), otherwise nothing substantial can be gained from the interviews.

Other threats to the trustworthiness of the research findings are specific to the credibility of the study and are similar to those found in quantitative research, they are temporal ambiguity,

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selection bias, treatment fidelity, history, maturation, and mortality (Polit & Beck, 2008). *Temporal ambiguity* refers to the relationship in time between the cause and the effect. The cause must precede the effect. This research was designed so that measurements occurred before the intervention and again after the intervention.

In research studies that have purposive or convenience samples, *self-selection* may suggest bias. Self-selection bias is problematic because the intervention and control group participants may not be equivalent (comparisons and conclusions may be made between apples and oranges). The study participants were placed in cohorts which helps alleviate, to some degree, the disparities. However, self-selection bias was an acknowledged bias in this study.

Credibility is also threatened by the *fidelity* with which an intervention was implemented. Bias is introduced when an intervention is not implemented according to the original plan. While the intervention, Green House, was not being measured directly, assumptions about the fidelity of the intervention were being made because the Green House guidelines are very specific. *Historical events* may also suggest a bias in research findings. The question is: did the intervention cause this outcome or did the historical event cause it? It is unlikely that historical events have confounded the outcome of this study.

The passage of time and the changes to the participants that are inevitable may be another source of bias. This cannot be controlled but was taken into account.

The final threat to the credibility of a research study is *mortality and attrition*. Participants drop out of studies due to death, boredom, or illness. Depending upon the extent of the attrition, research findings can be called into question. Mortality and attrition were not an issue in this study because the same individuals were not required for the follow-up focus groups. In Table

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12, the threats to the credibility of the study, an explanation, and strategies for reducing the risk are explained.

Table 12

Strategies for Reducing the Threats to Credibility

Threat	Explanation	Strategy
Temporal Ambiguity	Allows the researcher to infer the relationship between the cause and the effect of an intervention. The cause must precede the effect.	Interviews were scheduled to precede the move to Green House® and then scheduled to be conducted again after the move to Green House®. Thus the following design: O X O O
Self-Selection	Refers to the threat that the groups may not be equivalent if they have not been randomly assigned to intervention or control. The assumption is that bias is introduced by pre-existing differences in the groups.	It is not possible, nor is it ethical, to randomly assign individuals to live in or work in a new environment. Nor is it ethical to force or coerce individuals to move or to participate in research. Thus, those who chose to make a change were contacted to participate in the study. They were also given the opportunity to decline. The assumption is that those who agreed to participate are similar in terms of demographic characteristics such as age, education, occupation, etc.
Treatment Fidelity	Refers to the extent to which the treatment or the intervention was implemented accurately over the course of the research study.	The Green House® program has very specific protocols for the physical environment and for basic care practices.
History	Refers to events that happen over the course of the research study which may influence the outcomes of the study. In other words, it is not clear if the independent variable had an effect upon the dependent variables or if it was the historical event that influenced the outcome.	Not likely to be a factor in this study.
Maturation	Refers to the passage of time and the changes that individuals experience due to the passage of time (fatigue, emotional development) rather than the effects of the intervention.	This cannot be controlled for, but were noted. This is an aging and ill population so there may be some decline that will influence feelings about Green House®.

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Table 12 – Continued

Threat	Explanation	Strategy
Mortality/Attrition	Refers to participants dropping out of the research study due to death, illness, lack of interest, etc. This becomes problematic if there are comparison groups; one group may be over-represented than another or groups may no longer be equivalent.	Given the age of the participants, it is likely that some could have become too ill to participate or could have died. Because the study was not designed to have the same group of people at each time point, attrition is less of a problem. Additionally, time points are not at great distances from one another, so it was possible that some residence were able to participate at all three time points.

Procedures Related to the Focus Groups

In this section, the procedures related to organizing and conducting the focus groups is discussed and includes: staffing, location and timing of the focus groups, transcribing the data, and maintaining confidentiality

Staffing.

Focus groups were facilitated by the researcher who has more than ten years of experience working in behavioral research settings and 15 years of experience facilitating support and educational groups. The researcher was accompanied by either her dissertation chair or a master prepared gerontologist from VCUs department of gerontology. This individual was tasked with taking notes regarding the content of the conversations and any observations that he or she made.

Location and timing of focus groups.

All focus groups were held in a conference room or private dining room at VMRC in Harrisonburg, VA. Focus groups were scheduled for dates one month prior to the move, one month after the move, and three months after the move. Every effort was made to accommodate the participants' schedules. This researcher learned that late morning (between 10:00 and 11:45)

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is best for the elders; between shifts (between 1:30 and 3:30) is best for staff members; and late afternoon (5:30) is best for family members.

Transcripts.

A professional transcriptionist was recruited to transcribe the focus group tapes. This individual has more than 25 years of experience. It is unlikely that the transcriptionist will know anyone in the focus groups because the transcriptionist is located in York, PA. In addition, the facilitator did not use participants' full name. On the transcription, individuals were referred to as Person A, Person B, Person C, etc. to further protect the participants' privacy.

Confidentiality.

Instructions were given to the liaison at VMRC that staff members should not be present while residents or family members are being interviewed. Likewise, instructions were given that supervisors not be present when staff members are being interviewed.

In the event that a resident became upset during the course of the interviews, the researcher contacted the *Shahbaz* and requested help. If family members or staff became upset, the researcher contacted the liaison after gaining permission from the participant. The questions were not provocative and should not have elicited an emotional response.

Summary

In this section the qualitative research study was reviewed. The grounded theory approach to qualitative data analysis and interpretation was explained. Along with this, the focus group strategy of data collection, data management (developing codes, categories, memos, and theory), and strategies for enhancing the trustworthiness of the research were reviewed. Staff and other procedural issues related to the study were also discussed.

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The following section reviews the research methodology being used for the quantitative phase of this research.

Quantitative Study

Study design.

The quantitative phase of this study is non-experimental, exploratory, and cross-sectional. The aim of this research is to explore the Person-Centered Care Attitude Test (Per-CCat), a 42 item questionnaire, for construct validity. This step is necessary to ensure that this questionnaire has the appropriate number of questions to adequately measure the constructs of interest (Polit & Beck, 2008).

Sample.

This sample is a convenience sample. All staff (approximately 120) working at Oak Lea (traditional nursing home) and Woodland Park (Green House) were invited to complete the Per-CCat. VMRC distributed a letter of introduction from VCU along with the surveys. Staff members were informed about the questionnaire through the administrator of VMRC. Staff members were be required to complete the questionnaire. Questionnaires were picked up by the researcher when on campus. Appendices D and E provide a detailed study timeline.

Quantitative measure and related constructs.

The Person-Centered Care Attitude Test (Per-CCat), developed by Mary Catherine Ehlman, Ph.D. and Mandy Jones, B.S. at the University of Southern Indiana, measures staff members' attitudes toward person-centered care (see Appendix F). To date, the instrument has been subjected to face and content validity (Ehlman & Jones, 2011).

The Per-CCat, version 5, consists of 42 Likert-type questions ranging from 1 to 5, where 1 = strongly disagree, 2 = disagree, 3 = no opinion, 4 = agree, and 5 = strongly agree. The Per-

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CCat is divided into four sections that align with person-centered care principles (see Appendix A): The first section, labeled *Care,* is comprised of 11 items related to negotiation, collaboration and timilation; the second section, *Communication*, consists of six questions related to recognition of the individual's personhood and fostering relationships; the third section, *Culture and Community,* consists of 12 questions focused on both nursing home environment as well as recognition of the individual's personhood, negotiation, celebration, relaxation and creativity; and the final section, *Climate,* consists of 13 questions related to the nursing home environment, fostering relationships, recognition of an individual's personhood, negotiation, facilitation, validation, celebration, and creativity.

Demographic information such as age, education, number of years in the nursing home industry, number of years employed at VMRC, and job title were gathered via the Per-CCat. These data were collected in order to describe the sample.

Table 13 provides a summary of the Per-CCat questions, the construct (Factor), and the constructs' relationship to PCC. It will be helpful to the reader to reference Appendix F while using Table 13.

Table 13

Summary Table of Per-CCat Constructs

Per-CCat Construct (Factor)	Question Numbers	Associated PCC Constructs
Care: generally measures Resident Autonomy	1 through 11	Negotiation, Validation, Timilation & Collaboration.
Communication: generally measures the concept of fostering relationships	12 through 17	Recognition
Culture & Community: generally measures the nursing home environment	18 through 29	Recognition, Negotiation, Celebration, Relaxation, and Creativity
Climate: generally measures work climate	30 through 42	Recognition, Negotiation, Facilitation, Celebration, Validation, Creativity, and Holding

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Quantitative Data Analysis

In this section, strategies for quantitative data analysis will be discussed.

Data management. All quantitative data was stored and analyzed using SPSS version 21. Questionnaires were returned and data entered into SPSS version 21 by the researcher. To ensure the integrity of the data, cleaning the data included: (a) checking the accuracy with which the data were entered, (b) looking for missing data, (c) assessing assumptions, (d) transforming variables if necessary, and (e) looking for outliers.

Data cleaning.

Frequency distributions were run first and examined for outliers. If outliers were found, the completed questionnaire was examined to determine the cause of the error. Corrections to the data set were made based upon the findings. For example, if the outlier was a data entry error, the error was corrected. If appropriate, outlying or missing data were imputed, or coded as missing. Memos about any changes to the data were recorded and stored in the data binder created for this purpose. Measures of central tendency such as mean, median and mode were calculated on all demographic data, where appropriate. A mean score was calculated for each item on the Per-CCat . Measures of dispersion such as range, variance, and standard deviation were calculated for all data.

Significance criteria.

If statistics other than factor analysis are conducted (a comparison of means, for example), the probability of accepting a false positive, also called a Type I error (incorrectly accepting the hypothesis as true, when it is false) was set at .05 ($\alpha < .05$). The probability of accepting a false negative (incorrectly accepting the null hypothesis as true, when it is false) also known as a Type II error was set at 20%, with a power of .80 ($1 - \beta$). Factor analysis, which is

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the analytical method proposed for this study uses a different set of criteria which are described below.

Factor analysis.

***Research questions*.** Because the focus of the quantitative analysis is to establish construct validity of the Per-CCat, factor analysis was employed. Thus the following research questions were examined:

1. "How many factors are required to summarize the pattern of correlations in the correlation matrix" (Tabachnick & Fidell, 2007, p. 610)?
2. Which items produced the factors?
3. What do the factors mean?
4. How much variance is explained by the factors?
5. Which factors accounted for the most variance?

To establish construct validity (i.e., that the items in the Per-CCat are truly measuring four different dimensions of staff members' attitudes toward PCC) exploratory factor analysis (EFA) was employed. EFA is appropriate to use when a questionnaire is in the early stages of development. The aims of EFA are to identify items that are correlated so that a questionnaire can be condensed, and to generate hypotheses about the underlying factors (Tabachnick & Fidell, 2007). The Per-CCat , presently, is a 42 item questionnaire organized into four sections measuring distinct areas of PCC: (a) *Care* of residents; (b) *Communication*; (c) *Culture and Community*; and (d) *Climate*. EFA was used to investigate the appropriateness of the underlying factors, whether the items load onto the expected factors, and whether the factors co-vary or are each independent of the other factors (de Winter, Dodou & Wieringa, 2009; Tabachnick &

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Fidell, 2007). Results from EFA were also used to determine if and how the survey was able to be shortened.

Power and sample size. When employing exploratory factor analysis (EFA), there are two practical issues to consider. The first consideration is sample size. Statisticians generally agree that correlation coefficients are more reliable when estimated from a large sample (Tabachnick and Fidell, 2007); however, others suggest that the greater the number of variables with high loading (λ) markers (> .60), the fewer subjects needed to generate a meaningful correlation coefficient (de Winter et al., 2009). Indeed, a sample as few as 50 may be sufficient (Sapnas & Zeller, 2002). Assuming a factor loading (λ) of .60, 42 variables (p), and 4 factors (f) the minimum sample size required for this research is 71 (de Winter et al., 2009).

If the first distribution of the Per-CCat did not provide the required sample size (n = 71), the survey would have been redistributed. Instructions attached to the second wave of surveys asked that only staff members who have not completed the form to complete it. If the sample size is not achieved after the second attempt, another nursing home facility would have been asked to participate.

Factor interpretation. The second consideration is that certain assumptions be met in order to generate a meaningful EFA. While it is not necessary to have a normal distribution, a normal distribution enhances the results of EFA (Tabachnick & Fidell, 2007). It is essential, however, to have linearity among pairs of variables. This was assessed by examining scatterplots (Tabachnick & Fidell, 2007). Multi-collinearity and singularity (highly correlated variables) were also assessed. Tabachnick and Fidell (2007) point out that "if the determinant of R and eigenvalues associated with some factors approaches 0 or 1, then multi-collinearity or singularity may be present" (p. 614). The final step was to measure the factorability of R. If the

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correlation did not exceed .30, this indicates that there was nothing to factor and that the variable should be eliminated (Tabachnick & Fidell, 2007). For this factor analysis, screeplots and eigenvalues were examined to determine the correct number of factors. In addition, the following statistics were calculated: communalities for a variable, total variance, factor matrix, rotated factor matrix, and the factor transformation matrix.

Protection of Human Subjects

This research proposal was submitted to VCU's IRB under the exempt heading was reviewed and approved by the VCU IRB committee (VCU IRB number: HM1486)

Every effort has been made to maintain the privacy and anonymity of research participants. Stakeholders' names, addresses, phone numbers, social security numbers, etc. were not collected. Completing the Per-CCat questionnaire denoted consent. Questionnaires were shredded after the completion of data analysis.

Focus group participants were not identified by their full name on audio tape recordings. Tape recordings were destroyed three months following the focus groups. Individuals were identified as Person A, Person B, etc. on the transcriptions. Focus group participants were given a fact sheet that included a description of the study purpose, the focus group agenda, and a clause that stated that participants may withdraw their consent at any time during the focus group or after. At the start of the focus group sessions, participants were reminded that they may withdraw their consent at any time. A copy of the fact sheet is located in appendix G. The focus group manual that contained the focus group invitations, purpose, questions, and scripts can also be found in Appendix C.

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Procedures

Copies of the Per-CCat were copied by VCU and delivered to VMRC by the researcher on or around March 1, 2013. The liaison at VMRC will distribute the questionnaires to all staff working at Woodland Park and Oak Lea. The researcher will collect the completed surveys on or about March 15, 2013. If a sufficient number of surveys (n = 71) had not been completed, reminder cards and emails were sent to all employees (we will not know who did not complete a survey, so the reminders will not be targeted to individual staff members). If these efforts had failed, then another nursing home would have been recruited for this phase of the research study.

Study Limitations & Strengths

Qualitative study limitations.

The first limitation to the qualitative study is that the sample is a convenience sample; the participants were from one organization and were chosen by VMRC administration, which contributes to selection bias. The convenience sample recruitment approach was chosen for two reasons: first it is unethical to randomly assign individuals to live or work in a new environment; second, another approach (such as randomly selecting participants) would have required VMRC to release contact and other demographic information to VCU, which would introduce confidentiality issues. However, the bias is ameliorated to some extent because those who were chosen to participate in the study were also the same group of individuals who were living in the closing neighborhood (unit) of the nursing home

The second limitation is that all of the data were self-reported which contributes to response bias. The participants in the qualitative study may answer questions in a socially desirable way, rather than truthfully. By splitting the groups into their respective cohorts, the threat of answering questions in a socially desirable way may have been ameliorated because the

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groups are similar (all residents in one group, all family members in another, and all staff members in the third). No one in a caretaking or supervisory role was present during specific focus groups in an attempt to reduce the feeling of coercion and the need to answer in a socially acceptable way.

Third, it may be difficult to generalize the results of the qualitative data to the nursing home industry at large. The result of the study applied to organizations that have the same characteristics as VMRC, such as: religious affiliation, homogeneous race and ethnicity, geographic similarities, approximately the same income level, and have opened or are building Green House homes.

Fourth, this study was not designed to measure the extent to which the Green House philosophy is being practiced. While there were artifacts (the tangible or visible signs) of Green House about which the researcher can report, the degree to which Green House care strategies were implemented was not be known.

Finally, the study had to be completed during a narrowly defined timeline to correspond with the facility timeline; this, too, limits the study design. To increase the rigor of the research design, it would have been ideal to follow the participants for a year or more. This is impossible due to financial and time constraints.

Quantitative study limitations.

While staff members were not handpicked by VMRC administration for the *quantitative* study, all of the participants were from one organization, which contributes to selection bias; there is a difference between those who volunteer to participate and those who choose not to. Self-selection may limit the diversity of ideas and people as well. Finally, staff members may have felt pressure to complete the Per-CCat. Through introductory letters, attempts were made

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to explain the nature of the study and to assure potential participants that they were not required to participate.

Due to the nature of the Per-CCat questions, there may have been the suggestion of a response bias. Respondents may have felt that it was not socially acceptable to respond negatively to questions related to person-centered care. In addition, the questionnaire may have indirectly contributed to a change in attitude toward person-centered care. While the researcher is interested in attitudes toward person-centered care, the purpose of the study was to validate the Per-CCat. Nevertheless, truthfulness in answering the questions was important.

Because the sample size is small, data analysis was affected. The power and strength of the factor analysis may have been limited by the number of respondents; however, some statisticians believe that factor analysis can be conducted with a small sample (Sapnas & Zeller, 2002). If the present site was not able to provide enough respondents, another site would have been required (this would have required recruitment efforts and another IRB submission).

Strengths of both studies.

In spite of the above mentioned concerns, these research studies are worthwhile and possess several strengths. First, the qualitative (focus group) phase of this research provided information about the stakeholders' experience of the Green House phenomenon. Focus groups are the best forum for eliciting attitudinal information from the research participants. Additionally, the focus group approach allowed the researcher to hear opinions about Green House, observe the environment, and observe stakeholders' interactions with each other.

Second, this study is an example of applied research. VMRC contracted with VCU, Department of Gerontology to conduct research examining Green House outcomes. Thus, this research was generated from a community-identified need to (a) examine how VMRC's

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residents, families, and staff members (stakeholders) perceive Green House and the upcoming move to Green House; and (b) understand how their stakeholders are adjusting to the Green House environment.

Third, this research study is unique because a naturalistic intervention has been created by the addition of Green House homes on the VMRC campus, enabling a pre-move/post-move evaluation of the key stakeholders. Creating a Green House intervention as part of a research design would have been cost prohibitive.

While there has been some research about the effects of Green House, little attention has been paid to stakeholders' attitudes toward and expectations of Green House. Indeed, no research has been undertaken examining stakeholders' attitudes toward and expectation about *relocating or transitioning* to Green House.

Fourth, applying the grounded theory methods of data analysis, a well-established qualitative research method, not only helped organize the data, but has lead to theory development about Green House perspectives.

And finally, the survey validation element (quantitative) of this study is timely because there are no validated staff-centric person-centered care (PCC) attitudinal surveys in the literature. In addition, the trend in the nursing home industry is to adopt elements of culture change and PCC. Measuring nursing home employees' attitudes toward PCC may provide educators and administrators with information that can be used for training and hiring. As more continuing care retirement communities and nursing facilities build Green House facilities, the data garnered from this research may be useful to help stakeholders transition from the standard nursing home environment to Green House environments.

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Thus this research will add to the body of knowledge about culture change, and Green House in particular, by providing insight into stakeholders' transition to and perspective of Green House and also staff members' attitudes toward PCC.

Conclusion

This chapter provided an explanation of the research strategies used for both the qualitative and quantitative studies. The first study employed a qualitative pre-move/post-move method to explore stakeholders' interpretation and perspectives of the Green House phenomenon. The second study employed a cross-sectional quantitative design to investigate the construct validity of the Person-Centered Care Attitude Test.

Chapter 4 reviews the results of the qualitative analysis (Symbolic Interactionism and Grounded Theory) as well as the quantitative factor analysis of the Per-CCat . Conclusions and discussion are in Chapter 5.

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Chapter 4: Results

In this chapter, the findings of two research studies are described. The first study, qualitative, explores the stakeholders' transition from a skilled care nursing home to a Green House home. The second study, quantitative, explores the construct validity of the Person-Centered Care Attitude Tool (Per-CCat). Like Chapter 3, this chapter is organized by study. The results of the qualitative study will be described first, followed by the quantitative study.

Qualitative Study: Stakeholders' Attitude about Green House

In this section the study design is briefly reviewed. Following this, the characteristics of the study participants and research procedures are described. An illustration of the layout of Green House homes (GH) is provided along with a brief description of Woodland Park (WP). Finally the findings of the focus groups are presented.

To review briefly, this qualitative research study was designed as a non-experimental, prospective, correlational study employing a pre-move/post-move focus group method of data collection. The pre-move and post-move interviews were scheduled to take place one month prior to the first move and one and three months after the last group moved. In keeping with their timeline, VMRC moved the first group of residents and staff members into WP on January 15, 2013; the second group on February 1; and the last group on February 15, 2013.

The purpose of this study was to understand stakeholders' (residents, family members, and staff members) feelings and attitudes toward the Green House model of care, to better understand the lived experience of stakeholders living and working in the Green House homes.

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Analytic Grounded Theory and interpretive Symbolic Interactionism approaches were used to explore the individual experience and meaning assigned to the phenomenon of moving to VMRC Green House homes.

Sample.

The participants in this study were a convenience sample of residents, family, and staff members (hereafter called stakeholders) who had consented to move from Virginia Mennonite Retirement Community's Oak Lea nursing home (OL) to the new Woodland Park Green House home (WP). Virginia Mennonite Retirement Community (VMRC) closed one neighborhood in OL and gave stakeholders the option either to remain at OL but live or work in another neighborhood or to move to WP.

At the *pre-move focus group*, but before the sessions started, stakeholders were asked to complete a demographic questionnaire (see Appendix C: Focus Group Manual, for an example). Twelve residents, eight family members, and five staff members completed the questionnaire. Table 14 provides a description of the demographic characteristics of the focus group participants.

Table 14

Demographic Characteristics of Study Participants

Demographic Characteristics	**Measurements**	**Residents** *n = 12*	**Family** *n = 8*	**Staff** *n = 5*
Length of time living in a nursing home (not necessarily VMRC)	< 2 years > 2 years Don't know	16.7% 66.7% 16.7%		
Length of time living at VMRC	< 2 years > 2 years Don't know	25.0% 50.0% 25.0%		
Length of time with loved one at VMRC	< 2 years > 2 years		25.0% 75.0%	

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Table 14 – Continued

Demographic Characteristics	Measurements	Residents *n = 12*	Family *n = 8*	Staff *n = 5*
Are you the primary caretaker of the loved one?	Yes No		100.0% 0.0%	
How are you related to your loved one?	Spouse Son/Daughter		25.0% 75.0%	
Length of time working in the nursing home industry	< 2 years > 2 years			40.0% 60.0%
Length of time working in the nursing home industry	< 2 years > 2 years			0.0% 100.0%
What is your role at VMRC?	CNA LPN RN			80.0% 20.0% 0.0%
Highest level of education	High School Technical/Vocational Associate Degree BS/BA/BSN Graduate Degree Don't know	41.7% 8.3% 25.0% 8.3% 8.3% 0.0%	25.0% 0.0% 25.0% 25.0% 25.0% 0.0%	20.0% 40.0% 20.0% 20.0% 0.0% 0.0%
Gender	Male Female Refused	58.3% 33.3% 8.3%	25.0% 75.0% 0.0%	0.0% 100.0% 0.0%
Racial category	American Indian/Alaska Native Black or African American White or Caucasian Pacific Islander or Asian Other Refused	0.0% 0.0% 91.7% 0.0% 0.0% 8.3%	0.0% 0.0% 100.0% 0.0% 0.0% 0.0%	0.0% 20.0% 60.0% 20.0% 0.0% 0.0%
Hispanic Ethnicity	Yes No Refused	0.0% 91.7% 8.3%	0.0% 100% 0.0%	0.0% 100.0% 0.0%
Age	Elders < 65 65-74 75-84 85+	8.3% 8.3% 41.7% 8.3%		
	Refused	0.0%		
	Family & Staff 18-25 26-35 36-44 45-64 ≥ 65		0.0% 0.0% 0.0% 25.0% 75.0%	0.0% 0.0% 0.0% 100.0% 0.0%

Overall, *residents* making the move to WP had lived at VMRC for two or more years; were over 75 years of age; were well educated, ranging from high school diploma to post

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graduate degrees; and were predominantly male and Caucasian. All of the residents used wheel chairs. Many had hearing loss and poor eyesight. Four of the twelve residents were engaged in the conversation and provided answers to the focus group questions.

Inclusion criteria proposed in the methods section stated that residents with a BIMS score of 10 or greater (see Chapter 3, p. 7) could participate in this study. VMRC does not assess cognitive status using the BIMS; rather, they rely on a diagnosis from a resident's doctor and the cognitive functioning questions from the MDS. Thus the pre-move focus group consisted of individuals with varying levels of cognitive functioning, that were unknown to the researcher. At the follow-up time points, *Shahbazim* were instructed to ask only those residents, whom they deemed able, if they would like to participate in the focus group. This did not always yield a group of individuals capable of fully engaging in the focus group, but it always yielded at least one person who could. The number of able participants did vary from house to house.

All *family members* reported that they were the primary contact for their loved one. The majority of contacts were women. Two women were spouses whereas the remainder were children of residents. Most lived within easy driving or walking distance to Oak Lea. One family member drove several hours to visit VMRC. Family members were also well educated, 75% having an associate's degree or higher. The majority of contacts were over the age of 65.

All *staff members* had two years or more experience in the nursing home industry. Sixty percent had worked at VMRC for more than two years with one reporting that she had worked at VMRC for 26 years. The majority were certified nurse aides while one was an LPN. Education ranged from high school diplomas to a bachelor degrees. All staff members were 45 years of age or older. Stakeholders' demographic information was not collected at follow-up time points.

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Focus Group Procedures

Stakeholders who consented to move from OL to WP were sent a letter (Appendix C) that explained the purpose of the research study and an invitation to attend the focus group. The invitation letters were sent approximately one month prior to each of the scheduled focus groups. To ensure the participant's privacy, correspondence regarding the focus groups was handled by an administrator at VMRC.

Pre-move focus group sessions were held December 17 and 18, 2012, approximately one month prior to the move. One month post-move follow-up focus groups were held March 26 and March 27, 2013. Due to poor staff turnout (n = 0) in March 2013, the staff focus group was rescheduled and held April 25, 2013. Three-month follow-up focus groups were held July 9 and July 10, 2013. This date was deemed more appropriate since the one-month focus groups were not completed until the end of April. To limit the inconvenience to elders, follow-up focus groups were held in the Green House homes. Family and staff members' focus groups were scheduled to be held in a conference room in the main building. This plan was modified for the April 25, 2013 staff focus group so that the *Shahbazim* and other staff members were interviewed in their respective Green House homes. This arrangement was also made for the three-month staff members' follow-up.

In addition to date changes, the length of time allotted for each focus group was also altered to align with stakeholders' schedules. The residents' focus groups (three) were held in each house and were approximately 40 minutes in length. Focus groups started at 9:30 a.m. and finished at 11:45. The family members' focus group was held in a conference room in VMRC's Crestwood Building starting at 4:00 p.m. and ending at 5:00 p.m. The staff focus groups were also held in each of the houses and were scheduled between 12:45 p.m. and 3:30 p.m. These

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times bookended the end of one shift and the beginning of another. Those staff members who came in early or stayed late were compensated by VMRC for their time.

At each of the focus group sessions, the researcher was accompanied by either her dissertation co-chair (pre-move) or a Masters prepared gerontologist from VCU (all post-move sessions). Their roles were to take notes and make observations of the groups. All focus groups were recorded and later transcribed by a professional transcriptionist employed by the researcher. Immediately following the focus group sessions, the researchers memoed and discussed their impressions and observations. These notes were typed and imported into Atlas.ti 7. Due to researcher error the pre-move resident focus group was not recorded adequately. However, the researchers shared notes and observations immediately following the session. All other sessions were recorded successfully.

Appendix C also provides an example of the script that was used during the focus groups. The questions were semi-structured and open-ended, allowing for flexibility in the wording and the order in which the questions were asked. Probing questions were asked when necessary to clarify statements or to further explore an expressed thought.

Content Analysis

After each set of focus groups, audio tapes were hand delivered to the transcriptionist. Copies of the typed transcriptions were emailed back to the researcher, read, corrected, and imported into Atlas.ti 7. After the preliminary review, corrections to content were made. Any corrections, other than spelling, made to the transcripts were enclosed in brackets to help distinguish between the speaker and the researcher's corrections. No changes were made to grammar unless it was necessary for clarification. Corrections included finishing a sentence, or adding background content to put a remark into context. Some corrections to the transcriptions

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were made after listening to the tapes once more. Dialogue that was distorted or unintelligible because of ambient noise (such as pots and pans banging, doorbells, telephones, etc.), or because a participant was soft-spoken was not coded. Content that could not be clarified was not coded.

First Cycle coding (initial coding or open coding) in grounded theory serves two purposes: to determine fit and relevance:

> Your study fits the empirical world when you have constructed codes and developed them into categories that crystallize participants' experience. It has relevance when you offer an incisive analytic framework that interprets what is happening and makes relationships between implicit processes and structures visible (Charmaz, 2006, p. 54).

Direct quotations from a participant, single words, or phrases were used as codes. In this research, data were coded line by line: Saldana (2009) described this as microanalysis. Microanalysis, a thorough method, reduces the chance that significant statements will be overlooked. Codes were often first impressions; although, Culture Change and Green House vocabulary were also employed when a statement fit those constructs. Simultaneous coding was performed when a text seemed to have more than one meaning. Table 15 provides an example of

Table 15

Example of Simultaneous Coding

Quotation	Code
Staff "I would have more interactive time instead of all the hustle and bustle".	• Interaction with resident • Develop relationship • Less rushing to get job done Theme Expectations Sub-theme Green House ideology

simultaneous coding. First cycle codes were placed directly on the hard copy of the transcript. Once themes became apparent, the thematic code and related quotations were recorded on index

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cards, which were then sorted into thematic groups. Coding was done a second time in the data base, Atlas.ti 7, and cross checked with the index cards; recoding helped streamline the codes by identifying redundant codes and themes.

The intent during Second Cycle coding is to refine codes, identify themes, generate hypotheses, and look for patterns that suggest a theory (Saldana, 2009). In Grounded Theory, the systematic approach to data analysis, the constant comparative method, is used (Bernard & Ryan, 2010). Questions such as, “What is this sentence about?” and “How is this sentence similar to or different from other sentences in this grouping,” are asked of the data. Through the constant comparative method, themes, sub-themes, and codes were refined. To achieve the final grouping, the themes and codes for all of the transcriptions were spooled out of Atlas.ti 7, input into Microsoft Word, sorted, and viewed in the aggregate. It was during this phase that patterns were identified, not simply for one time point or for one cohort but between groups, within groups, and across time periods. Throughout the coding cycles, memos were kept in both notebooks, on the hardcopies of the transcriptions, and in Atlas.ti 7. Memos for this study will be discussed in Chapter 5.

Reviewing the codes and re-reading the transcripts generated new concepts and hypotheses, which were also placed in the memo function in Atlas.ti 7. The iterative process of reviewing codes reduced the initial number from more than 400 to 43. Subsequent content analysis resulted in organizing the codes under five broad themes (see Table 16 for a complete description of the categories): (a) Expectations about Green House living; (b) Adjusting to Green House living; (c) Attitudes, Feelings, and Perceptions; (d) Lived experience of GH and Culture Change ; and (e) Outcomes. *Expectations about Green House Living* captured words related to the hopes and ideals that the stakeholders expressed about their upcoming move to Green House.

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Table 16

Five Categories Resulting from Content Analysis

Category	Description
Expectations about Green House Living	Reflective of stakeholders hopes and ideals about Green House living.
Adjusting to Green House Living	Reflective of the challenges of and ongoing concerns with Green House living.
Attitudes, Feelings, and Perceptions	Words that expressed the individuals' perspectives or their emotion.
Lived Experience of Green House & Culture Change	Reflective of principles such as autonomy, teamwork, camaraderie, community, and connecting.
Outcomes	Observations of stakeholders about improvements in living and working at the Green House.

Adjusting to Green House Living is reflective of the challenges and ongoing concerns of living and working in the Green House. *Attitudes, Feelings, and Perceptions* of living/working in the Green House captured words and ideas that either expressed the individual's perspective or their emotions. *Lived Experience of Green House and Culture Change* is reflective of the principles of these approaches such as autonomy, teamwork and camaraderie, communication, and connecting. The final theme, *Outcomes*, is reflective of observations made by stakeholders about improvements in living and working that may be attributed to the Green House Project.

Appendix H contains a copy of the code book, arranged in alphabetical order, used to organize and analyze the qualitative data. The code word is in the first column and under the code word in italics is the related theme. Under the category, and in the same column, is a summary of the findings for this category over the three time points. In the next three columns, distinguished by the headings Pre-move, Post-Move One-Month and Post-Move Three-Months,

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are the quotations and/or summaries related to the code. Also present in the code book is an illustration of the broad categories and how they were hypothesized to interact.

Trustworthiness of the data.

Data were coded by the researcher, examined and re-examined, then the code book and data were sent to Drs. Welleford and Gendron, both of whom are gerontologists in the Department of Gerontology at VCU with extensive experience in qualitative research. All data, coding, and memos were reviewed for agreement and checked for bias. The following suggestions were made:

(a) Change and Adjustment overlap. Use adjustment as the category heading and place change data into adjustment.

(b) Privacy should be moved to expectations. It fits better there than in autonomy/choice.

(c) Connecting and community are similar. Use connecting.

(d) Coping style and adjustment are similar. Place coping style under adjustment.

Additional suggestions were made and completed to condense the codes even further resulting in the five broad categories described above.

Focus group implementation.

Table 17 provides a summary of the number of stakeholders who attended the focus groups during each time point. Twelve residents (four of whom contributed to the discussion), five staff members, and one family member attended the December 2012, pre-move focus groups. Pre-move and demographic information were collected for seven additional family members through telephone interviews with family members who agreed to be called. During these telephone conversations, detailed notes were taken that were then entered into a Microsoft Word document, and later imported into Atlas.ti 7.

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Table 17

Attendance Rates by Time Period

Time Period	Residents	Family	Staff
Pre-Move	12	1 & 6 (telephone interviews)	5
1-Month	9	3	0 & 16 (April 25, 2013)
3-Months	10	6	12

The follow-up focus groups which were originally scheduled for one month and three months post-move did not adhere strictly to the proposed timeline; availability of stakeholders, researchers, and conference rooms made scheduling difficult. Thus the first follow-up was held on March 26, 2013 and March 27, 2013. A total of nine residents, three family members, and no staff attended the scheduled focus groups. After discussions with the administrator at VMRC, it was decided that the researchers should return on April 25, 2013 and conduct interviews with the staff members in their respective Green House homes. This effort resulted in three focus groups for a total of 16 participants (house 1, n = 6; house 2, n = 7; house 3, n = 3). This same strategy was employed for the three-month follow-up.

The three-month follow-up was not conducted until July 9, 2013 and July 10, 2013. Throughout the remainder of this dissertation, this follow-up period will still be referred to as the three-month follow-up because that is how it was presented in Chapter 3 (Methods). During these focus groups, 10 residents, 6 family, and 12 staff members attended. Again, resident and staff focus groups were held in the Green House homes and family members met in the conference room.

Setting.

Before elucidating the focus group results, a brief description of the Green House (GH) homes is provided as background. There are three GH homes on the VMRC campus: 10 elders

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reside in each house. The staff consist of two *Shahbazim* during the day shift (7:00 a.m. to 4:00 p.m.); two during the night shift (4:00 p.m. to 11:00 p.m.); and one overnight (11:00 p.m. to 7:00 a.m.). Nursing staff, consisting of both RNs and LPNs, are responsible for medicine distribution, monitoring and procedures, and emergencies. Nursing staff float between the three houses. In addition, there is one guide for all three houses whose role is to provide staff support.

Figure 1 provides an illustration of the Woodland Park Green House homes' floor plan.

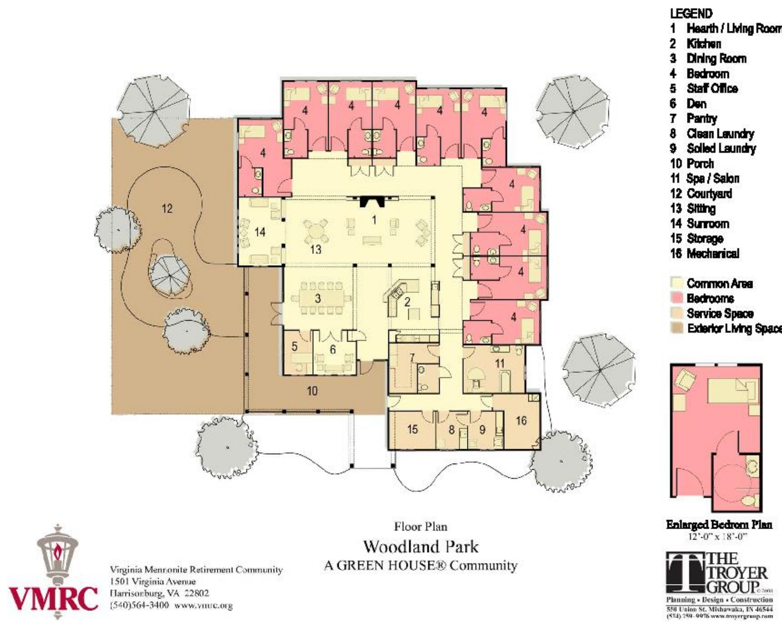

Figure 1

Note. Reproduced with permission from Virginia Mennonite Retirement Community, November 13, 2013.

As required by the Green House Project, the homes have 10 private bedrooms and baths, a hearth room, sunroom, open kitchen, large dining room and table, and safe, easy access to the outdoors. The interior of the homes is bright, cheerful, and comfortable, and the furnishings do not

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resemble institutional furniture: the bright fabrics used throughout are water resistant and durable. Residents have decorated their own rooms with personal items such as furniture and pictures. One *Shahbaz* commented "that there is not much left that looks like a nursing home. It just makes you feel right at home."

All three homes are situated in a pleasant setting near a grove of trees on the VMRC property not far from the main buildings; however, the houses are not connected to the main buildings. At the time of our final visit, the flower beds were bursting with wildflowers, and the fountains for the patios had just been installed. Two of the homes share a courtyard so residents and staff can pass across the patios easily to visit one another.

Overall, stakeholders agreed that the WP homes are lovely places to live and work. One family member commented that "It's much more pleasant to go into; and we can move about, we can stay in his room and have privacy, or we can move out [into the common areas]; and often other family members come and visit, and it's just more homelike."

Focus Group Results

Following the script (Appendix C), stakeholders were asked similar questions at each time point. The answers to those questions, along with participants' tangential thoughts, were used for content analysis. As described earlier, the content analysis revealed five broad themes: (a) Expectations about GH; (b) adjusting to GH; (c) Attitudes, Feelings, and Perceptions about Living and Working in GH; (d) GH and Culture Chang Principles; (e) and Outcomes. The following discussion of the findings is organized around the aforementioned themes and is presented by stakeholder group and by time point. Please note that due to researcher error, the resident pre-move interview was not adequately recorded and thus the data reported are from notes instead of recordings. At times, a remark made by a resident, family, or staff member was

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not caught on the tape recording, but was written down by the researcher: these notations are a direct quote or a paraphrase. Also, the pre-move interviews with family members were conducted via telephone and not recorded. Thus the pre-move family data are reflective of notes and quotations taken during the interview.

Residents.

Theme 1: expectations of Green House living. Resident participants used phrases like "excited" and "concerned" regarding their move to Green House. The theme expectations is reflective of codes such as "privacy," having private bedroom and bathroom, a hair washing sink, variety in meals, and eating warm food. Also included under expectations were codes such as receiving more attention from staff, more visitors, and fostering relationships with the staff.

At the one-month follow-up, residents stated that their expectations of privacy were met; however, one individual commented that staff "forgot themselves" and walked into his room without knocking, but by the time of this interview, this behavior had stopped. With regard to their meals, residents remarked that there was "more variety" and that it came to the table hot. Residents said that the GH homes are "beautiful." One said "I am happy here. You are so at home living here." But not everyone's expectations were met: one resident wanted the staff to be at her "beck and call."

At three months, the residents did not focus on expectations, rather they spoke about adjusting to the GH and their feelings about living at WP.

Theme 2: adjusting to Green House living. Prior to the move, residents expressed concerns about the staffing level. For example, one resident voiced a concern about having only one *Shahbaz* transfer him from the bed to his wheelchair; whereas, at OL two staff members would transfer him. One resident asked if the cost of living in the GH would be more than what

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he already paid to live at OL. And another asked if his wife could move with him. Residents expressed concerns about adjusting to the changes in living space and routines.

At the one-month follow-up residents still expressed concerns about staffing levels. One resident said:

> But you know, as far as helping us, some are good, some are bad. And they don't have enough help. That's really the thing, you know, having enough help to, you know, to be right at your beck and call. And I believe that that is terrible and they try. I mean they work harder, but I just mean that they really need more working in this nursing home.

This sentiment was echoed by another resident who said that the house seemed "understaffed". One resident stated that staff members, like the residents, were trying to adjust to new routines:

> The staff, like everyone else, were afraid of change. When they were first over here they were like a duck out of water. They didn't know quite what to do because everybody didn't train to do everything, but it took a while to work out the bugs, and they are still working on this.

More active residents were trying to adjust to the "isolation" of the GH. WP houses are not connected to the main buildings; and transportation to and from the main buildings was perceived as inadequate. Getting to OL for activities and programs was difficult if not impossible for some.

By the three-month follow-up, residents did not voice concerns about the staffing levels, but rather talked about adjusting to living with other people and the expectations of the staff. One resident commented that "everyone is different" and one must get used to that. Getting used to doing things for oneself has been a challenge for some residents. "Sometimes they ask me to

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do things I can't do." By contrast another resident wants to do more for herself, but is not permitted to. "They won't let me go anywhere alone, and I have to have that darn [walker] with me all the time."

When asked if the transportation issues that were discussed during the one-month follow-up had been resolved, one resident said "it seems like it's worse, but we have to put up with it," whereas another "thought that it was better."

Theme 3: attitude, feelings, and perceptions. At the *one-month follow-up,* residents expressed a variety of feelings about staffing and other residents. Residents noted a difference between the routines at OL and WP and thought that the staff were "kind of looser in my opinion than they had been at OL." One resident remarked that the staff "have more on their hands than what people think they do." About the other residents living at the GH, one resident commented, "You know, they think all these [staff] are maid workers."

One resident commented on the differences between OL and WP, saying, "I did not expect the change to be as radical as it was." When asked if they liked living at WP, residents said the following:

> A: Well, I think most of us are really appreciative of where we are [now]. I guess, if you can do nothing but that, it's what you do. I think it's very nice.
>
> B: I liked it better down at [Oak Lea]. This is a nice place, but I am so limited. I don't know if I like it.
>
> C.: I guess so.
>
> D: Yeah, I'm happy here, but I would like to be at home.

At the three-month follow-up, reflections upon GH living shifted from staffing and the physical environment to living with other people, perceptions of home, restrictions, and visitors.

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For example, one woman said that she lives with a “friendly bunch.” Another said that this house is “beginning to feel like home.” All of the residents stated that their bedroom is their favorite room. “I like my own room better than [the sunroom]. This is shared.” Even though the setting feels like a home, residents do have restrictions such as using their walkers at all times, not making their beds for fear of falling, and not entering the kitchen while the oven or stove is on. “There’s a lot of freedom now; and now when I say freedom, I mean you can do as you want, but the nurses are very particular about what you do and how you do it.” This same woman said about helping to feed other residents that “I don’t do that. I don’t because I am a patient and I am not allowed to do a whole lot.”

Theme 4: lived experience of Green House and culture change. At the pre-move focus group, residents were asked to describe GH; three residents were able to express their understanding of the environment and care practices. Residents stated that the environment would be “more home-like,” schedules would be less structured, and staff would be able to spend more time attending to each individual. Moreover, these residents knew which house they were moving into and their approximate move dates.

Providing an environment that is homelike, cheerful, and stimulating for elders is an aim of the Green House model of care. When asked about the atmosphere of the GH, at the one-month interviews, residents said that the home is “pretty,” “bright,” and “cheerful.”
Ms. M. said, “OL was dark, a gloomy place. It was maybe a little sad, a little depressed. You come over here and on go the lights, and everyone gets along real well, and there is something to do all the time.”

Ms. M. also said, “I like helping. I get to help. My job is the dishes. I set the plates, the placemats, and the meal.” Residents are stimulated not only by games and art projects but by

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engaging in meaningful work. "We gab, we play games, dominos, cards, whatever we can do. I have lots of company. Like today we had a big birthday party." Another said, "We try to help the girls. I like to help them because I get all bored."

Resident autonomy is an important Culture Change and Green House principle. During the three month follow-up, one resident commented that "I like its less regimented. I can do what I want to do. But they expect you to do a certain amount of things. Some things I can't do."

Bringing nature closer to the residents is another goal of Green House living. This was accomplished through large bedroom windows that faced a glen at the back of the house. All of the common living spaces have large windows and there is a French door leading out to the patios. In fact, one focus group session was held outdoors on the patio. Mr. B. was happy to share the view from his bedroom with the researchers and another resident: "You'd be amazed, there are daisies growing out there. You can see them through the windows. In the daytime I can see the daisies."

Building community, another Green House and Culture Change principle, was facilitated by a large dining table at which everyone, including the *Shahbaz*, sits to eat their meals. Ms. L.A. said that she enjoyed taking her meals at the table rather than staying in bed; staying in bed is boring.

Theme 5: outcomes: improvements in living and working. At the one month follow-up, residents noted improvements in their living situation. The food was warmer and there was more variety, the environment was "brighter" than OL, and there were more opportunities to meet new people. One residents said: "I met a few people here, and I like meeting people."

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At the three month follow-up, residents reported that it is “easier to get help,” there is more freedom, there are more opportunities to meet new people and to be social, and with the change in seasons there is more time spent outdoors. Residents also noted that they are “possibly” receiving more visitors because “we have more private room to see them”. “There was never a place like [the sunroom at Oak Lea]. Everything was so close [at Oak Lea], not like this place. It is a nice place.” Transportation between WP and the main campus had improved, so more WP residents thought they were better able to get to programs at OL. In addition, residents are able to go on outings: “They have a bus they use. Every week they go somewhere like on a bus ride to the country or out to buy an ice cream or things like that.”

Residents have been able to make their space their own. Two residents invited the researchers into their rooms. Both residents had decorated their rooms with furniture from home, with pictures, and with other mementos. They were eager to share stories about their mementos and pictures, and both had a spectacular view of the flowers and glen outside their windows.

Policy issues seemed to have limited residents’ ability to help around the house: “No, they don’t let you do any cooking. They do all that. We can’t help, but that doesn’t mean we don’t want to help.” In spite of some restrictions, Ms. M. is very active in the house and helps with setting the table, delivering food to the table, and so on. She said that she does not help “feed the ladies that need to be fed” because “I am a patient, and I’m not allowed to do a whole lot.”

Family members.

Theme I: expectations of Green House living. During the pre-move telephone conversations, family members identified specific expectations for their loved ones. Aside from anticipating a “home-like” environment, family wanted the GH environment to “have a calming

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effect on the residents", and to be stimulating enough to "draw out" their loved one. They stated that they "hoped" their loved-one would be more "active" by getting "out of [their] room" and be more "social."

Family members stated that cultivating a relationship between staff members and residents, and staff members and families was an important expectation. In addition, all family members were expecting the quality of care to improve due to improved staff to resident ratio. One family member made the following statement: "You know, their [*Shahbazim's*] main focus is on the residents, and they will take care of them first and then whatever else needs to be done, laundry or whatever, that can be done at another time."

As part of the pre-move interviews, family members were asked to provide their definition of quality care. Family members expected their loved-ones to be treated respectfully. One family member said that he wanted staff to "treat Mom with respect, do not get short with her". Other definitions of quality care included the following: (a) provide their loved ones with "patient and gentle care;" (b) "listen and respond" to the resident; (c) keep the residents and the setting "clean;" (d) provide "good nutrition;" (e) "know the resident;"(f) "know the family;" (g) "encourage the [resident] to participate in activities;"(h) give staff "access to what they need" to do their job; (i) and "respond promptly to family questions or concerns."

Theme 2: challenges and concerns. During the pre-move telephone calls, family were concerned about how their loved-ones would adjust to their new room because the "layout is different." Another family member remarked that his mother "moved from one neighborhood to another" in order to be on the WP list. He stated that her "anxiety had increased since their decision to move to WP", and he asked, "Will mother be able to adjust and be happy?" The move to WP will be the "second move in three months" for some residents.

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During the one-month post-move focus group, family members reported that their loved ones had adjusted "reasonably" well. Advanced planning on the part of the staff and family members helped make the transition easier.

> A: I thought it was very well planned for my husband's move, and he is in an advanced stage of Alzheimer's…I think he is going to be ok. It is difficult for him to adjust to a new environment, but I think he did very well considering he still has trouble staying overnight. I spent the first 24 hours with him just so he would have a constant. I was there for the first lunch.
>
> B: By the time [mom] got to Woodland Park and got set up, everything was ready for her. It was a nice experience and less confusion and not, "what are you doing with my furniture?" and "what are you doing with my clothes?"
>
> C: It was a reasonably good transition. At first it was different and scary for mom, but she got used to it, and now she seems very content there and she likes the staff.

Although family members believed that WP was a nicer environment for their loved one, they felt that they and their loved ones had given up conveniences they once enjoyed. Programming, Main Street, and the gym are located at OL; taking their loved ones to OL required advance planning and significant effort.

> A: Before I could go over to his room and push his wheelchair to the auditorium, and he could go to the barbershop and exercise especially, and we could stop down and pick him up for exercise. Things like that which really felt like it was a great loss when he moved [to Woodland Park]. It's just a much nicer

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place to live but not being able to get there as well as we could. I wish somehow they could have that kind of situation here to hook up with.

B: I think it's a tradeoff…I think [main campus has] so many buildings that are interconnected, and so we've gotten used to it. Everything is at our fingertips and not having to go outside in the weather for the programs. There is a tradeoff. For me I've got my own transportation, so I can get [to WP] when I'm done work. But with mom here [at WP] it's kind of difficult to visit with her with her memory issues and carrying on a conversation. It's just nice to be able to go to a program and just take her in her wheelchair to the auditorium for whatever is going on there is not possible right now.

The inconvenience of WP being separated from the main campus was expressed again during three-month focus group:

A: There is nothing in the evening as far as transportation that I know of. [Residents and family] are kind of out of luck. And I tried twice and my brother tried to bring [mom] up one time. He went the wrong way and ended up on another street…The next time I was over and she got a little bit loud in the reading so I took her out and walked her around. When I went back in the room it had broken up. I looked out the window and there was a huge storm cloud and lightning and thought "ok what do I do now?" It's like 8 o'clock at night, and I have got to get her back to the house. So I mean we ran, I went downstairs and got a blanket and one of the nurses sent me out the back door, the back entrance, and it was a little bit closer. We had about two minutes to spare. So I really had to go through a lot. I mean they have the jam sessions

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> every month that she used to really enjoy. There are lots of things, you know, right here. It's really hard. Plus the fact that it really gave us something to do. We couldn't have a conversation with her but we could enjoy the program. Like I said, I probably won't bring her back. They were told that.

The limited times that shuttles were available along with the absence of sidewalk ramps were barriers to taking their loved ones over to OL's activities.

Staff levels continued to be a concern at both the one-month and three-month follow-up. At one month a family member said, "I think staffing was one of the concerns I had [before the move]. It's still one of my concerns, especially at night when they have only one person to a house." A similar sentiment was expressed during the three-month follow-up: "I feel like the staff sometimes is a little understaffed." Understaffing contributed to one family's feeling of instability and stress:

> And sometimes they were running around and so there is not this calm confidence that really sort of calms the people. You know. What you need or want is the *Shahbaz* to be calming, confident, and "I can do what I need to do."

The sister-in-law of one resident commented at three-months that the nursing staff seemed "detached, aloof, and not connected to the houses": there was a lack of teamwork. This same family member wondered if "it might be a territorial thing, you know, like 'you don't need to do this, we're fine, we are the *Shahbaz* here and you're the nurse.' "

Some family felt that resident safety was being forfeited for the benefit of a more homelike environment. "I think because it's more of a home atmosphere and the nursing is not emphasized I noticed that maybe a week or so later that they were walking her in the walker but no belt and not even hands on, and I was thinking she might fall because she was really wobbly."

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Physical activity routines and church attendance have changed for residents living at WP. One family member said that her husband had been encouraged by physical therapy to use his walker as much as possible, but that he has not been able to.

> The therapist said they should walk him with his walker, but he is not supposed to walk by himself, just with the walker and they should walk him to and from meals. But at mealtime is their most busy time getting everybody there and serving up the food and all…To him, getting some exercise is very important, and I guess he still hopes he can walk again sometime. But at least if he can get up and walk with the walker at his pace, it makes him feel a lot better.

Another family member said that Woodland Park was "not at all prepared for [taking residents to church]".

> A: You know I wanted [mom] to go back to church.
>
> B: Is getting to church still difficult or a problem?
>
> A: It's not a problem because I come and take her, but if I didn't come here she wouldn't go. She needs somebody to physically take her.
>
> C: A bus comes and takes them to Oak Lea for the second service. You push her in a wheelchair, is that what you're saying?
>
> B: Yeah, she is in a wheelchair. Now it's warm. Let's just talk about transportation, they could improve on that.

Other concerns that emerged during the one-month follow-up continued to be issues at the three-month follow-up. The first of these was not knowing whom to address questions or concerns. Family members were not "quite clear of authority…who is responsible". Second, family members do not always know the staff or recall their names. There "is supposed to be a

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picture of the *Shahbaz* and a nameplate near the front entrance to the house": sometimes the pictures were not there or had not been changed from the last shift. Getting into the house had been difficult too because "no one but full-time staff" have key cards to enter the building. Everyone else must ring a doorbell and wait for someone to come to the door. Wait times had been "as much as 15 minutes". This was a concern expressed by both family and staff members.

Theme 3: attitudes, feelings, and perceptions. Codes that emerged under this theme were relevant to the residents and staff members. None could be assigned for the family members' interviews.

Theme 4: Lived experience of Green House and culture change. When asked during the pre-move telephone call, "What does Green House mean to you?", family stated that the GH would have a more "family-like environment", more "open spaces", "private bedrooms and baths", and "better resident to staff ratios". Green House ideals also emerged such as having a "flexible schedule", "encouraging [residents] to participate in food preparation", providing opportunities for residents "to be in nature", and planning "stimulating activities".

During this same time, one family member remarked upon the suitability of GH for his mother: "I saw a video with elders living in Green House, they seemed more mobile and verbal than mom."

At the three-month follow-up one family member shared a conversation that she had had about the suitability of GH for this population of elders:

> I was talking about it to some friends, about the house and so on, and [she told me about the] complaints from other people. She said people are thinking, "why waste those beautiful homes on people who don't really know where they are?" I said, "Oh, that's not true, not true at all." Even my husband in his condition

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> sensed immediately that he is not in a hospital and he is in a pretty home. And one woman, the first days we were there, she was telling me they took a whole house and fixed it up into a plantation estate. She thought it was a beautiful place.

***Theme 5: outcomes: improvements in living, visiting, and working*.** Family members were asked at three months if they had noticed any changes in their loved ones, such as being more engaged, better spirits, etc. One family member said that "he seems to enjoy being there more, because in his room he can look out at the flowers that are so pretty. All that seems to me he enjoys so much."

During the three-month follow-up focus group, family members wondered if policy and/or regulations were interfering with the time staff members' spent caring for residents. One family member said:

> I think the requirements they have to meet with the housekeeping, sometimes it seems to take priority and they really don't have a lot of time to spend with the residents other than feeding them, bathing them, getting them up in the morning and dressed and then ready for bed.

There are also health department policies, which place a burden on the staff's time. One family member said:

> The laundry water has to be a certain temperature, or they have to quickly clear off the food from the table when one of the residents is finished, and they have to take that away because they have the problem of another person eating that food off that plate even when they have their own food…They have all these rules that they have to go by.

Family members offered solutions to the researcher about the aforementioned problems.

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The wife of one resident said:

> It just seems to me that if they have a person that is a housekeeper and she does all the cooking and cleaning and everything, and then the *Shahbaz* can go around the table and feed people, and they would have more time for them. I think they need one housekeeper and the *Shahbaz* could do it with just the one housekeeper. Let the housekeeper have charge of the kitchen.

Another family member suggested retaining a person whose job is "housekeeping and cooking" with no resident care responsibilities. If the budget does not allow for this, then perhaps "they could have somebody running between the three houses" to help during the busiest times of the day. "Anything they can do to take a little bit of pressure off."

At the pre-move interview, family felt confident that VMRC "leaders chose good people to work at WP." At the three-month follow-up, family expressed feeling less confident in the staff members' ability to care for their loved ones. Various examples were given that suggested a lack of confidence. One family (wife and sister-in-law) said they had more confidence in the staff at the traditional nursing home where their loved one had been staying before transferring to VMRC.

> Maybe it's like we're stuck in this old hospital, like we were talking about, but the nurses provided a sense of confidence that there was somebody in charge and there is somebody who we trust to know the whole picture, and it just gave me a sense of when I'm seeing certain nurses cars outside, I am "phew she is on for the night."

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During this same time point, one family shared that her family felt compelled to hire a caretaker for her husband because they believed that he required more attention than the current staff could provide.

> It is working fine. Especially since we have this extra help around. He is one that really needs it. You know my daughter said I want to do it, so she is paying for it. It works well for him, and this way if he can go to the bathroom when he needs to and he gets to bed when he needs to and he gets pushed all around all over the campus in a wheelchair and he likes it.

Family members also perceived a lack of teamwork among the nursing staff and *Shahbazim*.

> There is no teamwork, I mean you think about all of it, a team kind of approach, but that is certainly not the impression I got when I heard the girls speaking. [The nurse] was not part of the team. So she came in and gave us, I can't remember what the context was, but we were talking about how quickly bells were answered and she actually motioned "this is the Shahbazim's house, I do medicine, but it's not my house."

Not all comments about the *Shahbazim* were negative. Family members believed that the *Shahbazim* and nurses were empathic, hardworking, and trying their best. "In general, having said those things, I think they are really caring and are trying to take care of her, and I think she seems to be eating better. She is talking a little bit more, and they tell me that she is walking better."

Staff members.

Theme 1: expectations of working in the Green House. During the pre-move focus group, staff members were asked to give examples of quality care; they said the following: doing

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a “thorough job”, meeting the needs of the residents, “making time to give a nice tub bath,” providing nourishment, “not allowing a resident to sit around bored, lonely, and depressed,” and “interacting and making [an elder’s] day something to speak of.”

When asked to describe their expectations about the GH, staff members’ responses were mixed. Some were expecting to have time to “sit down and speak to the resident like they are a person,” “connect,” and foster a “closer relationship with elders there, and [get] to be one-on-one instead of the hustle and bustle.” Others responded “I’m not sure what to expect,” and “I see total chaos”.

Anticipating problems or crisis and imagining possible solutions in advance of the move was a tactic that staff members used to ready themselves for their new roles. For example, a staff member said with regard to new schedules:

> So, what I can do is about planning. It’s gonna [*sic*] take a while, but in two or three weeks you will be seeing, “Okay, Mrs. Jones’ schedule is the same when I give her a bath and when I get her up, so [these other residents] we could go ahead and fit them to another schedule.”

This same CNA tried to allay her colleagues’ fears by saying:

> …come on now, we [are] used to having ten residents by ourselves…y’all [*sic*] don’t have to worry about picking up two, three, or four [more residents] because someone didn’t come in or someone had to leave early.

Staff member*s* expected their new coordinator roles, staffing levels, and team work to be challenging. Staff members said the following about these issues:

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A: I have to go along with the team to confront the issue and work the issue out and that is not a position I totally enjoy. I mean I can speak up, but I am not comfortable speaking up.

B: One of my greatest concerns is that there is just one CNA there at night to take care of people because sometimes you need two to handle residents.

By the one-month follow-up, expectations for work performance focused on teammates and the importance of working together: "If you work together and you are fully equal that way, you are going to have a good day. But if your partner is not pulling her weight, you wear yourself out in a short time."

Theme 2: adjusting to working in the Green House homes. During the pre-move interview, staff members expressed concern about their own ability to be assertive and confront issues without the support of a supervisor. "The *Shahbaz* team will be more responsible for problem solving, working out whatever the issues are in the house, and you have to be a team, and I am good for being a team player but to have to step up and be a little more dominant …well, be stronger. It's more dominant to me to step up."

An integral element the Green House paradigm is teamwork. A teamwork approach to the job was also a new idea for most of the CNAs; it made them uncomfortable to depend upon others.

A: I also would say one of the major concerns is working together as a team with people who are on my level. We have to work as a team to work out problems, and that puts me in more of a supervisory role. And that is a little scary because I have always been a person who is flexible to just know my position and work

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with my co-workers, you know, with no challenges, you know, in the area where the nurse didn't have a second opinion.

These concerns were still present during the *one-month follow-up*, but by the *three-month* follow-up staff members had begun to adjust to the new work paradigm.

A: If you work together and you are fully equal that way you are going to have a good day. But if your partner is not pulling his own weight, you wear yourself out in a short time and get confronted about it.

B: I don't want the conflict, I just want to do it and get it done. I don't want my work or anybody else's work not being done and put on the next staff coming in. I don't feel good about that, and I don't feel comfortable, and I don't want conflict, so I am not policing and saying anything. I feel like we are adults, and we should know better.

During the pre-move focus group staffing levels was a concern for these staff members, as was expressed by both residents and family, especially during the graveyard shift.

A: It is the resident-centered care plan that everybody can do whatever they want whenever they want is where I am really struggling as to how we are going to bring it together with only two aides.

B: One of my greatest concerns is as a night worker on what they call the graveyard shift …there is just one CNA there at night to take care of people. Because sometimes you need two to handle residents. Sometimes you need two in an emergency.

These worries did not abate over time. Indeed, by the three-month follow-up the call for additional staff was just as insistent as it had been at the one-month time point. Need for more

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staff was most acute in one of the houses because staff members had resigned. One *Shahbaz* said, "It's kind of difficult, so my partner that was here every weekend and all, she quit. So it's frustrating right now because I don't know who my partner is going to be." Burnout among the *Shahbazim* was a concern: "Physically we share the burden, but I would say mentally I burn out, because you are constantly on the go from the time you come in to the time you leave. And it's just like one thing after the other, and you are trying to keep on with what you have to do."

As part of the Green House model of care, *Shahbazim* have taken on new and challenging responsibilities: "Oh, you know, you have to take on coordinator role, scheduling role. It was all new to us." "Right, plus there were new jobs added to it; and you know, we didn't have to do the cooking or the dishes or the laundry and cleaning. Now we had to learn that and it [used to be] just regular care." Most *Shahbaz* felt ill-prepared to take on these coordinator roles and wished that they had had training in advance of the move rather than learning on the job. Although some were open to the challenge viewing it as an opportunity for career growth, "It's a challenge, but it's not bad. You just do more and expand more than what you were"; others resented it, saying, "It's just a lot of responsibility and I don't even really think it's worth the pay increase."

During the three-month interviews, staff mentioned three barriers to doing their work efficiently: the lack of key cards for part-time staff, small capacity washers and dryers, and the lack of access to new resident's records. The lack of key cards for the part-time staff is seen as an inconvenience and has resulted in staff being late to work; staff have waited for up to 15 minutes before gaining entrance. Laundering residents' clothing is the responsibility of the *Shahbazim*. It is felt that this chore cannot be done efficiently because the houses are equipped with small capacity front loader washers that are not on a platform. Thus, staff members must

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get down on their knees to put laundry in "and the opening is this big around (demonstrates small size with hands). It breaks your heart. You can put in like two pairs of pants and three shirts and the thing is full."

Getting to know a new resident was hampered by the lack of access to the electronic medical record. When *Shahbaz* wanted to know dietary needs and the likes and dislikes of a new resident, they had to leave the house and go to OL to retrieve the medical records.

Theme 3: attitudes, feelings, perception. Staff members talked about the challenges they would face in their new work environment: about the upcoming move a staff member said, "[it will be] challenging at first until we get into a pattern and learn a little more about the residents and what their needs are." Positive attitudes about the Green House model of care were also expressed: "I like the concept. I think it is going to be great for the residents and once we get, as they say, our groove as a team working with the residents, I think it's going to be really good."

Other thoughts were expressed during the pre-move focus group that did not necessarily answer a specific question but revealed the CNA's attitude toward work, person-centered care, and the elders under their care. "I just find [being a CNA] still fulfilling in some ways and hopefully it will be more fulfilling as I go on in my career." Staff attitudes toward person-centered care were mixed; some staff approved of the person-centered care approach because it "put quality of life into the residents' existence". Others were worried that there would be a lack of structure. In the quotations below, the staff members liken caring for the residents as caring for children.

A: I cannot imagine if I did not have structure in my home and my kids were little and to me, like, we always had our meals at a certain time and we always had homework at a certain time. We always had bedtime within a certain range.

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You have got to have some form of structure and I do not see that with [person-centered care].

B: So the point is we learn and they learn and we move around their schedules and once you do that it's like children. You have to basically over-run the schedule of what you planned. And you might have a child who don't like oatmeal and another child who does. Still you doing oatmeal and you doing cereal, but you still got that same schedule.

Staff members regarded the first month of working in the GHs as very difficult: "it was really hard." New challenges may have facilitated team work as evidenced by the following comments by *Shahbazim*:

A: I feel like we have probably a stronger team than we had when we were working over in Oak Lea. It not only comes together and, you know, just generally agreeing, we also care for each other a lot more.

B: We work well as a team. We just make sure that it's all done and it all works out.

C: We work together and I think you (addressing the RN) are very good about listening to what we have to say [compared to] over there (OL) having to go through this whole [chain of command].

While all agreed that it was difficult at first, most said that they preferred working at WP to OL. One staff member said, "I love it. I would not ever go back to a traditional nursing home." Another *Shahbaz*, speaking for herself and her partner said, "I think we both like it like this." Staff members "feel that [Green House is] better than a traditional nursing home." Others

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said “I like it here, I really do,” and there was an expressed commitment to the Green House model of care:

> I do think, if we had to shut the doors down and can't do the Green Houses no more [*sic*], what would y'all do? The answer is, we'd find a way to keep the doors open. We wouldn't go back.

But not all staff expressed satisfaction with working in GH homes: “In general, I prefer working at the home (OL). It is just that when I am over there, there is going to be less shuffle. And a bad day over there is still better. This is just mental overload”

Although GH homes have a much more pleasant atmosphere to work in, some staff are mentally burned out. Some commented that the work is “too overwhelming sometimes” and “I feel kind of like a fish out of water.”

By three-months, staff member's attitudes toward work had shifted from being task oriented to getting the work done for the good of the house:

> *Shahbaz* A: You sort of did your time, did your list, and did your thing. You did what you needed to [at OL]; but over here, you do what needs to be done for the house not for yourself.
>
> *Shahbaz* C: It's a lot more responsibility…there are things our supervisor used to do like quality control, things like documenting flush throughs, etc. It's a whole lot more as far as that goes, but I think it balances out.

Some Shahbaz continued to struggle with their roles at the three month follow-up:

> Am I the only one feeling this way or do you guys feel like these coordinator roles [are difficult]? I'm gonna [*sic*] talk to [my co-worker] because she is ready to quit; she is overwhelmed…I want to go back to being a CNA. The job itself was

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enough. So the increase they gave us to come over here doesn't amount to a hill of beans. I would be willing to pay them that extra dollar that I get and let them do the work. I will give them the $8.00 a day just so I don't have to do it…I mean it is too overwhelming and there is no help…No they didn't train us.

Theme 4: lived experience of Green House and culture change. Teamwork is a central tenant of the Green House model of care. During the one-month interviews, an appreciation for the mechanics of running a nursing home and the benefit of teamwork was expressed:

Shahbaz A: It opened my eyes, and I have more respect for what [supervisors and administrators] do. She schedules all the aides, all the nurses. It gives you a new aspect of what does it take to run a traditional nursing home.

Shahbaz B: Like over there (OL), work changed [and you didn't always know with whom you would be working], but here we know we are stuck with each other and we stick together.

Shahbaz C: I feel like we have probably a stronger team than we had when we were working over in Oak Lea. It not only comes together and, you know, just generally agreeing, we also care for each other a lot more.

Shahbaz D: We as a group, are pleased with this. We balance stuff between us because we have a lot to do.

Appreciation of coworkers has helped to shape the team; one staff member said of another:

And she is one of our greatest assets for on-call people. I mean, if you need anything [she] is the one that dayshift knows, and we appreciate you (speaking to the staff member), we really do. Without you, I don't know what we would do, you know?

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Open communication, a culture change concept, between staff members is integral to seamlessly providing care and other services. Most communicated well with the other full-time staff members. However, part-time staff members had difficulty remaining current because their presence in any one house is sporadic.

> We only have eight [staff members], I believe. We had ten; and we are trying to work back up to ten people. And even before, we would all communicate pretty well, but for the part-timers, it's hard because you aren't here, and you didn't get all [the information]…but I think we all are pretty good.

The culture of the Green House homes, as in any environment, is influenced by people interacting with each other and the objects in their environment. Residents contribute significantly to workplace culture; a *Shahbaz* said of one particular resident:

> And that's the one that you have when he says, 'do it', you have to do it. And it's not fair to the other nine, but you get dictated the way it's going to be. You have to do what they say.

Family also play a part in the culture of the workplace:

> And if it doesn't happen, the family member gets called, and you get called with, "Well, I think he should get put to bed right after breakfast." OK, well I feel like other people should get to eat their breakfast first. You know?

During the three-month follow-up, the *Shahbazim* agreed that there is a difference in stress level from one house to the next. One *Shahbaz* who floated between the three houses said of the Green colored house: "This [house] in my honest opinion is the nut house." She explained that the Red house is much calmer, and the staff there have time to sit down with the residents,

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whereas the Blue house is variable. This *Shahbaz* speculated that the Green colored house serves more high-needs residents.

The Green House model of care has its own vocabulary that is significantly different from the terms generally used in long-term care environments. During the pre-move focus group, one staff member offered her perception of the new terminology:

> For me, I would say Green House is not like that, because a lot of the folks are thinking Green House being a place you grow plants and things like that…To me, we are just plain people, we are not the big city type. For me I don't even use the term Green Houses anymore, I just say that we are taking the nursing home setting and putting it in a home-like environment to get them out of the hospital type appearance. But I wouldn't even use the term Green House anymore because it's something foreign. I don't use the term *Shahbaz* because people are like, "What in the world is that?" I am just a CNA. For me, I look at in a different way.

During the three month follow-up focus group, staff members discussed their perceptions of the tension between Green House/Culture Change ideology and the reality of working in the Green House. Green House ideology promotes teamwork, staff autonomy, and resident autonomy. However, staff did not feel prepared to take on the coordinator roles (care team leader, scheduling, etc.) that are integral to the smooth operation of the Green House. Nor did they feel prepared for resident autonomy. The notion of resident autonomy created some challenges for the staff members due to the high demands of a few residents.

> A: It's really hard because you have all that going on and you don't have, in my opinion, adequate training with acquiring whatever forms you need. I mean,

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it's been six months and I still don't understand half of the forms or what I need to do or what the protocol is.

B: I understand the residents have rights and I have no problem with resident rights, but they go way over and beyond. They think that they are the main [concern]…(staff member expressing her perception of some residents are thinking) "those other people, I don't care. I pay to be here and this is my house. You guys are supposed to do for me." OK, but there is [*sic*] no people to help, "I don't care, that's not my problem."

Theme 5: outcomes: improvements in living and working. When asked how the staff thought their residents adjusted to the move, they shared that most residents adjusted fairly easily: "the residents seem to be getting it all figured out for the most part. It's more ideal, so when you look at that, the residents are happy as they could be there." Moreover, residents started making improvements in some ADLs such as making more attempts at walking, eating at the dining table with the other residents and therefore eating more, sleeping better, and socializing more.

A: I actually do see a change in some of the status. That is, we did have people who did have a fear, who couldn't walk by themselves or, you know, didn't feel very well; and then they come over here and they start walking, they start getting better…I've seen them start feeling themselves when they come here.

B: She (resident) wouldn't eat over there (OL), and when we got her a peanut butter and jelly sandwich she would eat better. She wouldn't hardly come out of her room for a meal, and we can't keep her in the room now. She [goes] around and encourages people to eat and she [is] up doing things.

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Unfortunately there had been some negative outcomes as a result of residents' increased mobility. Of the woman above, the *Shahbaz* said that "she tried to do so much, and we're not watching her 24/7, and [she] fell [and broke her arm]".

Another positive outcome of WP was an increase in the number of visitors. One *Shahbaz* noted: "we see family members that weren't coming as much over [at OL] that are coming a lot more over here and a lot more in the evening. There is nonstop flow." When asked why they thought the number and/or frequency of visiting had improved, one *Shahbaz* responded: "It's enjoyable over here. They have their own private room, and they have the hearth room and the sun room, they can go outside, so they definitely feel more comfortable."

Not all the residents are happy at WP. "There are some that say, 'I hate it [here]' because they need more structure." *Shabazim* commented that some of the residents at WP are "not in the right place physically or mentally. It helps so much when they can be a part of [the goings on in the house]." This sentiment was expressed by another: "It's not beneficial over here for them: it hurts them more than helps them. It really does."

The concept of person-environment fit emerged from the following remarks about the perfect resident:

A: We recently got a gentleman too who is the perfect person. The only thing you really have to help him do is help with his cath [*sic*] bag and assist him with his showers.

B: See, if that was the kind of people that were here then two [*Shahbaz*] would be good.

A: And he's got his mind, you can talk to him and have conversations with him. He can have engagements with other people. He walks and cuts his meals and

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that. And he is just great. He is what you see on those videos who wants to go out and do some gardening, who wants to sit on the porch in the evening and watch the traffic go by, who want to talk to you. Most [residents] we have to engage the entire conversation.

C: Well we have one gentleman we just recently got up here…that takes three people to walk him. One on each side and one to put the wheelchair behind him, and there is only two of us. That lets you know right there that they don't even know what is going on over here. It takes three of us to walk a gentleman, and we are supposed to do this every morning and every evening with him.

D: A lot of them want to sleep; just like over [at Oak Lea].

E: They just want to get up, eat and go back to bed. I mean, I still think this is nice for them, but I don't think that the staffing is right, personally, for that acuity.

Another positive outcome of Green House has been team building. One *Shahbaz* said, "I feel like we have probably a stronger team than we had when we were working over in Oak Lea…we also care for each other more." Another said:

> Some of us are nurses and some *Shahbaz*. It's more like we are working together. I feel that she knows way more than me. I learned more too because we are able to communicate more, and they are able to explain situations better to us. So I think, you know, that there are still the motions. Now, if we have questions we can go to them and they can answer it. We work together and I think you are very

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good about listening to what we have to say…I think we are working together a lot more.

Shahbazim also felt taken care of by administration.

> [Administration] just told us to do things whenever we could, and do what is best for [the residents] too. [Administration] care about us too. We have a life where at other places they help the residents and don't care about us.

With regard to the training in preparation for working in the Green House, *Shahbazim* said:

> A: In the [training] video, they made it look like it was just one big assisted living people.
>
> B: They made it look like people you could communicate with and there are hardly any [at Woodland Park]. I sort of wished we would have went and visited another group home. I kind of wish we could see how they are doing like cooking a meal and doing the work. I would have liked to go for a night and see what they do.
>
> C: I think the core training we went through was a lot of review from, like, memory care and that stuff. I think the live practicing [would have been helpful].

Attending care planning meetings and completing administrative tasks (scheduling, meal planning) had been difficult for some:

> I struggle with having enough time for certain things. Like the care coordination scheduling without giving overtime. I don't envision [we] can do it because we can't take care of [scheduling] when we have stuff to do on the floor. Like the other day I was in care planning, and one of my co-workers got stuck on the floor

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by herself, and she was in a resident's room, and the doorbell was ringing, the phones were ringing, and resident bells were going off, and I constantly had to leave the care planning meeting to go take care of stuff. When a family member comes and they ask "can you help out mom?" You keep getting interrupted.

Death and dying are an expected part of caring for elders. In this setting, all staff members, nurses, and *Shahbaz* alike are involved in shepherding the elder and their family through the dying process. One nurse commented that in some traditional nursing homes, the body of the deceased is removed through the back door of the facility. When a resident at WP was dying the residents were invited into the resident's room; one resident stayed until her housemate died and was later taken to the funeral by staff members. In the short time since moving into the Green House, staff members have grown attached to residents and grieve the loss of an elder in their care.

Negative cases.

Collecting negative cases is a technique used in qualitative research to establish the trustworthiness of the data and to further understand the behavior in question, or to support a hypothesis (Lincoln & Guba, 1985). The decision not to move to Green House was explored through telephone conversations with two individuals. The first, the husband of an OL resident, was asked why he chose not to move his wife to WP. He replied that he "could not afford it". The second person was the daughter-in-law of an OL resident and a former VMRC nursing staff member. Her response to the question was twofold. With regard to her mother-in-law, she said that she was concerned about the staffing to resident ratio. She felt that the environment would not be "safe" for her mother-in-law. In addition, she believed that the "pretty environment" would be "lost on [her] mother-in-law" because she was in the late stages of a dementing type

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disease. Rather than work at WP, this woman decided to retire. First, the position she had held at OL was phased out because the floor she worked on was closed. Second, making the transfer to WP would have meant a demotion in her position and responsibilities. Finally, after visiting WP, she concluded that the environment was "too chaotic" and not a good fit for her.

Summary of the Qualitative Research

Thus far in this chapter, the execution of this qualitative research study was described and the results presented. The themes that emerged from the qualitative analysis included (a) the expectations of Green House living, (b) adjusting to the Green House which included challenges and concerns, (c) reflections upon the feelings, attitudes, and perceptions toward the entire Green House experience (from anticipating the move to the lived experience at one-month and three-months post move), (d) understanding Green House and living the Green House ® principles, and finally (e) outcomes of Green House which included both improvements in health status and living space and disappointments. The next section of Chapter 4 describes the execution and analysis of the quantitative study of the Person-Centered Care Attitude Test.

Quantitative Study: The Person-Centered Care Validation Study

In this section, the exploratory analysis of the Person-Centered Care Attitude Tool (Per-CCat) as well as the internal reliability and construct validity of the measure will be detailed. This description includes a brief summary of the study design, sample, and study execution, and a detailed summary of the analytic procedures.

Study design and purpose.

The purpose of this investigation was to explore the factor structure underlying the item responses to the 42-item Per-CCat questionnaire. This survey was also evaluated in order to

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establish internal consistency, split-half reliability, and reduce the number of redundant survey items.

Factor analysis has, as its key objective, reducing a larger set of variables to a smaller set of factors: fewer in number than the original variable set, but capable of accounting for a large portion of the total variability in the items (Tabachnick & Fidell, 2007. The identity of each factor is determined after a review of which items correlate the highest with that factor. Items that correlate the highest with a factor define the meaning of the factor as judged by what conceptually ties the items together. A successful result is one in which a few factors can explain a large portion of the total variability, and those factors can be given a meaningful name using the assortment of items that correlate the highest with it (Floyd & Widaman, 1995; Tabachnick & Fidell, 2007.

Sampling procedures.

A total of 120 surveys were distributed to employees working at both OL and WP. Completed surveys were returned to the researcher approximately one month after distribution. The first survey distribution resulted in 46 completed surveys. Another wave of surveys was distributed with a memo encouraging those who had not returned their surveys to complete and return them. This effort resulted in an additional 40 completed surveys for a total of 86 surveys.

Sample. This convenience sample was composed of all staff working at OL and WP (total n = 120). Eighty-six surveys were completed, accounting for a 72% return rate. Table 18 provides a summary of the demographic information. This sample was comprised of administrators (n = 7), direct care workers (CNAs, LPNs, RNs, Medical Aides, and Dietary aides; n = 45), activity coordinators (n = 2), housekeepers (maintenance, laundry, n = 2), and other (physical therapy, occupational therapy, life enrichment, etc., n = 11).

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Table 18

Frequency Distribution of Demographic Characteristics

Characteristics	Number	Frequency (%)
Administration		
CAN	7	9.5
RN	24	32.4
LPN	7	9.0
Medical Aid	12	16.0
Guide	2	2.4
Dietary Aid	1	1.0
Activities	11	14.9
Housekeeping/Laundry/Maintenance	2	2.7
Other: coach, foundation, human resources, life enrichment, marketing, support/resources	7	9.4
Total	*75*	*100.0*
Education		
Some HS / HS / Equivalent	16	21.9
Technical / Vocational	30	41.1
Associate Degree	10	13.7
BS / BA / BSN Degree	12	16.4
Graduate Degree	5	6.8
Total	*73*	*100.0*
Gender		
Female	68	91.9
Male	6	8.1
Total	*74*	*100.0*
Race		
American Indian/Alaskan Native	1	1.4
Black or African American	2	2.7
Caucasian/White	69	93.2
Other or more than one race	2	2.7
Total	*74*	*100.0*
Ethnicity		
Hispanic	1	1.4
Not Hispanic	73	98.6
Total	*74*	*100.0*
Age		
18-25	10	14.5
26-35	15	21.7
36-45	10	14.5

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Table 18 – Continued

Characteristics		Number	Frequency (%)
46-55		34	49.3
	Total	*69*	*100.0*
Years Working at VMRC			
≤ 5 years		34	44.7
> 5 years		42	55.3
	Total	*76*	*100.0*

Among the participants, there was a wide range of educational attainment. The majority, (36%) reported completing high school or a technical/vocational program; thirty percent (30.1%) had obtained an associates or bachelor's degree; and a small portion had obtained a graduate degree (6.8%: all of whom held administrative positions). The sample was mainly composed of female (92%), white (93%), and non-Hispanic (99%) participants. Many of the employees were 36 years of age or older (n = 44, 64%), with the majority being between the ages of 46 and 55 (49%). Additionally, over half of the sample (55.3%) reported working at VMRC for greater than five years.

Analytic procedures.

Screening and management of data. Following data collection, all data was organized and entered into a data file using the predictive analytic software, SPSS 21. Prior to computing composite scale scores and running statistical analysis, all survey item responses were reviewed and assessed for accuracy, missing data, extreme scores and then labeled according to their level of measurement. Skewness and kurtosis were computed for each item to examine the normality of the distribution. For all 42 items, Skewness was within the range of normal (between +/-1 to +/-2). However, the kurtosis statistic for four items' values (2.941; 3.184; 2.153; and 4.476) were greater than the "the rule of thumb" which is between +/-1 to +/-2. Nevertheless, these items were retained; the assumptions about the normalcy of the distribution are not in force with

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factor analysis (Tabachnick & Fidell, 2007). Frequency distributions were generated for all survey items to further assess potential outliers and missing data. Appendix H provides a summary of the frequency distribution for each question. No outliers were noted.

Exploratory factor analysis. Although the Per-CCat had been tested for face and content validity, measures of internal consistency and construct validity had not been previously assessed. Specific steps were taken to factor analyze this scale. These steps included determining the suitability of the data for factor analysis, deciding upon an extraction method, generating inter-item correlations, computing commonalities, generating the factor and rotated factor loadings, as well as creating scree plots and plotting the factor/item loadings in the rotated space. Once all these steps were taken, the data was evaluated and changes and/or groupings of structures were completed based on the factor solution and the theoretical framework driving this study. This factor analysis process was undertaken three times with a final result in a solution containing four factors and a reduction of items from 42 to 34.

First round exploratory factor analysis. Factorability of the data. The sample used for this exploratory factor analysis was comprised of those individuals who provided an answer to all 42 questions. Using the Listwise option in SPSS, the sample was reduced from 86 to 70. Therefore, data from 70 participants was included in this factor analysis. The 16 cases with missing data were tested to determine if the data were missing at random. Little's MCAR was significant (X^2 = 650.578, df = 544, p = .001) indicating that the data are not missing randomly. A solution to missing values is to impute the data either through prior knowledge of the subject, mean substitution, or regression (Tabachnick & Fidell, 2007). A decision to not impute data was made for several reasons: (a) it is useful to know in the developmental stage of a questionnaire what questions are being skipped; (b) imputed data are biased because error is not built into the

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imputed data set thus calling into question the standard errors that are generated using the imputed data set; (c) the data may fit together better than they ought because the imputed value is predicted using values from other variables; and specific to this data set (d) imputing a value using "no opinion" may not be an accurate representation of what the individual meant; "no opinion" may mean "I don't know because I do not have knowledge about this subject" or "I have knowledge about this subject, but I have no opinion" or "the question is confusing" or "I don't understand the question".

To determine the factorability of the data, Barlett's test of sphericty (BTS) and Keiser-Myers-Olkins' measure of sampling adequacy (KMO) were calculated using SPSS 21 FACTOR. BTS tests the hypothesis that the correlations in the correlation matrix are zero (Tabachnick & Fidell, 2007), thus suggesting that all the variables are uncorrelated (the matrix is not an identity matrix). The chi-square value from the BTS was significant ($X^2 = 2006.562$, $p = .000$) suggesting that the data do not form an identity matrix.

Since BTS is almost always significant (Tabachnick & Fidell, 2007), the KMO was also calculated to determine the factorability of the dataset. The KMO statistic, a more discriminating index, measures the magnitude of the observed correlations with the magnitude of the partial correlations (Pett, Lackey, and Sullivan, 2003). Based upon a scale of 0.0 to 1.0, a KMO value of .90 is considered "great", .80s are "good", .70s are "middling", .60s are "mediocre", .50s are "miserable", and below .50 is deemed "unacceptable" (Pett, et al., 2003). Table 19 provides a summary of the KMO and BTS. Sampling adequacy was demonstrated through a KMO value of .746. A value of .70 or greater is deemed acceptable (or "middling") (Pett, et al., 2003). Because the KMO value meets the minimum criteria (.60) it is not necessary to examine an anti-image correlation matrix (Tabachnick & Fidell, 2007).

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Table 19

KMO Measure of Sampling Adequacy and Barlett's Test of Sphericity

Factorability Test		Measurement
Kaiser-Meyer-Olkin Measure of Sampling Adequacy		0.746
Bartlett's Test of Sphericity	Approximate Chi-Square	2006.562
	df	861
	Sig.	0.000

Correlation matrix. The inter-item correlation results (Appendix I) displayed both positive and negative correlations among the items. This was expected due to the nature of the items and construct being measured. In addition, there were significant bi-variate correlations as demonstrated by p values less than .05. Significant correlations were also to be expected. Note that there were correlations greater than .30 which was another indicator that the data were factorable. If there had been no R values at .30 or greater, factor analysis would have been inappropriate (Tabachnick & Fidell, 2007).

Communalities. Communalities for each item represent the variance accounted for by the factors (Tabachnick & Fidell, 2007). Mathematically, communalities are the sum of the squared loadings of each item across factors (Tabachnick & Fidell, 2007; Walkey & Welch, 2010). Communalities are an estimate of the shared variance, the true value of which is unknown. In order to generate factors, it is necessary to estimate the commonalities so that those values can be placed in the factor matrix (Pett, et al., 2003). The initial value of the communality computed by SPSS 21 (using Principal Components Analysis, PCA) was 1.00; it is this value that was placed on the diagonal (similar to the correlation matrix). The extracted communality can range from 0 to 1.00 and represent the common variance accounted for by each item (see Table 20). Higher values indicate that the extracted factors explain more of the variance for a particular item (Pett, et al., 2003).

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Table 20

First Round Communalities for the 42 Item Per-CCat

Item	Initial Communality	Extracted Communality
C1 Staff schedule meals	1.000	0.750
C2 Choice of food	1.000	0.706
C3 When/Where to eat	1.000	0.746
C4 Staff schedule when to shower	1.000	0.789
C5 Choice when to bathe	1.000	0.761
C6 Antipsychotic	1.000	0.810
C7 Help manage agitation	1.000	0.718
C8 Positive social interactions	1.000	0.851
C9 Isolate if aggressive	1.000	0.702
C10 Staff preference to work with residents with AD	1.000	0.755
C11 Environment has little impact on outcome	1.000	0.793
Commun12 Finish work first	1.000	0.851
Commun13 Ask elder preference	1.000	0.710
Commun14 Don't wait for answer	1.000	0.563
Commun15 Endearment OK	1.000	0.698
Commun16 Conversation with elder unessential	1.000	0.704
Commun17 Staff conversation is OK	1.000	0.722
C&C18 Life story valuable	1.000	0.728
C&C19 Time with family	1.000	0.831
C&C20 Incorporate life story	1.000	0.828
C&C21 Bring items from home	1.000	0.748
C&C22 Uniform rooms	1.000	0.680
C&C23 Individually suited activities	1.000	0.828
C&C24 Designed with past life in mind	1.000	0.756
C&C25 Choose to sleep	1.000	0.755
C&C26 Community involvement not important	1.000	0.815
C&C27 Encourage creativity	1.000	0.726
C&C28 No fail activities	1.000	0.725
C&C29 Input into type of activities	1.000	0.667
Climate30 Elders have same needs	1.000	0.716
Climate31 I am flexible	1.000	0.640
Climate32 I am properly trained	1.000	0.784
Climate33 Celebrate holidays	1.000	0.647
Climate34 Learning new techniques	1.000	0.786

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Table 20 – Continued

Item	Initial Communality	Extracted Communality
Climate35 Follow ethical guidelines	1.000	0.660
Climate36 Work fast	1.000	0.722
Climate37 Attitude	1.000	0.734
Climate38 Increasing elder independence	1.000	0.726
Climate39 Team work	1.000	0.733
Climate40 Overwhelmed	1.000	0.601
Climate41 Routine repetitive	1.000	0.780
Climate42 Valued	1.000	0.718

Principal Components Analysis. Principal Components Analysis (PCA) was chosen for this data for the following reasons: (a) it is most commonly used for exploratory analysis; (b) it assumes that there is as much variance as there are variables and "that all of the variance in an item can be explained by the extracted factors" (Pett, et al., 2003, p. 91); (c) it assumes that extracted components are not correlated to one another (orthogonal) and that the components are a linear combination of the variables entered into the analysis (Pett, et al., 2003); and it is recommended when no *a priori* theory or model exists (Gorsuch, 1983). The final point may seem to be a contradiction because PCA attempts to establish that the Per-CCat is measuring person-centered care attitudes. Thus there is an established theory against which the Per-CCat items are being tested. However, the construct "attitude toward person-centered care" has not been theorized nor is there an existing model of the Per-CCat.

Principal components analysis uses the following terms: eigenvalues, eigenvectors, and factor loadings. An Eigenvalue is a single value that represents the total variance among all the items associated with a specific component, also known as a factor (Pett, et al., 2003). Eigenvectors are the linear combination of the variables (a column of weights given to each item) and are used to derive the principal components (Tabachnick & Fidell, 2008; Pett, et al.,

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2003). Mathematically, the components are derived by multiplying each eigenvector by the square root of the component's associated eigenvalue (Pett, et al., 2003); this is called a factor loading. Factor and component have the same meaning and are often used interchangeably. Throughout this section, the term component has been used for the sake of consistency unless the text is referring to factor loadings.

The analytic process "consists of repeatedly refining the solution to find a suitable eigenvector and associated eigenvalue from which the factor loadings for a [component] can be obtained" (Pett, et al., 2003, p. 93). Thus SPSS 21 generates a list of initial eigenvalues for each variable. SPSS 21 then produces the extraction sums of squares loadings until the initial eigenvalues begin to drop below 1.00, which is the standard cutoff (Tabachnick & Fidell, 2007). Two methods were used in this analysis to determine the number of components: (a) a scree plot and (b) eigenvalues ≥ 1.

The scree plot (see Figure 2), displays the eigenvalues on the ordinate axis (Y) and the components on the abscissa (X). If one were to draw a line with a straight edge through the lower value eigenvalues, the line would continue off of the curve approximately where the variance begins to increase; this appears to occur at component 11. There is an insignificant increase in the curve between component 23 and 24. However, the scree plot is an approximation and should not be depended upon exclusively. The extracted sums of squares loadings terminated after 11 components, the point at which the initial eigenvalues fell below the value of 1.00, thus validating the scree plot interpretation. The initial eigenvalues helped to identify the "possible" presence of a general factor (Walkey & Welch, 2010), which is a desired outcome for the first phases of the analysis.

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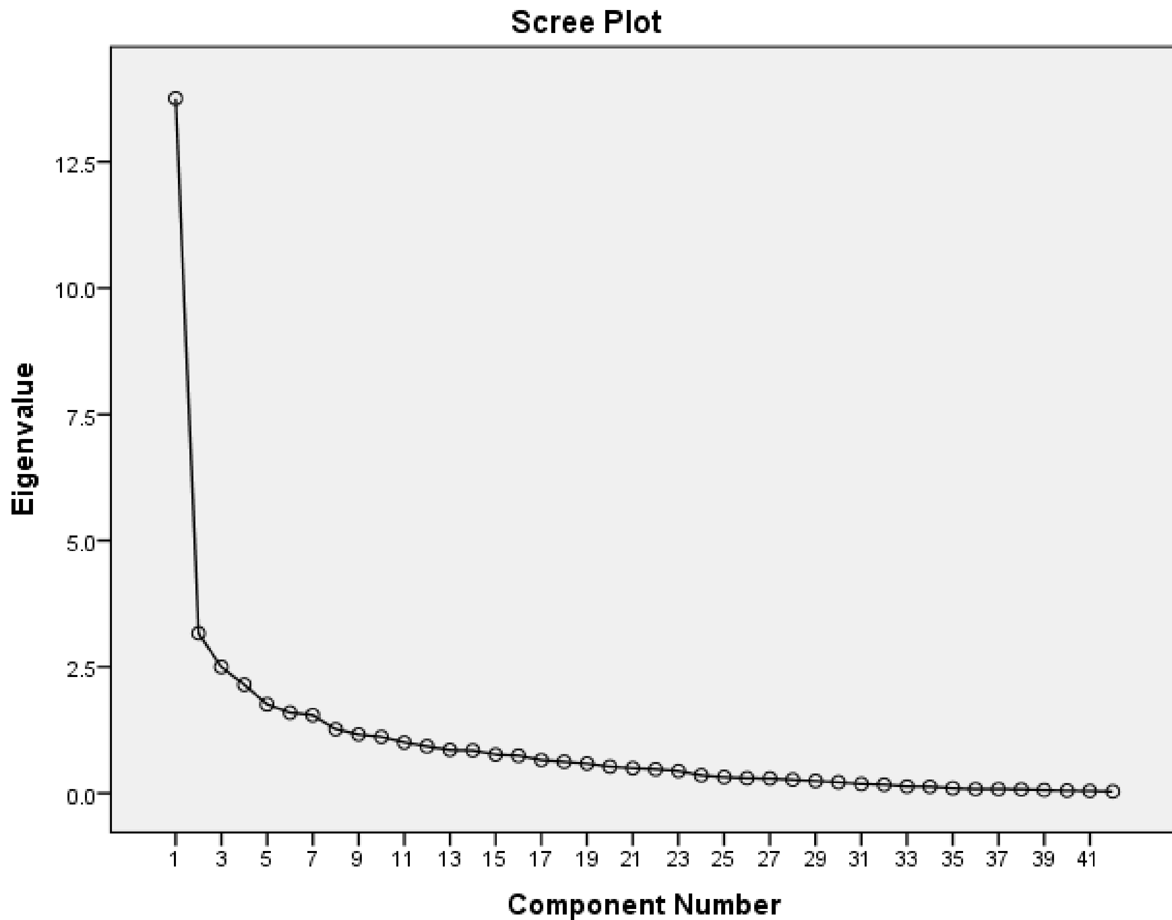

Figure 2

Scree Plot of Components and Related Eigenvalues for 42 Item Per-CCat.

Factor rotation was used to simplify the solution, making it easier to interpret and to confirm the presence of general factors. Because the factors are assumed to be orthogonal, Varimax rotation was used. Varimax rotation is widely used for exploratory factor analysis and is the default in SPSS (Pett, et al., 2003; Tabachnick & Fidell, 2008). Kaiser normalization is also a default in SPSS and is used to gain stability of solutions across samples (Pett, et al., 2003). Mathematically, the factors are scaled to unit length before they are rotated. Scaling is achieved by dividing each item's loading by the square root of its individual communality. Once factors are rotated, the item loadings are "rescaled to proper size by multiplying the generated loading by its communality" (Pett, et al., 2003, p. 148).

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Table 21 provides a summary of the total variance accounted for by each of the 11 factors; it also displays the rotated sums of squared loadings for the 11 factors. As expected, Component 1 explained the greatest amount of variance among the items (rotated: 24.191%).

Table 21

Rotated Factor Loadings for 11 Components and 42 Items

Total Variance Explained							
Component	**Initial Eigenvalues**			**Extraction Sums of Squared Loadings**			**Rotation Sums of Squared Loadings**
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total
1	13.757	32.754	32.754	13.757	32.754	32.754	10.160
2	3.164	7.534	40.288	3.164	7.534	40.288	2.439
3	2.499	5.949	46.237	2.499	5.949	46.237	2.430
4	2.149	5.116	51.353	2.149	5.116	51.353	2.366
5	1.756	4.180	55.533	1.756	4.180	55.533	2.333
6	1.593	3.793	59.327	1.593	3.793	59.327	2.308
7	1.544	3.677	63.004	1.544	3.677	63.004	2.273
8	1.267	3.017	66.020	1.267	3.017	66.020	1.951
9	1.160	2.763	68.783	1.160	2.763	68.783	1.813
10	1.112	2.647	71.430	1.112	2.647	71.430	1.583
11	1.004	2.391	73.821	1.004	2.391	73.821	1.348

Component	**Rotation Sums of Squared Loadings**	
	% of Variance	Cumulative %
1	24.191	24.191
2	5.808	29.999
3	5.785	35.784
4	5.634	41.419
5	5.555	46.973
6	5.496	52.469
7	5.412	57.881
8	4.644	62.526
9	4.317	66.842
10	3.768	70.611
11	3.210	73.821

Note. Extraction Method: Principal Components Analysis.

The aim of factor analysis is to find the simplest solution. Eleven components is far larger than is desirable and is larger than the original four subscales (Care, Communication, Culture and Community, and Climate). In addition, when each item was sorted according to component, it appeared that the 42 questions aligned strongly with the first five factors. Questions did load

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strongly (>.30) on more than one factor; therefore, the largest loading value was used to determine the placement of the item under a component. Items were organized based on the conceptual framework guiding the order of which items best fit with which component. In other words, did it make sense that questions clustered under a particular component? The answer to that question was equivocal.

Second round exploratory factor analysis.

To gain more clarity, the data were recalculated forcing a five-factor solution. A scree plot was created in SPSS 21 and did not differ from that in Figure 2. Reducing the number of components (factors) from 11 to five improved the total variance explained by the components. Thus component 1 accounted for 26.54% of the total variance among the 42 items (see Table 22), whereas component 1 accounted for only 25.19% of the total variance among the 42 items in the first round.

Table 22

Rotated Factor Loadings for Five Components and 42 Items

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total
1	13.757	32.754	32.754	13.757	32.754	32.754	11.147
2	3.164	7.534	40.288	3.164	7.534	40.288	3.918
3	2.499	5.949	46.237	2.499	5.949	46.237	3.318
4	2.149	5.116	51.353	2.149	5.116	51.353	2.899
5	1.756	4.180	55.533	1.756	4.180	55.533	2.041

Component	Rotation Sums of Squared Loadings	
	% of Variance	Cumulative %
1	26.542	26.542
2	9.329	35.870
3	7.901	43.771
4	6.903	50.674
5	4.859	55.533

Note. Extraction Method: Principal Components Analysis.

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Even though the variance improved, the items still loaded on more than one factor and the clustering was still not cohesive. Table 23 provides a summary of the rotated matrix and consists of the component, item, and the factor loading. The majority of items (n = 24) loaded on Component 1. The range of loadings was from 0.399 to 0.804. Six items loaded on Component 2 with loadings between 0.420 and 0.767. There were seven items that loaded on Component 3 ranging from 0.424 to 0.704. Three items loaded on Component 4 ranging from 0.507 to -0.697. Finally, two items loaded on Component 5 with loadings of 0.512 to 0.647.

Table 23

Rotated Component Matrix Containing Five Components and 42 Items

Item	Component				
	1	2	3	4	5
Care					
1. I believe staff members should schedule meal times for elders.	0.036	**0.638**	0.018	0.259	-0.040
2. I believe an elder in a care setting should have a choice to select food items from a menu.	**0.692**	0.156	-0.056	0.011	0.085
3. I believe elders in a care setting should have a choice when and where they eat.	**0.588**	0.211	0.110	0.327	0.298
4. I believe shower times for elders in care settings should be scheduled based on staff workloads.	0.139	**0.739**	0.004	0.070	0.175
5. I believe an elder in a care setting should choose the days and times he or she showers or bathes	0.415	0.360	-0.122	0.033	**0.512**
6. I believe the use of anti-psychotic medication improves quality of life for elders.	0.265	**0.420**	0.247	-0.257	0.344
7. I believe it is more important to help an elder manage his or her agitation rather than administering a drug.	0.364	0.092	0.365	-0.267	**0.512**
8. I believe elders in care settings experiencing positive social interactions have decreased agitation.	**0.527**	-0.018	0.191	-0.116	0.445
9. I believe it is important to isolate an elder if he or she is being physically aggressive.	0.074	**0.684**	0.022	-0.134	-0.176

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Table 23 – Continued

Item	Components				
	1	**2**	**3**	**4**	**5**
10. I believe elders with dementia are best served by staff members who express a preference to work with this population of elders.	**0.424**	-0.197	0.052	0.421	0.338
11. I believe the physical environment of a care setting has little impact on elders' care experience outcomes; it is the care itself that matters.	**0.399**	0.198	-0.163	0.365	0.061
12. I believe in getting my work finished before I initiate conversations with elders in the care setting.	0.201	**0.767**	0.065	0.069	0.060
13. I believe in asking elders about their preferences in the care I provide.	**0.711**	0.209	0.265	-0.039	0.152
14. I believe asking an elder a question is more important than waiting to hear the answer.	0.244	0.278	-0.019	**0.507**	.075
15. I believe that referring to an elder in a care setting by "honey" or "sweetie" is appropriate.	0.282	0.122	0.323	**0.597**	0.034
16. I believe that conversation with elders is not essential in order to complete my job duties.	**0.623**	0.465	0.145	0.168	-0.163
17. I believe there is a need to carry on conversations with fellow staff in the presence of an elder.	0.335	0.159	0.**424**	0.367	-0.210
Culture & Community					
18. I believe knowing an elder's life story adds value to the care I provide.	**0.534**	0.230	0.060	0.449	-0.008
19. I believe time spent with an elder's family member is not essential to learn about an elders.	**0.741**	0.338	-0.004	0.146	0.081
20. I believe it is important to incorporate an elder's life story into care, conversation, meals, and activities.	**0.780**	0.031	-0.109	0.355	-0.104
21. I believe an elder in a care setting should bring items from his or her home.	**0.651**	.067	0.259	0.187	0.007

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Table 23 – Continued

Item	Component				
	1	**2**	**3**	**4**	**4**
22. I believe all elders' rooms in a care setting should be arranged uniformly for consistency.	**0.500**	.398	-0.113	0.115	-0.196
23. I believe an elder in a care setting should have access to activity programs that are individually suited to their preferences.	**0.791**	.072	0.177	-056	0.056
24. I believe activities should be designed with an elder's past life story and past occupation(s) in mind.	**0.634**	-0.119	-0.032	0.315	0.196
25. I believe an elder in a care setting can choose if he or she wants to stay awake all night or "sleep-in" in the morning.	**0.653**	0.205	0.324	0.037	0.117
26. I believe involvement of the community is not important to an elder's quality of life in a care setting.	**0.781**	0.194	-0.054	0.151	-0.041
27. I believe creativity should be encouraged in interactions and activities with elders.	**0.804**	0.045	0.066	-0.023	0.095
28. I believe activities should be conducted with a "no fail" approach.	0.127	-0.016	0.015	**-0.697**	0.013
29. I believe an elder in a care setting should have input on what type of activities are implemented.	**0.628**	0.098	0.242	-0.041	-0.009
Climate					
30. I believe most elders have similar needs.	-0.032	0.036	-0.141	0.366	**0.647**
31. I believe I am flexible in my daily routines.	0.081	0.318	**0.603**	-0.111	0.059
32. I believe I am properly trained to meet the needs of a diverse elderly population.	0.350	0.139	**0.704**	0.068	-0.025
33. I believe that a care setting should celebrate holidays that the majority of elders believe in.	0.375	-0.036	**0.477**	-0.044	-0.234

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Table 23 – Continued

Item	Components				
	1	**2**	**3**	**4**	**5**
34. I believe in learning new techniques and strategies to improve my relationship with elders in a care setting	**0.758**	0.125	0.256	0.132	0.040
35. I believe it is important to follow ethical guidelines when interacting with elders in a care setting.	**0.705**	0.058	0.213	0.088	0.189
36. I believe it is important to work fast in order to finish my daily work responsibilities.	0.151	**0.542**	-0.009	0.247	0.215
37. I believe my attitude towards work affects the care given to the elders.	**0.758**	0.095	0.217	-0.026	0.117
38. I believe in increasing the independence of the elders.	**0.711**	0.160	0.268	0.157	0.187
39. I work with a team to provide top quality care to elders.	**0.638**	-0.076	0.470	-0.026	-0.049
40. I feel overwhelmed with my workload.	-0.046	-0.119	**0.548**	-0.025	0.207
41. I feel my daily routine in this care setting is repetitive.	-0.026	-0.382	**-0.437**	-0.380	-0.145
42. I feel valued as an employee at this care setting.	0.159	-0.204	**0.546**	0.189	-0.147

Using Table 23 as a reference, note that items 2, 3, 5, 8, 11, 13, 16, 18, 19, 20, 21, 22, 23, 24, 25, and 26 seemed to be associated with the person-centered care (PCC) principle of choice and personhood. Interestingly, items 27, 29, 34, 35, 37, 38, and 39 also loaded on Component 1 and seem to be associated with attitudes toward work. There appeared to be two subscales under one component.

The items clustering on Component 2 (1, 4, 6, 9, 12, and 36) appeared to be describing ways in which staff members might control their work environment. Whereas the items associated with Component 3 (31, 32, 40, 41, and 42) seemed to describe the staff members'

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work experience or perceptions about their work climate. Those items that loaded on Component 4 and 5 do measure a PCC principle, but together do not form a scale. After careful evaluation of the items and the components to which they aligned, it was determined that the survey contained five components and that eight items should be removed.

Third round exploratory factor analysis. Table 24 provides a summary of the items that were deleted from further analysis and the reasons for so doing. With the exception of items 14 and 28, deleted items loaded on more than one component which suggested that there was a correlation between components on these items.

Table 24

Explanation for Deleting Items from Further Analysis

Item	Loading	Component	Comment
6. I believe the use of anti-psychotic medication improves quality of life for elders.	0.420 0.344	2 5	In addition to loading on more than one component, the frequency distribution of this item indicated that 40% (29 of 73) respondents had no opinion.
10. I believe elders with dementia are best served by staff members who express a preference to work with this population of elders.	0.424 0.421 0.338	1 4 5	In addition to loading on more than one component, the item does not seem to "hang together with any of the other items in component 1.
14. I believe asking an elder a question is more important than waiting to hear the answer.	0.507	4	This item does not align with the other items under Component 4.
15. I believe that referring to an elder in a care setting by "honey" or "sweetie" is appropriate.	0.323 0.597	3 4	This item loads more strongly on component 4, but does not make sense in this context. Also, this item does not make sense in the context of component 3. Frequency distribution of this item also shows that 22 (30%) individuals had no opinion
17. I believe there is a need to carry on conversations with fellow staff in the presence of an elder.	0.335 0.424 0.367	1 3 4	This item loaded on three components.
28. I believe activities should be conducted with a "no fail" approach.	-0.697	4	22 (30%) individuals had no opinion 5 (6%) individuals skipped the question.
30. I believe most elders have similar needs.	0.366 0.647	4 5	This item is one of only two items under component 5. In addition this item loaded on two components.
33. I believe that a care setting should celebrate holidays that the majority of elders believe in.	0.375 0.477	1 3	This item does not align with other items under this component. In addition this item loaded on two components.

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Items were further reviewed through frequency distributions to determine if the item under consideration had a large proportion of "no opinion" or skips. Three questions had a large number of no opinion. Four items did not fit well logically with other items aligning under a specific construct and were also removed from the analysis.

Factorability of the data. Once again the data were tested for factorability. Due to the deletion of 8 items, the KMO value improved from the first round factor analysis KMO (KMO = 0.802). The BTS was significant (X^2 = 1667.535, df = 561, p = 0.000). See Table 25 for KMO and Bartlett's Test of Sphericity.

Table 25

Sampling Adequacy for the 34 item Per-CCat

Factorability Test		**Measurement**
Kaiser-Meyer-Olkin Measure of Sampling Adequacy		0.802
Bartlett's Test of Sphericity	Approximate Chi-Square	1667.535
	df	561
	Sig.	0.000

Final principal components analysis. Principal Components Analysis was conducted on the dataset again with the eight items listed above removed (new total = 34 items) and forcing a four-factor solution. It was decided to reduce the factors to four because the five factor solution contained only two items with high factor loadings (refer to Table 22). The Scree Plot (Figure 3) showed no difference from Figure 2 while Table 26 showed that communalities ranged from 0.310 to 0.788.

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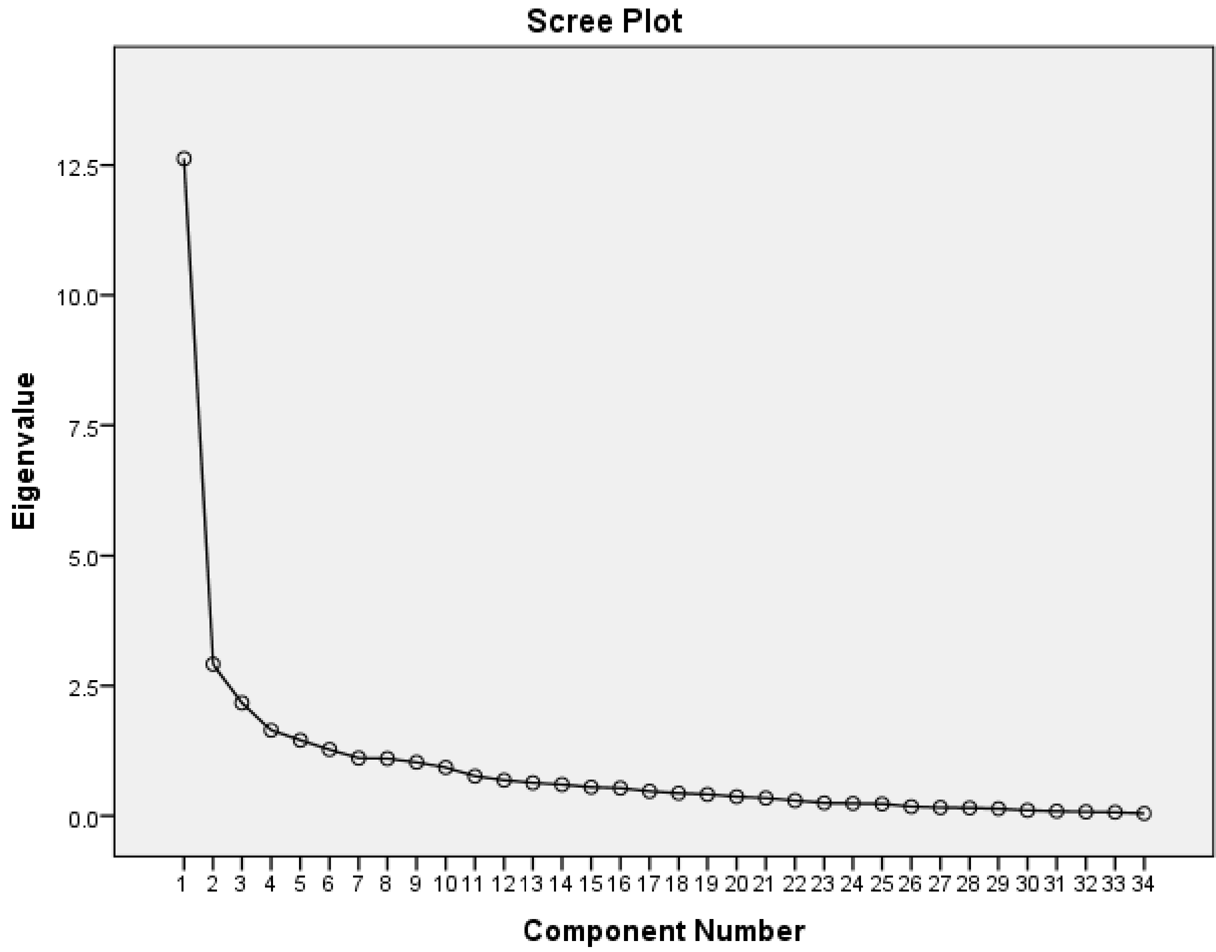

Figure 3

Scree Plot of Components and Related Eigenvalues for 34 Items

Table 26

Communalities of the 34 Remaining Items

	Initial	Extraction
Care1R	1.000	0.561
Choice of Food	1.000	0.574
When/Where to Eat	1.000	0.533
Care4R	1.000	0.584
Choice When to Bathe	1.000	0.541
Help Manage Agitation	1.000	0.399
Positive Social Interactions	1.000	0.435
Care9R	1.000	0.527
Care11R	1.000	0.449

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Table 26 – Continued

	Initial	Extraction
Com12R	1.000	0.609
Elder Preference	1.000	0.647
Com16R	1.000	0.564
Life Story Valuable	1.000	0.644
CC19R	1.000	0.660
Life Story Into Care	1.000	0.788
Bring Items	1.000	0.523
CC22R	1.000	0.412
Individually Suited Activities	1.000	0.687
Activities Designed	1.000	0.552
Choose Sleep	1.000	0.611
CC26R	1.000	0.683
Encourage Creativity	1.000	0.673
Input Type Activities	1.000	0.530
Flexible	1.000	0.517
Properly Trained	1.000	0.610
Learning	1.000	0.687
Follow Ethical Guidelines	1.000	0.611
Clim36R	1.000	0.310
Attitude	1.000	0.666
Increasing Independence Elders	1.000	0.672
Team Work	1.000	0.629
Clim40R	1.000	0.409
RepetitiveR	1.000	0.582
Valued	1.000	0.472

Note. Extraction Method: Principal Components Analysis.

Table 27 provides a summary of the initial eigenvalues and extraction sums of squared loadings. More than half of the variance was explained by the first four components. Component 1 accounted for 37.13% of the variance. Components 2, 3, and 4 explained 8.57%, 6. 38%, and 4.82% of the variance respectively. Using an orthogonal rotation to simplify the

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Table 27

Initial Eigenvalues and Extracted Sums of Squares for Four Components

Component	**Initial Eigenvalues**			**Extraction Sums of Squared Loadings**		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	12.625	37.132	37.132	12.625	37.132	37.132
2	2.915	8.574	45.706	2.915	8.574	45.706
3	2.172	6.389	52.095	2.172	6.389	52.095
4	1.641	4.825	56.920	1.641	4.825	56.920

solution resulted in the following sums of squared loadings (Table 28): Component 1 explained 22.78% of the variance; Component 2 explained 16.21%; Component 3 explained 10.64%; and Component 4 explained 7.27%. The four-factor solution without the eight questions, improved the distribution of the variance. This was especially noticeable among Components 2, 3, and 4.

Table 28

Rotated Component Matrix: Four Components Containing 34 Items

Total Variance Explained			
Component	**Rotation Sums of Squared Loadings**		
	Total	% of Variance	Cumulative %
1	7.746	22.783	23.783
2	5.514	16.219	39.003
3	3.620	10.648	49.651
4	2.472	7.270	56.920

Note. Extraction Method: Principal Components Analysis. Rotation Method: Varimax with Kaiser Normalization.

Rotated factor loadings showed that several items still aligned with more than one factor: 2, 3, 4, 13, 19, 20, 21, 22, 23, 24, 25, 26, 27, 31, 32, 34, 35, 38, 39, and 41. In spite of the

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multiple loadings for some items, the clustering of items using the highest loading value, with a few exceptions, remained in line with the conceptual framework used to create the scale (see Table 29). Component 1 contained items 2, 5, 7, 8, 13, 16, 18, 23, 25, 27, 29, 34, 35, 37, 38, and 39. The clustering of items 2 through 29 in Component 1 suggested that resident autonomy was being measured. Items 34, 35, 37, 38, and 39 were work related items and appeared to be measuring care practices.

Table 29

The 34 Item and Four Factor Rotated Components Matrix

Item	1	2	3	4
Care				
1. I believe staff members should schedule meal times for elders.	-0.125	0.293	**0.673**	0.078
2. I believe an elder in a care setting should have a choice to select food items from a menu.	**0.643**	0.303	0.197	-0.175
3. I believe elders in a care setting should have a choice when and where they eat.	0.461	**0.498**	0.261	0.069
4. I believe shower times for elders in care settings should be scheduled based on staff workloads.	0.124	0.162	**0.736**	0.022
6. I believe an elder in a care setting should choose the days and times he or she showers or bathes.	**0.497**	0.139	0.466	-0.241
7. I believe it is more important to help an elder manage his or her agitation rather than administering a drug.	**0.559**	-0.033	0.117	0.268
8. I believe elders in care settings experiencing positive social interactions have decreased agitation.	**0.650**	0.064	0.040	0.084
9. I believe it is important to isolate an elder if he or she is being physically aggressive.	0.184	-0.112	**0.689**	-0.079

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Table 29 – Continued

11. I believe the physical environment of a care setting has little impact on elders' care experience outcomes; it is the care itself that matters.	0.032	**0.643**	0.186	0.009
Communication				
12. I believe in getting my work finished before I initiate conversations with elders in the care setting.	0.173	0.168	**0.734**	0.113
13. I believe in asking elders about their preferences in the care I provide.	**0.620**	0.393	0.183	.272
16. I believe that conversation with elders is not essential in order to complete my job duties.	0.410	**0.495**	0.336	0.193
Culture & Community				
18. I believe knowing an elder's life story adds value to the care I provide.	0.156	**0.742**	0.205	0.168
19. I believe time spent with an elder's family member is not essential to learn about an elders.	0.498	**0.575**	0.284	-0.004
20. I believe it is important to incorporate an elder's life story into care, conversation, meals, and activities.	0.379	**0.801**	0.017	-0.055
21. I believe an elder in a care setting should bring items from his or her home.	0.435	**0.540**	0.091	0.184
22. I believe all elders' rooms in a care setting should be arranged uniformly for consistency.	0.271	**0.449**	0.349	-0.122
23. I believe an elder in a care setting should have access to activity programs that are individually suited to their preferences.	**0.756**	0.333	0.040	0.048
24. I believe activities should be designed with an elder's past life story and past occupation(s) in mind.	0.374	**0.632**	-0.065	-0.089
25. I believe an elder in a care setting can choose if he or she wants to stay awake all night or "sleep-in" in the morning.	**0.630**	0.340	0.183	0.256

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Table 29 – Continued

26. I believe involvement of the community is not important to an elder's quality of life in a care setting.	0.474	**0.648**	0.183	-0.073
27. I believe creativity should be encouraged in interactions and activities with elders.	**0.713**	0.406	0.020	0.009
29. I believe an elder in a care setting should have input on what type of activities are implemented.	**0.700**	0.160	0.106	0.058
Climate				
31. I believe I am flexible in my daily routines.	0.268	-0.119	0.337	**0.563**
32. I believe I am properly trained to meet the needs of a diverse elderly population.	0.492	0.030	0.191	**0.575**
34. I believe in learning new techniques and strategies to improve my relationship with elders in a care setting	**0.657**	0.451	0.095	0.207
35. I believe it is important to follow ethical guidelines when interacting with elders in a care setting.	**0.595**	0.454	0.025	0.226
36. I believe it is important to work fast in order to finish my daily work responsibilities.	0.066	0.163	**0.525**	-0.053
37. I believe my attitude towards work affects the care given to the elders.	**0.744**	0.297	0.151	0.047
38. I believe in increasing the independence of the elders.	**0.596**	0.478	0.165	0.247
39. I work with a team to provide top quality care to elders.	**0.650**	0.155	-0.133	0.407
40. I feel overwhelmed with my workload.	0.090	-0.060	-0.136	**0.615**
41. I feel my daily routine in this care setting is repetitive.	-0.146	0.340	0.387	**0.544**
42. I feel valued as an employee at this care setting.	0.136	0.145	-0.286	0.593

Note. Rotation Method: Varimax with Kaiser Normalization; Rotation Converged in 9 Iterations

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Component 2 contained items 3, 11, 16, 18, 19, 20, 21, 22, 26. This cluster of items suggested that fostering social interactions and community were being measured. Component 3 contained items 1, 4, 9, 12, and 36. Component 3 appeared to be measuring the work culture whereas Component 4 contained items 31, 32, 40, 41, and 42, which appeared to be measuring work climate.

Reliability statistics. The internal consistency—the extent to which individual items on an instrument measure the same trait—of the Per-CCat was examined through Cronbach's alpha. Cronbach's alpha, also known as coefficient alpha, is interpreted similarly to other reliability coefficients (Polit & Beck, 2008). The value of Cronbach's alpha is between 0.00 and 1.00 with a higher value reflecting a higher internal consistency. A coefficient alpha of 0.70 or greater is desirable. Table 30 displays Cronbach's alpha for the 34 items remaining in the analysis (n = 73 surveys). The coefficient was 0.926 suggesting that the items in the Per-CCat were reliable.

Table 30

Cronbach's Alpha: Internal Consistency

Reliability Statistics		
Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.926	.940	34

Split-half reliability, another means of establishing internal consistency was also calculated. The split-half statistic takes the scores from one half of the survey and correlates them with the scores on the other half of the survey. A high correlation (> 0.70) between the two halves suggests that the instrument is measuring the same trait. Cronbach's alpha statistics suggested that the Perc-CCat had good split-half reliability: 0.882 for the first 17 items and 0.870 for the next 17 items with the correlation between forms equaling 0.741 (n = 73 surveys). Other coefficients were

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calculated as the default in SPSS 21 and they too demonstrate that the Per-CCat 34 item questionnaire was measuring the same trait (see Table 31).

Table 31

Split-half Reliability

<table>
<tr><td rowspan="5">Cronbach's Alpha</td><td rowspan="2">Part 1</td><td>Value</td><td>0.882</td></tr>
<tr><td>N of Items</td><td>17[a]</td></tr>
<tr><td rowspan="2">Part 2</td><td>Value</td><td>0.870</td></tr>
<tr><td>N of Items</td><td>17[b]</td></tr>
<tr><td colspan="2">Total N of Items</td><td>34</td></tr>
<tr><td colspan="3">Correlation Between Forms</td><td>0.741</td></tr>
<tr><td rowspan="2">Spearman-Brown Coefficient</td><td colspan="2">Equal Length</td><td>0.851</td></tr>
<tr><td colspan="2">Unequal Length</td><td>0.851</td></tr>
<tr><td colspan="3">Guttman Split-half Coefficient</td><td>0.845</td></tr>
</table>

Cronbach's alpha was also calculated to explore the internal consistency of the four component subscales. The Cronbach's alphas for components 1 through 3 were within the acceptable range: Component 1 = 0.923; Component 2 = 0.873; and Component 3 = 0.722. Component 4's alpha score was low at 0.596. Table 32 contains a summary of the component and its coefficient alpha. It may be concluded that each of the first three components (or subscales) were consistently measuring separate constructs according to PCC principles.

Table 32

Cronbach's Alpha for Components 1 through 4 for 34 Items

Component	**Sample N**	**Item N**	**Cronbach's Alpha**
1	79	14	.923
2	81	10	.873
3	82	05	.722
4	76	05	.596

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Summary

The results of the exploratory factor analysis suggested that the Per-CCat was measuring a general construct: Person-centered care. Cronbach's alpha results supported the internal consistency of the instrument as well. However, there was overlap among items on components which may be a result of questions not being understood, not applying to an individual, or the small sample size. Clearly, more analyses using a larger sample will be necessary to confirm the present analysis.

Conclusion

In this chapter the results of the qualitative study, stakeholders' attitudes toward Green House, and the quantitative study, the Per-CCat Validation Study, were presented. The qualitative study results suggest that stakeholders are adjusting to Green House living. The environment is brighter and offers more privacy. Because of the environmental changes and because the Green House homes feel like a home, family members enjoy visiting their loved ones. Staff members work in teams and have greater control over their schedule. *Shahbazim* have shifted their mindset from getting work finished in order to fulfill a task list to working for the good of the house. Residents and staff members perceived an increase in the number of visitors and improvements in mobility, meaningful work, eating, and socializing.

Some stakeholders expressed dissatisfaction with the Green House model of care. Three residents felt cut off from the main campus and moved back; some family members were confused by the informality of the Green House model and worried that their loved-ones may not be receiving adequate care; some staff members missed the predictability of OL and wished they could "just be a CNA".

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During the first few months following the move, all stakeholders perceived that staff members were overwhelmed by their new roles. Nevertheless, *Shahbazim* were supportive of Green House ideals and wished for the success of this care model at VMRC. Residents and family members were pleased, overall, with the Green House model of care.

The quantitative research study, through Principal Components Analysis, demonstrated that the Per-CCat possessed adequate psychometric properties as evidenced by communalities above .4 and eigenvalues and extracted sums of squared loadings close to .57. Cronbach's alpha results also suggested that the Per-CCat possessed internal consistency and split-half reliability. In addition, scores on the Per-CCat demonstrated that staff members at both OL and WP possess person-centered care beliefs.

In the following chapter the results of both research studies will be discussed along with the interpretation of the Principal Components Analysis. The themes, theoretical model, and theoretical links to the data that were developed through the use of grounded theory and the constant comparative method will also be discussed, and the implications, limitations, and future research direction for each study will be detailed.

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Chapter 5: Discussion

In this chapter, the findings from the qualitative and quantitative studies are presented. As with the previous chapters, this chapter is divided into two sections. The qualitative study is presented first and includes an explanation of the theoretical findings, the challenges, limitations, and future research questions. The second section focuses on the findings of the quantitative analysis of the Person-Centered Care Attitude Tool and includes a discussion of the final model from the Principal Components Analysis, challenges, limitation, and future research questions. This chapter ends with a summary of both studies and implications for future research.

Qualitative Study

This qualitative research study examined stakeholders' perceptions and expectations about and attitudes toward the Green House model of care one month and three months post-move from a traditional nursing home setting. A mixed method of focus group and interviews were conducted using a grounded theory approach to data analysis to better understand residents', family members', and staff members' lived experience of the phenomenon of Green House.

Discussion of findings by stakeholder cohort.

Residents. During the pre-move focus groups, the majority of participants were male. However, this trend did not continue during the follow-up focus groups: the majority of participants were female. From researcher observation, it appeared that the majority of residents

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residing at Woodland Park were female. It is not clear why the pre-move focus group had an over-representation of men. It may have been that these men on this day were able to and had the interest to participate.

During the pre-move focus group, residents defined Green House care using Green House vocabulary, described their new homes, and identified the building into which they were moving. Pre-move education and periodic meetings with the residents were effective in preparing them for the move. Overall, the residents were satisfied with the GH homes; they enjoyed their own bedrooms, hot meals, community dining, and their closeness to nature. Some believed that they had traded the conveniences of Oak Lea (such as Main Street, auditorium, and the chapel) for a more pleasant living environment. For three residents, the trade-off was not acceptable, and by the three-month follow-up they had returned to OL. Transportation issues, such as inadequate vehicles (type of vehicle) and scheduled operating times, had been a barrier to participating in activities at OL. By the three-month follow-up, transportation problems had been corrected.

Fostering resident independence and autonomy and providing opportunities for residents to engage in meaningful work are goals of GH living. In keeping with GH philosophy, *Shahbazim* encouraged residents to act independently by requesting them to do more for themselves (e.g., brushing their own teeth) and by allowing residents to help around the house (e.g., setting and clearing the table, making cake batter).

In the present study, staffing levels were a concern for residents at the pre-move and one-month follow-up focus groups; however, by the three-month follow-up, staffing issues were not mentioned. Self-report and staff observation suggested that residents were attempting to do more for themselves, socializing more, eating and sleeping better, receiving more guests, and

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improving in mobility. In spite of the fact that three residents were not satisfied at Woodland Park, these outcomes are in keeping with other Green House and small house nursing home research studies (Hutchings, Wells, O'Brien, Wells, Alteen, & Cake, 2011; Kane, Lum, Cutler, Degenholtz, & Yu, 2007).

Family members. During the pre-move interviews, family members defined Green House and were hopeful that their loved ones would benefit from the environment. Expectations about living in the GH homes ranged from their loved ones having privacy to participating in cooking. The education sessions and planning meetings that were held prior to the move helped answer questions that family members might have had regarding the move. Family members knew in advance which staff were moving to Woodland Park and into which house their loved one would be moved.

A recurring theme at all three time points was a concern about staffing levels. At the one-month follow-up, the safety and well-being of loved ones was called into question after family members observed that their loved ones were not being supported when walking with a walker or were not getting adequate exercise. Along with these issues, policies and standards (institutional and governmental) were perceived as potential barriers to the *Shahbazims*' ability to efficiently perform their duties; this concern was present at both post-move time points. For example, because of their roles as housekeepers, *Shahbazim* had to be more aware of regulations regarding handling food, laundry, and cleaning—tasks they did not have to do while working in the traditional nursing home. Hutchings and colleagues (2011) reported similar findings: family members participating in their qualitative study expressed concern about the staff-to-resident ratio. In particular, family members thought that staff were being stretched too thin because of the addition of housekeeping tasks to their care task (Hutchings et al., 2011).

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There was a noteworthy change in the family members' confidence in staff. Pre-move, family expressed confidence in VMRC's choice of staff. By three months, some family members were disappointed with the staff members at Woodland Park. One family hired an aide to supplement the care their loved one received at WP, and another family said that the staff did not elicit a feeling of confidence. In the first case, it is not clear if additional help would have been required if the gentleman had remained at Oak Lea. It may be that his disease process would have required additional help regardless of the setting. In the second case, the gentleman had transferred into WP from another nursing home. The family may not have had the benefit of the education that others had received and therefore may have expected care similar to that found in a traditional nursing home. Nevertheless, no one mentioned removing their loved-one from the GH environment.

Staff members. Overall, *Shahbazim* believed that the Woodland Park environment was an improvement over the traditional LTC facility for most residents. The majority of *Shahbazim* were satisfied with working in the GH homes and would not want to return to a traditional LTC setting. This finding is not surprising: Doty and colleagues found that nurse aides who worked in culture change environments reported higher work satisfaction than those who did not (Doty, Koren, & Sturla, 2008).

Similar to Bowers and Nolet's (2011) findings, the *Shahbazim* at WP had difficulty with the concept of staff empowerment and a flattened hierarchy. In particular, some WP *Shahbazim* did not feel prepared to engage in (a) administrative roles, (b) conflict resolution, (c) collaboration to efficiently complete work tasks, (d) meal preparation, (e) housekeeping, or (f) planning activities. Some commented that they preferred working at Oak Lea or that they

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wished they could "just be a CNA". However, by the three-month follow-up, *Shahbazim* were beginning to feel more comfortable with their new roles.

Some *Shahbazim* noted that since moving to Woodland Park they have developed a collegial relationship with nursing staff—a difference from the hierarchical relationship that was present at Oak Lea. Woodland Park nurses were more open to sharing their knowledge, less likely to criticize, and more willing to collaborate. However, some *Shahbazim* believed that there was still a distinction between work roles; *Shahbazim* managed housekeeping and daily operations and nurses managed resident care. Similar results were reported by Bowers and Nolet (2014) who found that both an "integrated nursing model" (collegial approach) and a "parallel nursing model" (role specific approach) were being practiced in the GH homes they studied (p. S59).

Shahbazim enjoyed connecting with the residents and learning more about their lives. Taking residents to ball games and funerals was important to the *Shahbazim*. There was clearly a desire among the staff members to help residents live their lives as meaningfully as possible. This also contributed to the feeling that the work that they do is meaningful. Dilley and Geboy (2010) also found that nurse aides felt contentment with and pride in their work: "That their jobs were not only fun but also contributed to other people's happiness fostered a sense of pride and purpose in their work…" (p. 180).

Theoretical findings.

Themes emerged during each time point that were reflective of stakeholders' expectations about the move; their attitudes, feelings, and perceptions about the move; their knowledge of the Green House model of care; and their anticipation of the adjustment process. The overarching theoretical concepts that emerged as a result of the constant comparative

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method included Person-Environment Fit, Space Place, Thriving, and Personhood. Finally, self-efficacy beliefs were hypothesized to be underlying residents' and staff members' decision to move. Figure 4 provides an illustration of the conceptual model.

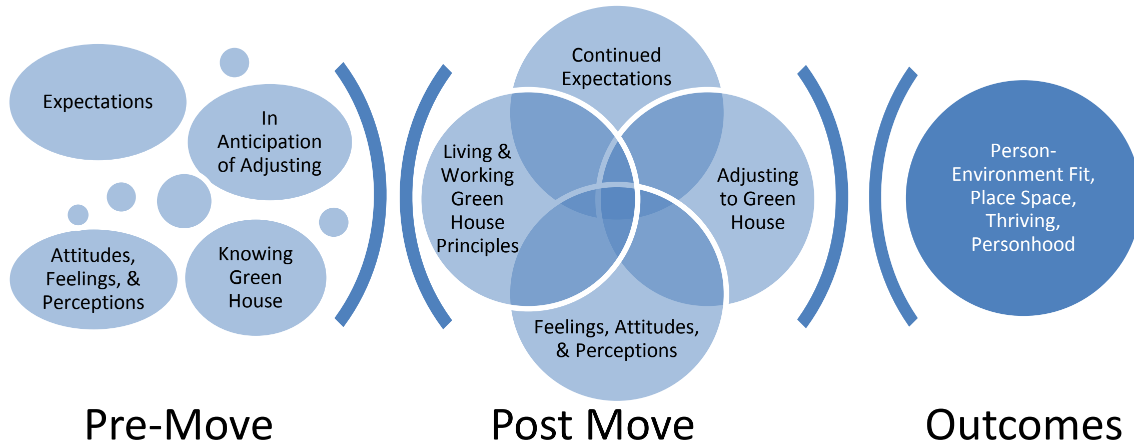

Figure 4

Conceptual Model

The creation of the underlying self-efficacy beliefs hypothesis was guided by the data and confirmed through the literature (Montano & Kasprzyk, 2008). The underlying beliefs are believed to have contributed to stakeholders' decisions to move, their attitudes, feelings, and perceptions of the move, and their ability to adjust to the move. These underlying beliefs are hypothesized to be: (1) autonomy beliefs (that one can exercise a choice to either move or stay; that the new environment will offer more independence and privacy for residents and family; and, for staff, that they will have more independence in their work life); (2) control beliefs (that one has the skills and endogenous resources to master the new environment); (3) memories (calling on past experiences to cope with the transition); and (4) normative beliefs (that families and staff members are supportive of the move and that the organization is supportive of the move). These self-efficacy beliefs are represented in the conceptual framework as the free-

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floating bubbles which appear during the pre-move stage. The post-move time point themes are similarly named to the pre-move labels but are reflective of the GH *lived* experience. The hypothesized factors are believed to remain influential during the post-move time points and distributed among the post-move themes. A review of the environmental gerontology literature was conducted to confirm the interpretation of the hypothesized constructs and factors. Two theories were identified that seemed most appropriate for this research: the ecology theory of aging and the behavioral model of elder migration.

The first of these theories, the ecology theory of aging (ETA) was first proposed by Nahemow and Lawton (1973) as a way to explain the fit between and elder and their environment. “A fundamental assumption of the ETA is that unique combinations of personal competence and environmental characteristics determine an individual’s optimal level of functioning” (Wahl, Iwarsson, & Oswald, 2012, p. 307). Also known as person-environment fit or person-environment congruence, the ETA suggests that the fit between the demands from the environment (environmental press) and an individual’s ability to perform in the environment contributes to aging well (Foos & Clark, 2008). Figure 5 illustrates the relationship between environmental press and behavioral outcomes. If the environmental press is beyond an elder’s competence, negative emotional and physical outcomes result (i.e., depression, frustration, and injury). Likewise, if the environment is too restrictive or accommodating, negative emotional outcomes result (i.e., depression, frustration, and boredom) (Foos & Clark, 2008; Lawton & Nahemow & Lawton, 1973). Ideally, the environmental press should be congruent with the individual’s physical capacity to cope with the environment (Nahemow & Lawton, 1973; Rowels & Bernard, 2013; Wahl et al., 2012).

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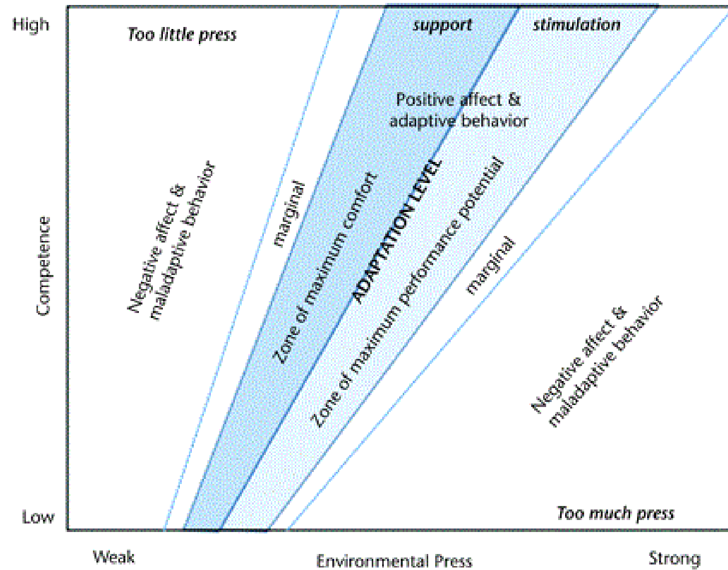

Figure 5

Person-Environment Fit

Note. Taken from: http:www.aginginplace.com/wp-content/uploads/2013/03/EP1.gif.

The Person-environment congruence model also considers social and psychological variables that contribute to an individual's ability to function optimally in their environment (Foos & Clark, 2008). Person-environment congruence is achieved if the an individual can perform tasks competently in their environment, feels as if they fit with the other people in their environment, if they have a positive feeling about the place, and if the elder has a sense of their identity in that place.

Over the life course, individuals change environments or make changes to an environment in order to create a balance between the environmental press and their physical, social, and emotional capabilities. Achieving this equilibrium requires both internal and external resources in the way of personal health, money, family and friends, and knowledge about what services are available and how to access them. These concepts are explored further through the behavioral model of elder migration.

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This second theory, the behavioral model of elder migration (BMEM), explains that there are endogenous and exogenous factors that contribute to aging well. Among the endogenous factors are personal resources such as health, income, and memories. Memories serve as a personal resource by recalling how previous moves or other family crises were coped with (Wiseman, 1980). Exogenous factors, such as the present housing market or the stock market, also affect an individual's ability to change their environment. For example, if the value of a home decreases, there is less money for an elder to use to move into a retirement community; or if rent increases, an elder might be forced to move to a lower rent apartment that is not in an area that is safe or has easy access to public transportation, shopping districts, friends, or family.

Wahl et al. (2012) suggested that "experience driven belonging" and "behavior driven agency" are important additions to the person-environment fit model (p. 308). Belonging is described as a reflection of an individual's sense of connectedness with other people and the environment (Kitwood, 1997; Wahl et al., 2012. Agency is defined as the proactive or intentional behavior of making choices about one's life (Hendricks & Russell Hatch, 2009). Including the constructs of belonging and agency with person-environment fit provides a more complete picture of the person-environment relationship. In this enhanced model, it is possible to explore place attachment and decision making along with environmental press, especially as these factors apply to the Green House model.

The Application of Theories and Factors to This Sample

In this section, the application of several theories to the research findings will be detailed. The ecological theory of aging (also called person-environment fit), space place, thriving, and personhood have been identified as constructs that explain stakeholders' perceptions about and interactions with the GH environment.

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Ecological theory of aging and person-environment fit.

For those residents who were capable of making their own choice about moving, their interpretation of, attitudes toward, and perceptions of the upcoming move may have been connected to their belief that they had control over the change—that they were a proactive participant in the decision making process rather than a passive participant. The proactivity hypothesis suggests that older adults look for or create new environments that meet their needs (Golant, 2003; Lawton, 1990). With the construction of Woodland Park, residents could exercise a choice about which environment suited them. By exercising their choice to move to an environment that was perceived to align with their needs, residents may have improved the likelihood that they would be satisfied with living at WP.

The person-environment relationship is characterized by an individual's ability to control how they use the environment (agency), and their ability to give meaning (belonging) to this space by creating a homelike place (Oswald & Wahl, 2013). *Shahbazim* believed that some residents could not adjust to the new environment because the environmental and emotional demands were greater than their personal coping resources. As a result, these individuals could not commit themselves to their Green House and create their belonging. Likewise, environmental press affected the *Shahbazim*. Through training, past experiences with change or personal challenges, and support from co-workers, many staff members were able to adjust and gain mastery of their environment while others felt the environmental press to be beyond their capabilities. Those who had problems adjusting wished to return to a more stable daily routine.

Space place.

Home is an environment in which the individual can express and reconstruct him or herself; it is integral in "facilitating self-realization in later life" (Bartlam, Bernard, Liddle,

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Scharf, & Sim, 2013, p. 256). Home imbues belonging and being in place. With each move, the individual must recreate a new way of being in place (Rowels & Bernard, 2013). Residents at WP made efforts to create belonging by bringing cherished mementos from home, participating in meaningful work such as setting the table, gardening, feeding the birds, and helping decorate for parties and holidays. Those residents who were able reached out to other residents to form friendships. These efforts helped to reinforce residents' relevance and belonging to the Woodland Park community. Many traditional nursing homes in the U.S. have adopted person-centered care and redesigned their interior spaces to evince a feeling of home (Doty, Koren, & Sturla, 2008), thus providing residents with an opportunity to create place.

There was observed evidence that residents were reconstructing their sense of self, sense of place, and personhood. Resident individuality was expressed through decorating their rooms with personal mementos and sharing their life stories. Residents were anxious to share the views from their windows and to talk about the artwork hanging in their rooms. A connection between two residents was made during the focus group when one shared that she was from Texas. To this, another participant responded that his children and grandchildren live in Texas. This exchange, which went on for several minutes, ended in an invitation from one resident to another to come into his room to look at the flowers and animals outside his window.

Most residents keep their personal belongings inside their rooms; although, in one house, a resident pushed her personal boundary to include a few feet of space outside her door. There she had placed two decorative geese that she dressed according to the season and the holiday. No one seemed to mind the intrusion into common space, and indeed looked forward to seeing how the geese were going to be dressed on any given day. Bartlam and colleagues (2013) suggested that it is not unusual for individuals to personalize their space, and to press their

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personal boundaries out a little further. Residents living in a retirement community in England created personal gardens on a common lawn outside their doors in an attempt to stretch their boundaries (Bartlam et al., 2013).

Thriving.

During the pre-move interviews with family members, the word "thrive" was introduced by the daughter of one of the female residents making the move to Woodland Park. While no other family members used the word "thrive", they all described characteristics of psychological and physical thriving when explaining what they hoped for from the move to Green House. Family members wanted their loved-ones to be more physically active and social (within their ability), to make choices about food, bathing, and resting, and to be better cared for. Bergland and Kirkevold (2001) suggested that thriving is an elder's experience of well-being. Thriving for a frail elder living in a nursing home will look different from that of an independent active older adult of the same age. Thriving should take into account the progressive loss of physical function in nursing home residents without assuming that the individual has no satisfaction with his life. The focus should be on fostering a sense of well-being and creating new roles in the face of physical declines. Therefore failure to thrive and thriving should not be viewed on a continuum. "Thriving is therefore related to an attitude of making the best of the situation, taking part in activities and social relationships according to their capacity and wishes" (Bergland & Kirkevold, 2001, p. 431).

By the time of the one-month follow-up, there were residents who were thriving in the GH environment which was evidenced through their self-report of helping around the house, enjoying the views from the windows, having hot meals, liking and participating in activities, making friends, and saying that they liked living in the Green House. Engaging in activities that

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are meaningful to an individual contributes to their psychological and physical well-being (Persson, Erlandsson, Eklun, & Iwarsson, 2001). By contrast, there were three residents who missed the easy access to programs (concerts, church, and lectures) and the hustle and bustle (visitors and staff members coming and going) at Oak Lea and were not thriving in the GH environment. These residents chose to move back to OL, an environment that was congruent with their emotional and physical needs.

Thriving can also be extended to the Woodland Park staff members. At the beginning of their tenure at WP, many staff members felt overwhelmed by their new role and responsibilities. Indeed, most commented during the pre-move focus groups that they were both anxious and excited about working in the GH homes. However, by the three-month follow-up, the majority of staff members were pleased with their working environment and could be said to be thriving in their new roles. Not everyone felt this way though: a minority said that WP was chaotic and that they preferred the predictability of OL.

Personhood.

An important goal of the GH philosophy of care is to provide a warm, caring, homelike environment for elders who are unable to live independently and who require skilled care. Implicit to this model is the preservation of the individual's personhood. Through WP's houses and setting, the commitment of staff to their residents, the love and support of family, VMRC's commitment to person-centered care, efforts among staff to learn about the residents' past life and families, providing opportunities for residents to be creative and be in nature, the GH homes at VMRC have honored and fostered the personhood of their residents.

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Implications

Building a community based research relationships.

From this community based research, many lessons were learned that are worth noting. First, it is essential for the researcher and organization gatekeepers to develop a strong working relationship defined by open communication regarding the research purpose and methodology. For instance, VCU Department of Gerontology researchers met with and talked on the phone regularly with VMRC administration to clarify research objectives and implementation strategies. Since the researcher did not have intimate knowledge of stakeholders' schedules, scheduling focus groups was placed in the hands of an administrator at VMRC. This approach helped increase participation, but may have introduced bias. When designing community based research, it is important to consider ways to reduce the bias that may be inadvertently introduced through the administration's involvement.

Stakeholder education.

Education about the GH environment and care philosophy prior to the move was helpful for this sample. Because of the steady stream of information from the VMRC administration about Green House, stakeholders had a good grasp of the care philosophy and how the transition would be organized. However, *Shahbazim* mentioned during the focus groups that they would have benefited from visiting other GH homes prior to the move so they could observe the GH care philosophy in action. This opportunity was given to VMRC administrators, but not extended to the CNAs who were making the transfer. The CNAs exclusion from the visit placed them at a knowledge base disadvantage which may have contributed to their reported state of feeling overwhelmed. Organizational change researchers suggest that change efforts are most successful when stakeholders, from the top down, are included in all aspects of the

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organizational change (Schein, 1980; Schein, 2010; Shortell, Gillies, & Wu, 2010; Slocombe, 2003; Sterns, Miller, & Allen, 2010; Burke, 2011). It is not clear to what extent the VMRC CNAs were involved in the Green House planning meetings. Perhaps being active participants in the Green House planning would have eased their transition into that work environment.

Prior to the move to Woodland Park, VMRC *Shahbazim* would have benefited from visiting an existing Green House and engaging in experiential learning exercises. Kemeny, Boettcher, DeShon, and Stevens (2006) found that care staff who participated in person-centered care experiential learning sessions made efforts to practice person-centered care, used PCC techniques to make their jobs easier, felt comfortable using PCC techniques, and felt more prepared to use PCC techniques in their jobs. These behaviors and attitudes remained constant at the two-month post-training follow-up (Kemeny et al., 2006). Green House training that includes experiential learning opportunities is recommended for staff members making a transition from standard nursing home care to small house nursing home environments to enhance their understanding of person-centered care, increase adherence to GH principals, and improve their self-confidence.

It was also noted by staff and family members that the education videos produced by the Green House Project were not representative of the type of resident moving to Woodland Park. The training videos showed elders who were more physically active and less cognitively challenged than the residents moving to WP. For this reason, staff members felt somewhat misled and family members worried about the ability of their loved ones to adjust to what appeared to them as a more demanding environment than Oak Lea. A Green House Project video representing elders with a higher level of acuity interacting with the environment would be an excellent addition to the already existing educational materials. In addition, and especially for

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those nursing home's considering GH homes, moving elders with lower acuity into GH homes first may facilitate the *Shahbazim's* adjustment to their new roles and work environment. After the *Shahbazim* have become accustomed to their roles, residents with higher acuity could be moved in as space becomes available.

In spite of training sessions prior to the move, staff members felt ill prepared for their roles. While the training was effective in providing education about the purpose and philosophy of Green House, there was little to no training provided for conflict resolution, time management and organization, electronic record keeping, and activity preparation. Bowers and Nolet (2011) reported similar outcomes in their GH research. Other researchers have reported that long-term care nursing staff (RNs, CNAs, and LPNs) feel unprepared to care for elders living with complex co-morbidities that often include dementia (Bourbonnier & Strumpf, 2008; Lerner, Resnick, Galik, & Gunther Russ, 2010). Inadequate training in dementia care contributes to psychological stress, burnout, and turnover (Stone & Wiener, 2001; Yeatts, Cready, Swan, & Shen, 2010). Dementia care training programs have been shown to increase job satisfaction (Coogle, Head, & Parham, 2006). Indeed, CNAs perceptions that training opportunities were always available to them held positive attitudes about their jobs and themselves (Yeatts et al., 2010).

Policy.

At a national level, the nursing home industry increasingly places paraprofessionals in positions of responsibility without the benefit of adequate training. This trend is due, in part, to an industry wide shortage of geriatrics trained professionals (nurses and nurse practitioners) and paraprofessionals such as CNAs and LPNs (Institutes of Medicine, IOM, 2008). There is a threefold problem facing the LTC industry: (1) an aging population living longer with chronic and often complex health issues; (2) a lack of interest in geriatrics and gerontology among

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student’s entering the health care field (Koren et al., 2008; Plonczynski, Ehrlich-Jones, Robertson, Rossetti, Munroe, Koren et al., 2007); and (3) for those paraprofessionals working in the industry, inadequate training (IOM, 2008; Stone & Wiener, 2001). Formal CNA training and continuing education should include skills training in team leadership and task managing practices. Policy at both the federal and state levels is needed to catalyze changes in in these care professional groups. Finally, efforts should be made to encourage students and new members of the workforce to consider gerontology and geriatrics as a career path.

As more nursing home organizations adopt person-centered care (as mandated by CMS), nursing and administrative personnel will need to be familiar with PCC philosophies. Thus it will be important to introduce curricula during the formal stages of nurse aide, nursing, and nursing home administration training. In addition, caregivers (i.e., CNAs, RNs, and LPNs) would benefit from exposure to small house nursing homes, traditional nursing homes, and PCC practices during their formal instruction. This type of curricula expansion will provide a foundation upon which students can make an informed decision about the work setting they would prefer. However, such a plan would require that nursing curricula include education about person-centered care, culture change, and culture change models.

Conclusion.

Finally, as this study suggested, the small house nursing home environment was perfect for some but not for others. Some residents and staff members missed the routine and the perceived safety of Oak Lea, the standard nursing home. Indeed, some staff members did not think that the extra pay was commensurate with the increased responsibilities. In addition, some family members were confused, disappointed, and worried when the care at Woodland Park did not resemble their expectations: that of a traditional nursing home. Moreover, some nursing

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home staff struggled with the idea that a person living with dementia could thrive in LTC and derive satisfaction from the environment.

Educating consumers about culture change and related philosophies of care (e.g., Eden Alternative, Green House, Wellspring, etc.) and outcomes may help consumers make educated decisions about the type of environment that is best for themselves or loved ones in the event that long-term care is needed. Hospital networks, the medical home (primary care physicians and/or geriatric practitioners), local nursing homes, and lifelong learning programs are ideal settings for disseminating education about philosophies of long-term care.

Challenges

This community based research project provided the researcher with a unique opportunity to learn about stakeholders' perceptions of their lived experiences through interviews and focus groups. While the collected qualitative data proved to be quite rich, there were a number of challenges to collecting it.

Fist, this research was a collaborative effort between VCU and VMRC. A good working relationship was fostered, and therefore most data collection efforts were completed easily. Nevertheless, VMRC controlled what data the researcher could collect, when, and how it could be collected. For instance, VCU depended upon VMRC to provide BIMS scores; however, VMRC did not know how to access them, which resulted in missing data. Data were also collected at the organization's convenience, which resulted in a deviation from the research timeline. The lack of a cognitive marker to assess resident's appropriateness for the focus groups and delays in data collection were deviations from the original research design and introduced bias.

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Another challenge included hearing loss and/or poor eyesight among the residents; many were confused and lethargic or sleepy. These disabilities made it difficult to communicate with the residents. At the pre-move focus group, several residents required help completing their demographic questionnaires. Nevertheless, there were four residents who enthusiastically participated. Although scheduled for two hours, the focus group lasted only one hour due to participant fatigue. In fact, all subsequent resident follow-up focus groups and interview sessions were stopped at one hour or earlier depending upon the elders' attention span and level of fatigue.

The family member pre-move focus group was poorly attended in spite of reminder phone calls; only one family member attended. The other family members were reached through telephone calls. This is a deviation from the research protocol, but could not be helped. Because the pre-move focus groups were planned for the middle of December, having the groups scheduled so close to the holidays may have prevented family members from coming. There may also have been miscommunication between the administrator and the residents. When family members were contacted via phone calls, they consented to participate and provided rich information.

Working around staff members' work schedules proved challenging as well. Staff members did not attend scheduled focus groups at the one-month follow-up. Staff focus groups were then held later in April and were very well attended. Because of the delay, recall of events and staff members' feelings surrounding the move may have been faulty. Psychological research outcomes have demonstrated that recall of events becomes less accurate the further away in time one moves from the event (Gazzaniga & Heatherton, 2006).

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It is not clear why staff members did not attend the one-month follow-up focus groups. It was surmised that staff members felt overwhelmed by their new duties and could not fit another task into their schedule. The location of the meeting may have also been a barrier to attending: staff members were required to leave their Green House and walk to another building either at the end or the beginning of their shift. There also may not have been adequate staff to cover the end or beginning of the shift. This problem was rectified by holding future focus groups in the staffs' respective Green House. In addition, the administrator at VMRC scheduled additional staff to cover for those who were in the focus group.

Ambient noise and interruptions sometimes made it difficult to hear one another. At times, background noise dominated the tape recordings as well. Researcher error also contributed to lost recorded data (2 interviews). Fortunately, memos and other notes helped fill in when the tape was inaudible. In spite of these difficulties, much of the focus group conversations were recorded and were interpretable.

Resident follow-up focus groups were well attended in one Green House, but not well attended in the other two. Attendance may have been prohibited by the time of day, conflicts with other activities, lack of interest, or a decline in ability to participate.

All of these challenges posed threats to the trustworthiness of the data and will be discussed further. For the reader's convenience, the tables from Chapter 4 referencing trustworthiness criteria and the strategies to reduce the threats to credibility have been reproduced below.

Trustworthiness of the Findings

In qualitative research, threats to validity are referred to as threats to trustworthiness. In this section, the trustworthiness of the research findings will be detailed. Trustworthiness criteria

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include: credibility, dependability, confirmability, transferability, and authenticity (see Table 33). Threats to trustworthiness include: temporal ambiguity, self-selection, treatment fidelity, history, maturation, and attrition (see Table 34).

Table 33

Trustworthiness Criteria, Parallel Terms, and Associated Research Methods

<table>
<tr><th>Trustworthiness Criteria</th><th rowspan="2">Definition</th><th rowspan="2">Research Method to Address Criteria</th></tr>
<tr><th>Parallel Quantitative Term</th></tr>
<tr><td>Credibility</td><td>Measures how faithful the researcher was to the description of the phenomenon (Beck, 1993); refers to the believability of the research findings and demonstrating the credibility of the research to readers/evaluators (Polit and Beck, 2008).</td><td rowspan="2">• Use of grounded theory, a well established research method.
• Ongoing relationship with VMRC.
• Constant comparative method
• Triangulation
• Field notes
• Tape recordings
• Transcriptions
• Memoing
• Debriefing with supervisor
• Negative case analysis
• Peer review

(Shenton, 2004; Tuckett, 2005)</td></tr>
<tr><td>Internal Validity</td><td>The extent to which it can be concluded that the independent variable rather than moderating or control variables "caused" the observed change (Polit & Beck, 2008).</td></tr>
<tr><td>Dependability/ Auditability</td><td>Refers to the stability of the findings over time and conditions. In other words, will the same results be found when using the same or similar subjects in the same or similar conditions

(Polit & Beck, 2008).</td><td rowspan="2">• Scripted questions for the focus groups.
• Audit trail (field notes, transcripts, memoing journals to include thoughts about emerging theories)
• In depth description of the procedures.</td></tr>
<tr><td>Reliability</td><td>Similar to dependability in that the aim is to achieve the same results when study methods have been repeated exactly as the original study.</td></tr>
<tr><td>Confirmability</td><td>Refers to the extent to which the data reflect the experiences and opinions of the subject and not the preferences of the researcher (Shenton, 2004; Polit & Beck, 2008).</td><td rowspan="2">• Member checking
• Triangulation
• Bracketing
• Theoretical audit trail</td></tr>
<tr><td>Objectivity</td><td>The extent to which two researchers would draw the same conclusion concerning the data (Polit & Beck, 2008)</td></tr>
</table>

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Table 33 – Continued

Transferability/ Fittingness	Refers specifically to how detailed a description of the research procedures was provided so that a generalization of the findings can be applied to a similar population at a different site (Polit and Beck, 2008).	• Literature review—"Thick" description of the populations under study • Detailed description of the research procedures as they occur in the field.
External Validity	The extent to which the results of the study can be generalized to populations other than the one studied (Beck, 1993; Polit and Beck, 2008).	
Authenticity	A distinctly qualitative criteria, authenticity refers to the extent to which the reader is drawn into the world of the people being described. The aim is to invoke in the reader a sense of the mood or the experience of the individual (Polit & Beck, 2008).	• Tape recordings • Field notes • Transcriptions • Peer review
No counterpart in quantitative research.		

Table 34

Strategies for Reducing the Threats to Credibility

Threat	Explanation	Strategy
Temporal Ambiguity	Allows the researcher to infer the relationship between the cause and the effect of an intervention. The cause must precede the effect.	Interviews were scheduled to precede the move to Green House and then scheduled to be conducted again after the move to Green House. Thus the following design: O X O O
Self-Selection	Refers to the threat that the groups may not be equivalent if they have not been randomly assigned to intervention or control. The assumption is that bias is introduced by pre-existing differences in the groups.	It is not possible, nor is it ethical, to randomly assign individuals to live in or work in a new environment. Nor is it ethical to force or coerce individuals to move or to participate in research. Thus, those who chose to make a change were contacted to participate in the study. They were also given the opportunity to decline. The assumption is that those who agreed to participate are similar in terms of demographic characteristics such as age, education, occupation, etc.

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Table 34 – Continued

Threat	Explanation	Strategy
Treatment Fidelity	Refers to the extent to which the treatment or the intervention was implemented accurately over the course of the research study.	The Green House program has very specific protocols for the physical environment and for basic care practices.
History	Refers to events that happen over the course of the research study which may influence the outcomes of the study. In other words, it is not clear if the independent variable had an effect upon the dependent variables or if it was the historical event that influenced the outcome.	Not likely to be a factor in this study.
Maturation	Refers to the passage of time and the changes that individuals experience due to the passage of time (fatigue, emotional development) rather than the effects of the intervention.	This cannot be controlled for, but were noted. This is an aging and ill population so there may be some decline that will influence feelings about Green House.
Mortality/Attrition	Refers to participants dropping out of the research study due to death, illness, lack of interest, etc. This becomes problematic if there are comparison groups; one group may be over-represented than another or groups may no longer be equivalent.	Given the age of the participants, it is likely that some could have become too ill to participate or could have died. Because the study was not designed to have the same group of people at each time point, attrition is less of a problem. Additionally, time points are not at great distances from one another, so it was possible that some residence were able to participate at all three time points.

The faithfulness to which grounded theory methodologies were adhered was a strength of this qualitative research. In qualitative analysis terms this is called credibility: the parallel term in quantitative research being internal validity. Internal validity in the strictest sense does not apply to this study because there was not an intentionally created (by the researcher) or manipulated independent variable (IV), nor were any dependent variables (DV) identified. However, building and subsequently moving staff and residents into the GH homes was a naturalistic experiment with respect to the effects (perceptions) which were being observed and

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recorded. The research methods used to secure the credibility of this research were the use of grounded theory, the constant comparative method of data analysis, and remaining in close contact with VMRC.

Another trustworthiness criterion is confirmability. Comfirmability is the extent to which the data reflect the thoughts and feelings of the participants and not the researcher. The parallel quantitative term, objectivity, is the extent to which two researchers draw the same conclusion concerning the data. Through the use of bracketing (acknowledging and recording the researcher's opinion about the subject being studied; for example, the researcher had to acknowledge her preference for small house nursing homes), theoretical audit trail, and peer review, the confirmability and objectivity of the data were established.

The fourth trustworthiness criterion is transferability or external validity (qualitative and quantitative terms respectively). Both terms refer to the extent to which the results can be generalized to populations other than the one studied. The findings of this research study may not be transferable to other nursing homes across the U.S.: 0nly one nursing home located in Harrisonburg, Virginia, a predominantly Caucasian (85%), non-Hispanic (7% African-American) community was studied (US Census Bureau). The facility was non-profit and religiously affiliated. In addition, the residents were Caucasian (100%) and middle to upper-middle class. Staff members were also predominantly Caucasian (60%) and non-Hispanic (20% African-American; 20% Asian). The small sample size at the resident focus groups may also reduce transferability because the data represent the perceptions of a few residents. Perceptions of GH living may look different in another region of the country with a different socio-economic class or racial/ethnic distribution. This is an acknowledged threat to the transferability criterion. Until the study is reproduced, the dependability of this study cannot be addressed.

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The final trustworthiness criterion, authenticity, has no counterpart in quantitative research. Authenticity refers to the degree to which the reader is drawn into the world of the research sample. As Polit and Beck explain, the aim is to invoke in the reader a sense of the mood or the experience of the individual (2008). Through the use of tape recordings, field notes, transcriptions, and peer review, every attempt was made to remain faithful to the tone and spirit with which the stakeholders' recounted their stories. Transcripts and code books were peer reviewed and no comments were made about the veracity of the content or the tone in which the data were reported.

There are acknowledged threats that weakened the credibility of the study. Refer back to table 34 for an explanation of the specific threat and the strategy first proposed to decrease the threats.

In an experimental design, trustworthiness is threatened by temporal ambiguity as it allows the researcher to infer a relationship between the cause and the effect of an intervention. In this research study, strategies to decrease temporal ambiguity through a pre-move/post-move design were planned. The focus groups occurred one month prior to the move to Woodland Park Green House homes and twice following the move. Thus, temporal ambiguity was mitigated.

Deviations from the original research schedule became necessary when family members did not attend scheduled focus groups. Because of budget and time constraints, pre-move family focus groups could not be rescheduled and data were collected over the phone (as discussed earlier). One-month post-move staff focus groups were not attended and were rescheduled for six week later, resulting in a good participation rate. However, the six week lag and scheduling issues pushed the three-month follow-up to three months later than the originally scheduled date. Due to scheduling changes, a maturation effect (such as fatigue, emotional changes, education,

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declining health) may have influenced stakeholders' perceptions of their GH experience and their willingness to participate in the focus groups. Scheduling changes also weaken the transferability of these results (refer back to Table 33).

Because self-selection bias is a concern in research studies conducted with human subjects, random assignment to the control or intervention groups is standard research procedure; it is performed to evenly distribute inherent differences among the groups. Nevertheless, those individuals who agree to participate in research are different from those who do not participate. In this research, an assumption was made that those stakeholders who chose to move to the WP Green House homes were inherently different from those who decided to remain at Oak Lea. It was also assumed that those stakeholders who agreed to move had similar demographic characteristics such as age, education, and occupation. The purpose of this research study was to learn about stakeholders' perceptions of GH living and working, not to assess the efficacy of the Green House model of care. Thus randomly selecting focus group participants was not undertaken.

It is also unknown how VMRC chose which OL neighborhood would be closed. Residents living in the closing neighborhood were given a choice to remain at OL but live in a different neighborhood or to move to one of the Woodland Park Green House homes. In this case, coercion is not a threat to validity. But, bias could have been inadvertently introduced by the administration if the neighborhood choice was not made randomly. It could be that the closing neighborhood's residents' acuity levels differed significantly from those residents living in the other neighborhoods.

A final concern is related to conducting the focus groups in the GH homes. While meeting in the GH homes was convenient for residents and staff (family members were met in a

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conference room on the main campus), participants may have felt as if they could not speak openly and honestly because members of the other group were within hearing distance. In addition, participants may have felt compelled to tell the researcher what they thought the researcher wanted to hear. There was no evidence on tape recordings or in field notes that a Hawthorn effect was taking place, but it is an acknowledged possibility that contributes to weakening the credibility of the data.

Future Research

Self-efficacy beliefs.

Throughout the analysis process, several questions arose that are worthy of further research. First, the self-efficacy beliefs (autonomy beliefs, control beliefs, memories, and normative beliefs) are supported by research conducted with elders who were making transitions from their personal home to a nursing home or with those who had made modifications to their home. More research should be conducted with elders who are making a transition from LTC to small house nursing homes to clarify the self-efficacy beliefs' role in the decision making process and in making the adjustment to a new environment. Examining the influence of personality characteristics on adjustment and decision making is a natural corollary to the aforementioned research.

Demographic focus.

The geographic location of this research study (Harrisonburg, VA), a predominantly white community, limits the generalizability of these findings. Future GH perceptions research should be conducted in other geographic locations, and include ethnically diverse populations.

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Personality.

Shahbazim implied that some individuals, residents and staff alike, may not have the personality traits necessary to thrive in the GH setting. Gazzaniga and Heatherton (2006) suggest that there are three levels of personality: dispositional traits (broad but stable dimensions of personality), personal concerns (developmental tasks and challenges), and life stories (memories, internal narratives). How do these three characteristics combine to influence coping strategies, decision making, and adjusting to new environments? Is personality an important variable when choosing who should work or live in a small house nursing home? What personality characteristics make someone a suitable candidate for working or living in a small house nursing home?

Elements of Green House.

The Green House Project has been studied for over a decade and has demonstrated improvements in residents' quality of life, quality of care, family satisfaction, and staff satisfaction. Perhaps the most striking element of Green House is its resemblance to a house or an apartment building. Regardless of the setting (urban, suburban, or rural), all GH homes have several physical features in common: the square footage of the home is on average between 6,400-7,000 square feet; an open-plan great room (hearth), a dining area with a single dining table and open kitchen; private bedrooms and baths; and an easily accessible and secure outdoor space (Zimmerman & Cohen, 2010). Comparisons of GH homes to traditional nursing home sites suggested that GH staff members had higher direct care time, increased engagement with elders, less stress, and improved care outcomes (based upon the number of acquired pressure ulcers in GH homes). Cost analysis comparisons between GH homes and culture change nursing homes showed that GH operating costs are at the median national level. In fact, capital costs are

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less than standard nursing homes because of lower square foot costs. Finally, the nursing model practiced in the Green House—removal of the formal nursing hierarchy—did not compromise the quality of care that residents received. In fact, *Shahbazim*, due to their familiarity with the residents, were able to respond quickly to changes in residents' health (Kane et al., 2007; Sharkey et al., 2008-2009; Jenkens et al., 2011; www.greenhouseproject.org).

Other GH researchers have also reported improvements in health status, mobility, and socialization, and later loss ADLs (Annunziato et al., 2007; Burack, Weiner & Reinhardt, 2012a; Burack et al., 2012b; Kane et al., 2007). A similar set of questions should be asked of the Woodland Park Green House model of care: (1) Do residents living in the WP Green House enjoy better health and quality of life than residents who are living at Oak Lea? (2) If there is a difference, what elements of the Green House model of care contribute to improvements or declines in health status? (3) What objective measures best capture the experiences and outcomes of elders living in Green House? (4) Do resident acuity levels affect their experience of the Green House? (5) Is the Green House model of care fluid enough to handle the changes in acuity that an elder will most likely experience? (4) Is there a difference in satisfaction and thriving between traditional nursing home residents and GH residents? (5) How might other personality characteristics, such as resilience associated with individual adaptation to change (Wagnild, 2003), contribute to elder's satisfaction with and ability to thrive in Green House?

Acuity of residents.

In this research study, residents with varying degrees of disability moved to the Woodland Park Green House. The level of acuity was not revealed to the researcher; however, *Shahbazim* commented that their new roles coupled with residents' high acuity contributed to feeling overwhelmed. Future research should include examining Green House Project sites that

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have entrance criteria based upon acuity levels. This would enable comparisons of outcome variables across sites and between sites. Using acuity criteria, the following question could be asked: Does acuity level affect an elder's ability to adjust to the GH setting? How do resident quality outcomes differ between high and low acuity sites? Do resident acuity levels affect staff members' adjustment to the GH setting?

The meaning of home.

Researchers in the field of environmental gerontology have studied the meaning of home for elders through research on changing places (relocation to a more suitable environment) and changing spaces in order to age in place (making adjustments to one's home). Cutchin (2013) suggests that individuals build relationships with their environment. For elders (indeed, all of us) "environments are holistic, dynamic, and meaningful entities with histories and evolutionary trajectories with which we have intimate relationships—and on which we depend" (Cutchin, 2013, p. 110). Moving into a new place requires that a new relationship between the elder and environment be forged. After the boxes are unpacked and objects that symbolize a life are placed, elders, their family, and caregivers must work at place-making. "Such place-making transforms a generic space into a place that has meaning for the older person and develops the 'hearth' aspects of home" (Cutchin, 2013, p. 110): imbuing a place with meaning makes it a home.

Cutchin's work inspired research questions related to the elders living in Woodland Park. How do individuals living with dementia make a space their place? Do these elders view the Green House as their home? Indeed, do any of the residents, regardless of their cognitive abilities, feel as if they are at home? How long does it take for the Green House to feel like home (if ever)? What elements of the Green House model of care have contributed most to

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feeling at home? Conversely what elements of the Green House model of care have interfered with an elder's sense of home (Cutchin, 2013)? What new roles have elders created for themselves while living in Green House? Do GH residents identify themselves as residents of the home or as patients?

Staff expectancies.

Continued research into nursing home culture change, especially adoption of person-centered care, in different care settings is necessary to identify the expectations that staff members have regarding these culture change models. For example, the *Shahbazim* in this study experienced a discordance between what they expected of the work environment based upon a training video and didactic lectures and their lived GH experience. Have *Shahbazim* working in other GH settings experienced the same discordance? How can the Green House Project education programs be enhanced to bring staff members' expectations in line with the reality of working in a Green House?

Expectancy theory researchers suggest that motivation in health care settings is the end product of four internal factors: job outcomes (rewards or negative outcomes), valence (individual's feelings—whether positive, negative, or neutral—regarding job outcomes), instrumentality (the perceived link between performance and job outcomes), and expectancy (individual's perceptions of the link between effort and job outcomes). In this model, job outcomes contrast valence and instrumentality contrasts expectancy (Fottler, O'Connor, Gilmartin, & D'Aunno, 2006). This theory applies to culture change to the extent that without adequate education or communication about the impending changes (as described earlier), motivation among staff members may be lacking because the organization has not promoted the value of the change (e.g., Green House or person-centered care), the ways in which good

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performance will be rewarded (both intrinsically and extrinsically), or the link between effort and performance (both intrinsically and extrinsically).

The nursing home market.

Other important variables that are worth incorporating in future GH research include differences in staff members' salary and benefits between an organization's standard care nursing home, their GH homes, and the current job market. Knowing how the benefits differ between facilities may offer one explanation for the motivation of some staff members to move from one environment to the other. Having a sense for the LTC job market in the community where the research is being conducted may also contribute to understanding the motivation of staff members who remain in their present job or who move to another organization. For instance, a staff member who is unhappy working in the Green House may not have any other options because the local LTC market is saturated (the locale having numerous nursing homes, but all positions being filled) or it is too lean (few LTC facilities in the locale).

Green House fidelity and nursing models.

Finally, this study suggested that nurse-*Shahbazim* relationships as well as nursing models differed across houses. It is not clear if these differences affected the quality of care that residents received. It is also not clear if nursing model differences were a reflection of the "growing pains" that Woodland Park staff members were feeling as they adjusted to a new model of care. It would be useful to evaluate nursing models at different time points (implementation, one month, three months, six months, 12 months) to determine what nursing model predominates, if nursing models on a campus converge after time (so that eventually the nursing models are similar), and if the nursing model adheres to GH philosophy. Knowing the extent to which staff members are truly practicing the Green House model of care needs to be

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examined. In addition, having a clear Green House nursing model is necessary to truly evaluate the efficacy of the Green House model of care. Currently, there are no Green House nursing guidelines (Bowers and Nolet, 2014).

Quantitative Study: Person-Centered Care Attitude Tool Validation Study

In this section, the results of the exploratory factor analysis will be further explored; the strengths and weaknesses of the results will be discussed along with the challenges of conducting this study. This section will end with a discussion about the future directions of the Per-CCat research.

This study was designed as a non-experimental cross-sectional exploratory research study; the purpose of which was to explore the construct validity and internal consistency of the Person-Centered Care Attitude Tool (Per-CCat). To that end, exploratory factor analysis, specifically Principal Components Analysis was used to provide information about (a) the degree to which individual items contributed to a factor, and (b) which questions could be eliminated from the survey. Principal Components Analysis (PCA) was used as it provides a straight forward and simple factor solution that is easy to use and interpret (Tabachnick and Fidell, 2007).

Findings.

The results of the present study suggested that (a) the sample size was adequate to perform PCA as supported by a KMO of .801 and a BTS of .561, (b) the correlation matrix was not an identity matrix (thus the data were factorable), and (c) the Per-CCat possessed good psychometric properties. Construct validity was supported through factor loading values greater than .448; while moderate, .488 (and above) is still acceptable. The extracted sums of squares loadings suggested that the final four-factor model explained nearly 57% of the variance.

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Whereas the individual communalities (which are the sum of the squares loading—or R^2—for each item) represent the proportion of variance in that item which is explained by the four factors. The higher the communality value, the more in common that item has with the other variables; a low communality value indicates that the item has less in common with the other variables.

At this exploratory stage, it can be concluded that the Per-CCat measured what it was purported to measure, i.e., attitudes toward person-centered care. The stability and consistency of the Per-CCat was also supported through a Cronbach's alpha of .926. Split-half reliability values were also high (.882 and .870) which further supports the stability of the measurement. Some statisticians argue that alpha coefficients are not appropriate for ordinal data because they may underestimate the reliability among the items especially if assumptions are violated (Svensson, 2001; Yang & Green, 2011). The alpha coefficients for these data were quite high suggesting that individuals responded in like fashion for specific groupings of items. Therefore, there is little concern about the misuse of the coefficients.

The final round of the Principal Components Analysis (PCA) revealed that the Per-CCat contained four factors, which have been labeled: (a) Resident Autonomy (items 2 through 29) & Care Philosophy (items 34 through 39), (b) Social Interaction & Community (items 3 through 26), (c) Work Culture, (items 1 through 36), and (d) Feelings about Work, (items 31 through 42). A complete description of the revised questionnaire is displayed in Table 35. This table is organized according to the component (factor or subscale), the survey item, and the person-centered care principle (PCCP) to which the component items adhere. Person-centered care espouses the following: resident choice regarding daily routines, activities, and health care; a homelike environment; resident and staff enrichment through education (especially for staff

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Table 35

Revised Per-CCat: Component, Item, and Person-Centered Care Principle (PCCP)

Component	**Items** *I believe…*	**PCCP**
1	2. staff members should schedule meal times for elders. 6. an elder in a care setting should choose the days and times he or she showers or bathes. 7. it is more important to help an elder manage his or her agitation rather than administering a drug. 8. elders in care settings experiencing positive social interactions have decreased agitation. 13. in asking elders about their preferences in the care I provide 23. an elder in a care setting should have access to activity programs that are individually suited to their preferences. 25. an elder in a care setting can choose if he or she wants to stay awake all night or "sleep-in" in the morning. 27. creativity should be encouraged in interactions and activities with elders. 29. an elder in a care setting should have input on what type of activities are implemented.	Resident Autonomy
	18. knowing an elder's life story adds value to the care I provide. 34. in learning new techniques and strategies to improve my relationship with elders in a care setting. 35. it is important to follow ethical guidelines when interacting with elders in a care setting. 37. my attitude towards work affects the care given to the elders. 38. in increasing the independence of elders. 39. I work with a team to provide top quality care to elders.	Care Philosophy
2	3. elders in a care setting should have a choice when and where they eat. 11. the physical environment of a care setting has little impact on elders' care experience outcomes; it is the care itself that matters. 16. that conversation with elders is not essential in order to complete my job duties. 19. time spent with an elder's family member is not essential to learn about an elder. 20. it is important to incorporate an elder's life story into care, conversations, meals, and activities. 21. an elder in a care setting should bring items from his or her home. 22. all elders' rooms in a care setting should be arranged uniformly for consistency. 26. involvement of the community is not important to an elder's quality of life in a care setting.	Social Interaction & Community

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Table 35 - Continued

Component	**Items** *I believe…*	**PCCP**
3	1. staff members should schedule meal times for elders. 4. shower times for elders in care settings should be scheduled based on staff workloads. 9. it is important to isolate an elder if he or she is being physically aggressive. 12. in getting my work finished before I initiate conversations with elders in the care setting. 36. it is important to work fast in order to finish my daily work responsibilities.	Work Culture
4	31. I am flexible in my daily routines. 32. I am properly trained to meet the needs of a diverse elderly population. 40. I feel overwhelmed by my workload. 41. I feel my daily routine in this care setting is repetitive. 42. I feel valued as an employee at this care setting.	Feelings about Work

members), activities, social interactions, and a stimulating environment; and a work climate and culture that is supportive of staff members.As can be seen in Table 35, the majority of items aligned under Component 1. This component, called Resident Autonomy and Care Philosophy, appears to have two sub-scales: one distinctly measuring resident choice and the other measuring staffs' approach to care. It is typical in PCA to have the majority of items load under one component with residual loadings scattered among the remaining components (Tabachnick & Fidel, 2008). The Social Interaction and Community (Component 2) items aligned well under this component. Two items (21 and 22) were specific to residents' living environment. These two items seemed at first to be misplaced, but upon further reflection it can be argued that the living environment fosters social interaction and a sense of community (Hinman & Heyl, 2002). Component 3 (Work Culture) reflects values, beliefs norms, and traditions of the nursing home that guide how care is given. Component 4 (Feelings about Work) reflects what it feels like to work at a "this" nursing home.

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Table 36 displays the original Per-CCat subscales and the revised Per-CCat subscale titles. There is not much difference between the two; however, there was a significant realignment of questions which necessitated minor changes to the subscale headings. Appendix I provides a formatted copy of the Revised Per-CCat. In order to see how the tool changed, it may be useful to compare the Per-CCat version 5 with the revised version (Appendices F and G).

Table 36

Comparison of the Per-CCat Subscales.

Person-Centered Care Attitude Tool Hypothesized Subscales	Revised Person-Centered Care Attitude Tool Hypothesized Subscales
Care Communication Culture & Community Climate	Resident Autonomy & Care Philosophy Social Interaction & Community Work Culture Feelings about Work

Implications. Person-centered care, a central tenet of culture change in long-term care, is described as a holistic approach to providing care to nursing home residents (Morgan & Yoder, 2011. Under PCC practices, residents' personhood and autonomy are maintained in spite of cognitive declines (Kitwood, 1997); relationships between staff members, family, and residents is fostered (Edvardsson, Windblad, & Sandman, 2008); communicating with residents is placed before tasks (Brooker, 2004); and there is recognition that the physical environment is important to supporting residents' social and psychological needs (Hinman & Heyl, 2002). Nursing homes across the United States are making changes congruent with person-centered care; however, little is known about employees' attitudes toward it.

In recent years, researchers have made efforts to measure the efficacy of culture change (Annunziato et al., 2007; Bott et al., 2009; Burack et al., 2012a; Burack et al., 2012b; Doty et al., 2008; Sterns et al., 2010) and the degree to which culture change principles have been adopted (Doty et al., 2008; Sterns et al., 2010). Elements of person-centered care have also been

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measured through observational techniques (Ervin & Koschel, 2012), and survey methods (Chappel et al., 2007; Edvardsson et al., 2010; Edvarddson & Innes, 2010). While there are several published surveys measuring the efficacy and adoption of culture change and person-centered care, few have been validated. Moreover, there are no instruments measuring staff members' attitudes toward person-centered care. The vision for the Per-CCat is that it will serve as a tool to identify gaps in knowledge, to aid in formulating training programs, and evaluate the fit between a prospective employee and a nursing home. This exploratory study is the first step toward providing a validated PCC attitude measurement for practical and academic uses.

Preliminary descriptive statistics of the individual items of the Per-CCat suggested that employees, for the most part, have positive attitudes toward PCC principles. Within every category, more than 60% of staff members—as high as 95%—agreed with PCC principles. This suggests that the employees at VMRC possess foundational knowledge and positive attitudes toward person-centered care. This also suggests that there is room for improvement in knowledge and attitudes in certain areas (e.g. use of psychotropic medication to control agitation, isolating an elder who is aggressive). Continuing education for direct-care staff about PCC practices is recommended.

Employees who work in a PCC environment reported greater satisfaction with their jobs (Doty et al., 2008) and had a decreased rate of absenteeism (Frank, Farrell, & Brady, 2013; Thomas, 2003) compared to those whose workplace had not adopted person-centered care or Culture Change (Doty et al., 2008). Furthermore, there is a positive relationship between staff members' attitudes toward dementia care, particularly person-centered care, and work satisfaction (Zimmerman, Williams, Reed, Boustani, Preisser, Heck, & Sloane, 2005).

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The Per-CCat research suggested that staff members held positive attitudes toward PCC principals and were satisfied with their jobs. What is not clear is how job satisfaction and PCC attitudes differed between Oak Lea and Woodland Park. The fidelity of the Green House was not evaluated; so, if there were attitudinal differences between OL and WP staff, it would be hard to tease out. The differences may have been due to the work environment, the care philosophy, work benefits, colleagues, residents, and so on. Nevertheless, this study's finding reinforce the benefits to adopting a PCC philosophy for both residents and staff members.

Challenges and limitations.

Because this research was conducted in the community, there were particular challenges to implementation: time, limited control, and distance. Survey distribution was handled by VMRC administration and was done when it was most convenient for them. Thus, the timing of the survey distribution did not adhere to the research plan. Fortunately, there were no follow-up time points, so this discrepancy had no impact on results. Having VMRC handle the surveys benefited both VCU and VMRC; surveys were distributed through interoffice mail eliminating the need to mail surveys to the employees, thus negating the necessity of giving VCU's research staff contact information and also eliminating the cost of postage. Due to the distance between VMRC and the researcher, frequent trips to VMRC to manage the research study were not feasible. Instead, coordinating was accomplished through email, the US Postal Service, and telephone.

Administrator support and involvement was a key element to the success of this research study; however, it inadvertently contributed to situational contamination. For instance, survey distribution was under the direction of a VMRC administrator, and surveys were ultimately returned to the administrator. It is possible, although unlikely, that participants were selected by

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administration even though all staff members were eligible. While directions on the survey indicated that participation was voluntary, staff members may have felt otherwise. In addition, because the purpose of the survey was to measure PCC attitudes, staff members may have given answers they thought the researcher wanted. For an accurate measure of the construct validity of the survey, the intent of this study, it is important that answers be truthful. Coercion, self-fulfilling prophecy, and the Hawthorn effect (or response-set bias) are acknowledged limitations to this study.

Another source of bias, administration variation, is related to the survey redistribution. It was necessary to redistribute the surveys to help increase the response rate. However, it is possible that some people filled out a questionnaire twice. There was little evidence of this trend, but it does remain a possibility because no identification was used to link a person to a survey. In addition, transitory personal factors such as mood or fatigue may have contributed to staff members' willingness to complete a survey (Polit & Beck, 2008).

Another limitation to this study was the small sample size. Tabachnick and Fidell (2007) noted that factor analysis should not be undertaken with a sample size less than 300. This study used a sample of 86 which was reduced to 70 because of missing data. Nevertheless, there were moderate to high factor loadings on the first component, and the Kaiser-Meyer-Olkin Measure of Sampling Adequacy (KMO) indicated that this sample size was "middling". Although the KMO score was middling, the data were still factorable (Pett, Lackey, & Sullivan, 2003). Nevertheless, caution is recommended in interpreting the statistics. Further research is necessary to firmly establish the validity and reliability of the Per-CCat.

Also, the sample was comprised of individuals with different responsibilities; 70% were caregivers (CNAs, LPNs, RNs, etc.), and 30% had other roles. It is possible that some of the

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questions on the Per-CCat were difficult to answer because the question did not pertain to an individual or their role. For example, it would not be expected that a person working in maintenance know about antipsychotic medication use in managing symptoms of dementia.

Additionally, there was very little diversity in this sample. Nearly all of the respondents were women (90%) and white (98%). Geographically, Harrisonburg, VA is predominantly white (85%), thus the lack of ethnic diversity could not be avoided. Because of the unique characteristics of VMRC and this geographic location, the results may not be generalizable to other nursing homes.

Finally, Tabachnick and Fidell (2007) stated that Principal Components Analysis has three limitations: (a) no external criteria, such as group membership, against which to test the solution; (b) ambiguity with respect to the interpretation of the solution because following extraction, "there are an infinite number of rotations available, all accounting for the same amount of variance in the original data, but with the factors defined slightly differently (p. 608); and (c) PCA is often used to save questionable data and is therefore associated with "sloppy research" (p. 609). Nevertheless, PCA is used frequently in social science, and is frequently used to establish the construct validity of a scale or measure (Henson & Roberts, 2006). It is regarded as the best first step in exploring a survey because it is succinct and easy to interpret. It is especially useful for summarizing a large number of items into a smaller number of factors (Pett, et al., 2003). In addition, steps were taken to assure the factorability of these data. This analysis remains exploratory.

Future research.

The exploratory phase of the analysis of the Per-CCat suggested that the instrument has strong internal consistency and reliability and that a general factor, person-centered care, exists.

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Stronger declarations about the survey cannot be made without further testing. Future testing of the Per-CCat should include confirmatory factor analysis, test-retest reliability, interrater reliability, and predictive validity.

Confirmatory factor analysis should be conducted using the revised version of the Per-CCat (see Table 35 and a sample of 300 people or more from a different geographical location (for example, in an urban area). If possible, the sample should be ethnically diverse. The survey should be tested using a homogeneous group with regard to training (for example, CNAs only). The stability of the instrument should be established through test/retest reliability. In other words, administer the instrument twice to the same group of people and compare their scores through reliability coefficients. If the coefficients are similar, then the stability of the survey has been established (Polit & Beck, 2008).

Testing for equivalence through interrater reliability should also be performed. Scoring equivalence means that two or more independent coders come to an agreement about how an instrument should be scored and how the score should be interpreted (Polit & Beck, 2008). Another related research question is, what score denotes high PCC beliefs, middling PCC beliefs, and low PCC beliefs? A corollary question is, what do these labels mean? Independent confirmation of the PCC constructs must be established through interrater reliability approaches. The goal is to achieve consensus among the coders about the construct being measured (Polit & Beck, 2008).

In addition, the Per-CCat should be further studied to establish its ability to predict and or confirm behavior. This will require that the Per-CCat score be correlated with some external criterion. For example, an individual with a Per-CCat score that indicates a positive attitude toward PCC care should also score "high" on a measure of PCC practices or be observed

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practicing person-centered care. Criterion related validity, the approach just described, is difficult to establish because it necessarily requires that the criterion measure be validated. As previously mentioned few PCC scales have been validated. The predictive validity of the Per-CCat should also be established. Predictive validity refers to the extent to which a positive or negative score on the Per-CCat predicts a caregiver's behavior toward an elder in their care (e.g., being flexible with the schedule, allowing resident to have a choice, etc.).

Finally, research of the Per-CCat should be conducted to determine if there are differences in scores between those working in GH homes and those working in other LTC settings. Differences in scores may indicate that more staff education about person-centered care is required.

Summary of the Quantitative Study.

The exploratory analysis established that the Per-CCat is measuring elements of person-centered care and that the instrument has strong internal consistency and reliability. Future research should include recruiting a larger sample from different geographic locations on which to conduct a confirmatory factor analysis of the Per-CCat, tests of reliability, and validity. Using the Per-CCat as a hiring and training tool is a primary goal. As the nursing home industry moves toward adopting culture change and person-centered care, it will be important to have staff members at all levels that PCC attitudes and skills.

Conclusion

In conclusion, both the quantitative and qualitative research studies provided valuable insights to PCC attitudes and the transition from traditional skilled care nursing to a more person-centered approach such as that embodied in GH homes. The Person-centered Care Attitude Tool (Per-CCat) had good internal consistency and construct validity. Moreover, this

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exploratory study also demonstrated that staff members at VMRC have positive attitudes toward PCC principles and are knowledgeable about PCC practices. There is one caveat to the above comment: until the Per-CCat undergoes further testing the results should be regarded as preliminary.

The qualitative findings suggested that the overall satisfaction with the GH environment was high. Moreover, there were perceived improvements in resident outcomes such as increased mobility, socializing, enjoyment of the outdoors, and eating. There was also a perceived increase in the number and frequency of visitors. Among the staff members, there was a reported improvement in job satisfaction, and a desire to know the resident and family members better. Family members commented that Woodland Park was a more pleasant place at which to visit their loved one. However, there was regret that Woodland Park did not have better access to the programs at the main buildings. There seemed to be a tension between family members' concepts of a traditional nursing home along with the security that the rigid rules offered against the greater autonomy and risk taking that accompanied the GH environment. Nevertheless, family members remained pleased with Green House and did not wish to remove their loved ones. Overall, the transition appears to have had primarily positive effects on all three groups of stakeholders.

At a micro level, further research should be conducted to firmly establish the efficacy of VMRC's Green House model of care. Comparisons between residents living in the VMRC GH homes and those living in the traditional nursing home through objective health measures is recommended. At a macro level, further research is necessary to define, develop, and refine a standardized nursing model of care that is congruent with Green House principles. In addition,

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Shahbazim training should be expanded to include experiential learning opportunities, management, and conflict resolution.

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Appendix A

Nursing Home Culture Umbrella

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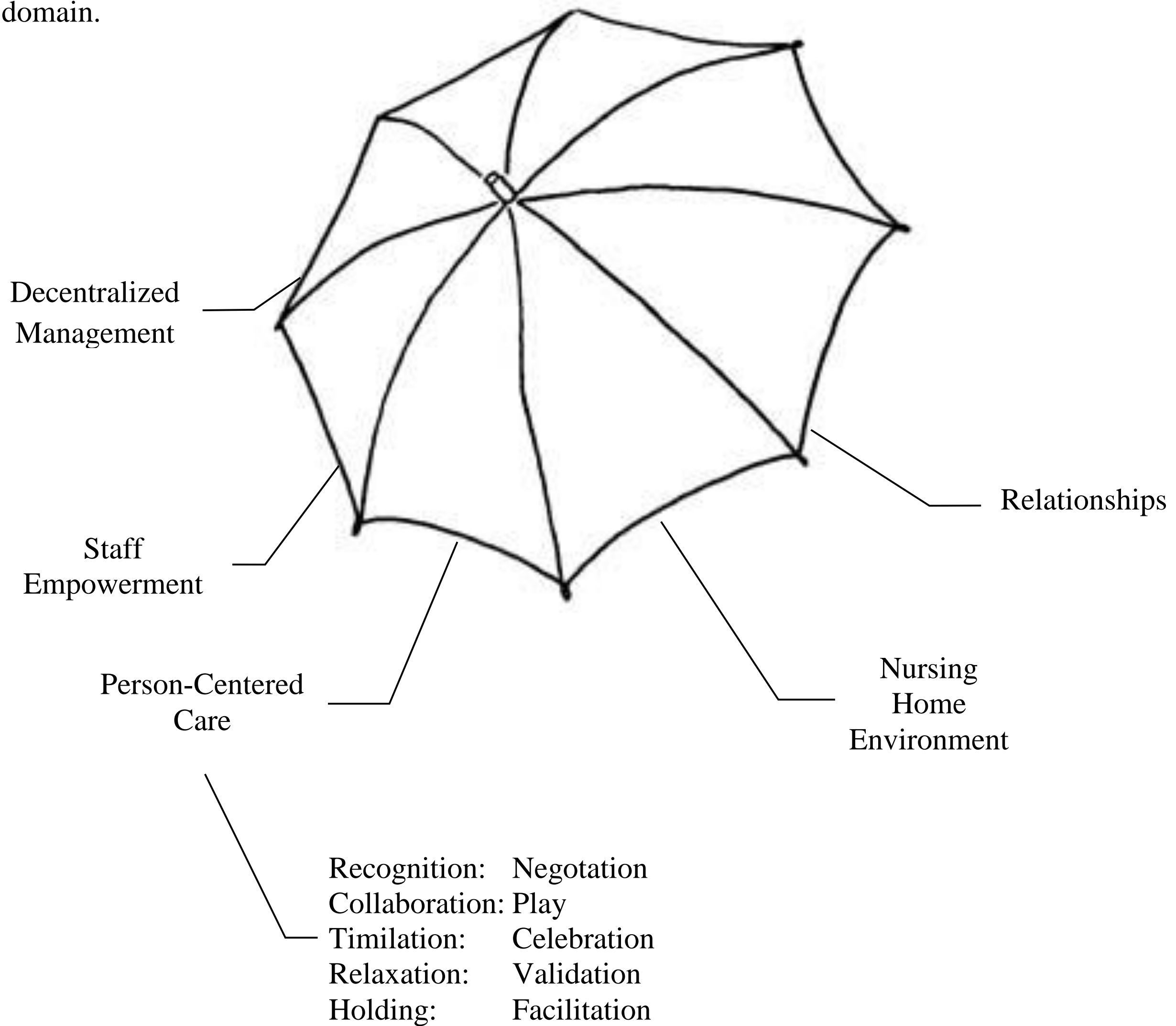
Nursing Home Culture Umbrella

Nursing home culture change can be imagined as an umbrella with each panel representing a domain.



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Appendix B

Constant Comparative Method

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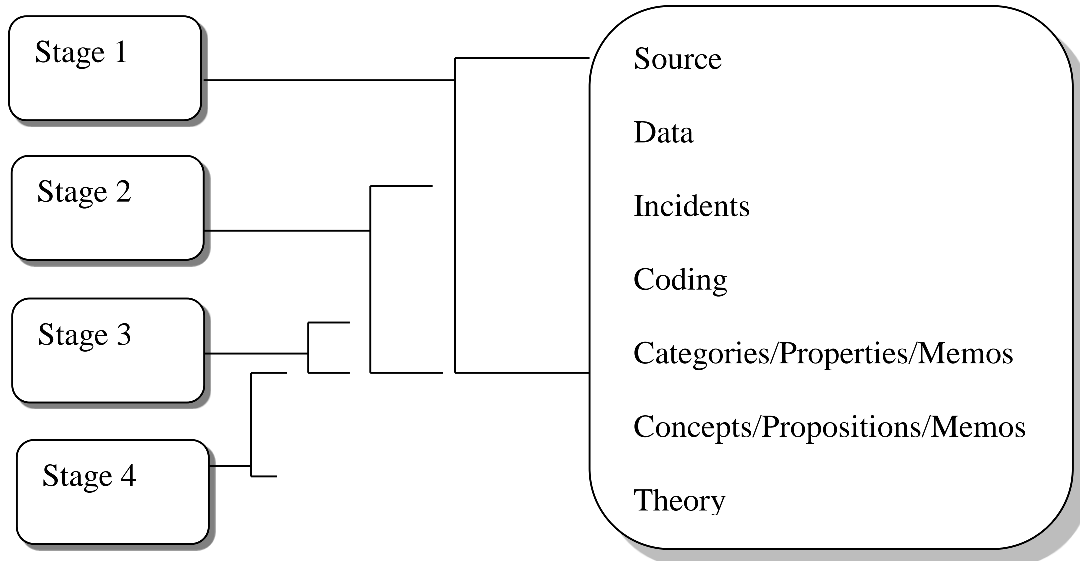
Constant Comparative Method



Note. From Pickler, R.H. (1990). Premature infant-nurse caregiver interaction. Doctoral Dissertation, UVA. Downloaded from Pro-Quest Dissertations and Theses, 1998. Retrieved September 1, 2012.

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Appendix C

Focus Group Manual

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Focus Group Manual

Focus Group Purpose Statement

The purpose of this focus group is:

To find out from residents who will be moving to Woodland Park the following: What do residents know about Green House? What are their expectations for Green House living? How might it be different from Oak Lea? Ultimately, were their expectations met? What aspects of Green House do they like best, like least?

To find out from staff who will be transferring to Woodland Park the following: What do staff know about Green House? What are their expectations for working at Green House? How might it be different from working at Oak Lea? Ultimately, did they feel prepared to work at Woodland Park? What do they like most about working at Woodland Park? What do they like least? Were their expectations met?

To find out from family of residents who are moving to Woodland Park the following: What do they know about Green House? What are their expectations of Green House for their loved one? What aspects of the Green House do they like best? What do they like least? Were their expectations met?

1. Attributes of focus group participants:
    a. Elders should be moving to the Green House

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b. Should speak fluent English
c. Should not be overly shy – I'd like the residents to be chatty
d. Same attributes for Staff and Family.

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2. Focus Group Invitation:

VCU Letterhead

Date

Mrs./Mr. First Last
Address
Harrisonburg, VA zipcode
Dear Mrs./Mr. Last Name,

Virginia Commonwealth University (VCU), Department of Gerontology and VMRC are working together to study how different living arrangements affect elders' well-being. Because your opinions are important to us, we invite you to participate in a focus group on [DATE, Time, VMRC Room ___]. The focus group should not take more than 90 minutes. Refreshments will be served.

VCU and VMRC are interested in your thoughts, feelings and opinions about moving from Oak Lea to Woodland Park. We are excited about the new Green House and are anxious to hear your opinions. We hope that you can attend. Enclosed is a response card. Please complete the card and return it to us. A stamped envelope is enclosed for your convenience.

Please call _________ at ___________ or Christine at 717-825-4421 or email at harropsteinc@vcu.edu.

Thank you for your time and interest.

Sincerely,

J. James Cotter, Ph.D.

Associate Professor, Department of Gerontology

Virginia Commonwealth University

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Focus Group Invitation Response Card

Name ____

- ☐ I am planning on attending the focus group at Virginia Mennonite Retirement Community on December 10, 2012 at _________.
- ☐ I am unable to attend the focus group.

If you have any questions about the focus group, please feel free to call Melissa Fortner at VMRC.

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3. Focus Group Questions

Focus Group with Residents

Research Questions Pre-Move:

a. How would you describe your current living situation?
    i. What is challenging, what do you wish you could change?
b. What do you know about Green House?
    i. How might you describe Green House?
c. What are your expectations about living in GH?
    i. How do you think it might be different from living at Oak Lea?
d. What are your thoughts and feelings about the move?
    i. For example, are you anxious, nervous, sad, excited, and hopeful?
    ii. Are there things that you are wondering about with regard to this move?
e. In your opinion, what are the pros and cons to making this move?
f. Give me examples of good care, of mediocre care, of poor care.

Research Questions Post-Move:

a. Is the Green House how you thought it would be? How is it or not like you thought?
    i. What are you surprised about?
b. What do you like most about GH?
c. What do you like least about GH?
d. Tell me about the staff at the Green House: how are they the same, how are they different?
e. Tell me about the care here: how is it the same, how is it different?
    i. If a friend asked you about whether or not they should move into a Green House nursing home, what would you tell them?

Focus Group with Family Members

Pre-Move Focus Group Questions:

a. What do you know about Green House?
    i. How would you describe it to a friend?
b. What are your expectations about Green House?
    i. How do you think it might be different from living at Oak Lea?
c. What are your thoughts and feelings about the move?
    i. For example, are you anxious, nervous, sad, excited, and hopeful?
    ii. Are there things that you are wondering about with regard to this move?
d. In your opinion, what are the pros and cons to making this move?
e. Give me examples of good care, of mediocre care, of poor care.

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f. How were you involved in your loved ones' decision to move to Green House?
g. Overall what are your impressions of the care at Oak Lea?

Research Questions Post-Move:

f. What surprised you about Green House? What changed the most between GH and Oak Lea?
g. What do you like most about GH?
h. What do you like least about GH?
i. What is different about your loved ones' life now that they are living in GH?
j. How do you perceive your loved ones' QoL? Is there an improvement since the move?
k. How has the care improved?
    i. In your opinion, is GH an improvement over Oak Lea

Focus Group with Staff

Pre-Move Focus Group Questions:

a. What do you know about Green House? How would you describe it to a friend?
b. What do you think it will be like to work in the Green House?
c. What are your thoughts and feelings about the move to GH?
    i. What are you wondering about?
    ii. Do you feel prepared? How were you prepared?
d. How do you describe quality care?
    i. In your opinion, what are the key elements of care?

Post-Move Focus Group Questions:

a. Were your expectations about GH met?
b. Are you satisfied with your new position in the GH?
c. How is your work different?
d. How is the care you are giving different?
e. How do you think the residents have adjusted to the move?
f. How do you perceive the QoL of the residents?
g. Do you feel that you were given ample training to do your new job?
h. What do you like most about working in the GH setting?
i. What do you like least about working in a GH setting?

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4. Focus Group Script

Pre-Move Focus Group Script
Resident

Opening 5 minutes

1. Welcome the group and thank them for coming, introduce self and the project. Explain the purpose of the focus group.

2. Ask participants to introduce themselves.

3. Present the agenda for the meeting

Script: *Welcome to the group, and thank you for taking the time to join us. My name is ______ and I am a researcher at VCU, in the Department of Gerontology. This is one of a series of focus groups that is being conducted to gather information about people's thoughts about the Green House. We are interested in understanding how you feel about moving to the Green House and what you are looking forward to and what you are concerned about. The information you provide will help VMRC make your transition to Green House easier and also give researchers insight into your thoughts about Green House.*

A focus group enables people to come together and share their opinions about a topic. Each of you is representing your own opinion; you do not need to view your comments as a representative of all the others who are making the move to Green House. Please be as honest and open as possible in your responses. Your anonymity will be protected. No one at VMRC or at VCU will know who said what. You are free to withdraw consent and/or leave the room at any time.

We will move quickly through a series of questions and should be done in about an hour and a half. Let's start by introducing ourselves.

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Warm up – 5 minutes – Introductions

Question 1. – 10 minutes

Our first question is related to your current living situation. Are you all coming from Oak Lea?If not, where are you coming from? Have you been happy in your current living situation? Are you happy with care, the staff?

Question 2. – 10 minutes

What do you know about Green House? If someone asked you to define it, what would you say about it, how might you describe it?

Question 3. – 15 minutes

What do you think it might be like living in Green House?

Question 4. 15 minutes

What do you wonder about with regard to this move? What are your thoughts and feelings about the move? For example, are you anxious, nervous, sad, excited, hopeful? Are there things that you are worried about with regard to this move?

Question 5. 10 minutes

In your opinion, what are the pros and cons to making this move?

Question 6. 15 minutes

Describe for me what you think is good care? What makes up quality care? What are the key elements to care?

Closing 10 minutes

Thank you for sharing your thoughts and feelings with us. If there is anything else that you would like to add, there are sheets of paper _____ on which you may write your comments. The

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information you shared will be summarized and used to help with your transition to the Green House, and will also contribute to the larger body of research about older adult.

We wish you happiness in your new home.

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Pre-Move Focus Group Script

Family

Opening 5 minutes

1. Welcome the group and thank them for coming, introduce self and the project. Explain the purpose of the focus group.

2. Ask participants to introduce themselves.

3. Present the agenda for the meeting

Script: *Welcome to the group, and thank you for taking the time to join us. My name is ______ and I am a researcher at VCU, in the Department of Gerontology. This is one of a series of focus groups that is being conducted to gather information about people's thoughts about the Green House. We are interested in understanding how you feel about your loved one's upcoming move to the Green House. We'd like to know what your concerns and expectations are. The information you provide will help VMRC make your loved one's transition to Green House easier and also give researchers insight into family members' thoughts about Green House.*

A focus group enables people to come together and share their opinions about a topic. Each of you is representing your own opinion; you do not need to view your comments as a representative of all the others who are making the move to Green House. Please be as honest and open as possible in your responses. Your anonymity will be protected. No one at VMRC or at VCU will know who said what. You are free to withdraw consent and/or leave the room at any time.

We will move quickly through a series of questions and should be done in about an hour and a half. Let's start by introducing ourselves.

Warm up – 5 minutes – Introductions

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Question 1. – 10 minutes

What is Green House (GH)? Prompt: If someone asked you to define Green House, what would you say about it?

Question 2. – 10 minutes

How were you involved in your loved ones' decision to move to GH?

Question 3. – 15 minutes

What are your expectations about the move to Green House?

Question 4. 15 minutes

What are you wondering about with regard to the move? What are your thoughts and feelings about the move? For example, are you anxious, nervous, sad, excited, hopeful? Are there things that you are worried about with regard to this move?

Question 5. 10 minutes

Give me examples of quality care? What makes up quality care? What are the key elements to care?

Question 6. 10 minutes

Overall, what are your perceptions of the care at Oak Lea?

Closing 10 minutes

Thank you for sharing your thoughts and feelings with us. If there is anything else that you would like to add, there are sheets of paper _____ on which you may write your comments. The information you shared will be summarized and used to help your loved one with their transition to the Green House, and will also contribute to the larger body of research about older adult. Thank you again.

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Pre-Move Focus Group Script

Staff

Opening 5 minutes

1. Welcome the group and thank them for coming, introduce self and the project. Explain the purpose of the focus group.

2. Ask participants to introduce themselves.

3. Present the agenda for the meeting

Script: *Welcome to the group, and thank you for taking the time to join us. My name is ______ and I am a researcher at VCU, in the Department of Gerontology. This is one of a series of focus groups that is being conducted to gather information about people's thoughts about the Green House. We are interested in understanding how you feel about moving to the Green House and what you are looking forward to and what you are concerned about. The information you provide will help VMRC make your transition to Green House easier and also give researchers insight into your thoughts about Green House.*

A focus group enables people to come together and share their opinions about a topic. Each of you is representing your own opinion; you do not need to view your comments as a representative of all the others who are making the move to Green House. Please be as honest and open as possible in your responses. Your anonymity will be protected. No one at VMRC or at VCU will know who said what. You are free to withdraw consent and/or leave the room at any time.

We will move quickly through a series of questions and should be done in about an hour and a half. Let's start by introducing ourselves.

Warm up – 5 minutes – Introductions

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Question 1. – 10 minutes

Our first question is about Green House. How would you define Green House to someone who has never heard of it before?

Question 2. – 15 minutes

What are your expectations about working at the Green House? What do you think it might be like?

Question 3. 15 minutes

What are you wondering about with regard to this move? What are your thoughts and feelings about the move? Prompt: are you nervous, concerned, excited, hopeful?

Question 4. 10 minutes

In your opinion, are you prepared to take on your new role at the Green House?

Question 5. 15 minutes

How do you define quality care? Can you describe quality care for me? What would be considered poor quality care? Prompt: What makes up quality care? What are the key elements to care?

Closing 10 minutes

Thank you for sharing your thoughts and feelings with us. If there is anything else that you would like to add, there are sheets of paper _____ on which you may write your comments. The information you shared will be summarized and used to help with your transition to the Green House, and will also contribute to the larger body of research about caring for older adults. Thank you again and good luck in your new job.

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Post-Move Focus Group Script

Resident

Opening 5 minutes

1. Welcome the group and thank them for coming, introduce self and the project. Explain the purpose of the focus group.

2. Ask participants to introduce themselves.

3. Present the agenda for the meeting

Script: *Welcome everyone, and thank you for taking the time to join us. My name is ______ and I am a researcher at VCU, in the Department of Gerontology. This is one of a series of focus groups that is being conducted to gather information about people's thoughts about the Green House. We are interested in knowing how you feel about living in the Green House. The information you provide will help VMRC make your stay in your new home more comfortable and also give researchers insight into your thoughts about Green House.*

A focus group enables people to come together and share their opinions about a topic. Each of you is representing your own opinion; you do not need to view your comments as a representative of all the others who are making the move to Green House. Please be as honest and open as possible in your responses. Your anonymity will be protected. No one at VMRC or at VCU will know who said what. You are free to withdraw consent and/or leave the room at any time.

We will move quickly through a series of questions and should be done in about an hour and a half. Let's start by introducing ourselves.

Warm up – 5 minutes – Introductions

Question 1. – 20 minutes

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Our first question is related to your current living situation. How is the Green House like you thought it would be? What do you like most about Green House? What do you like least? What were you surprised about?

Question 2. – 10 minutes

What does Green House mean to you? If someone asked you to define it, what would you say about it, how might you describe it?

Question 3. – 15 minutes

How is the care you are receiving different from what you received at Oak Lea? What is different?

Question 4. 15 minutes

Tell me about the staff here: are they the same group of people or are they different? How is the care they provide to you different from Oak Lea?

Question 5. 10 minutes

Would you recommend Green House nursing home to a friend?

Closing 10 minutes

Thank you for sharing your thoughts and feelings with us. If there is anything else that you would like to add, there are sheets of paper _____ on which you may write your comments. The information you shared will be summarized and used to help make your stay in your new home as comfortable as possible. Your information will also contribute to the larger body of research about older adult.

Thank you!

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Post-Move Focus Group Script

Family

Opening 5 minutes

1. Welcome the group and thank them for coming, introduce self and the project. Explain the purpose of the focus group.

2. Ask participants to introduce themselves.

3. Present the agenda for the meeting

Script: *Welcome everyone, and thank you for taking the time to join us. My name is ______ and I am a researcher at VCU, in the Department of Gerontology. This is one of a series of focus groups that is being conducted to gather information about people's thoughts about the Green House. We are interested in knowing how you feel about Green House now that a loved one is living in one. The information you provide will help VMRC make your loved one's stay in their new home more comfortable and also give researchers insight into your thoughts about Green House.*

A focus group enables people to come together and share their opinions about a topic. Each of you is representing your own opinion; you do not need to view your comments as a representative of all the others who are making the move to Green House. Please be as honest and open as possible in your responses. Your anonymity will be protected. No one at VMRC or at VCU will know who said what. You are free to withdraw consent and/or leave the room at any time.

We will move quickly through a series of questions and should be done in about an hour and a half. Let's start by introducing ourselves.

Warm up – 5 minutes – Introductions

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Question 1. – 20 minutes

Our first question is related to your loved one's current living situation. Are you happy with their new living arrangements? What do you like most about GH? What do you like least about GH?

Question 2. – 10 minutes

Is your loved one happy in their new home? How is their life different?

Question 3. – 15 minutes

How do you perceive your loved one's quality of life since the move to Green House?

Question 4. 15 minutes

Are you happy with the care that your loved one is receiving at Woodland Park? Be specific about the elements of care that you are most satisfied with.

Question 5. 15 minutes

Are you comfortable visiting your loved one? What do you do when you visit?

Question 6. 10 minutes

How comfortable are you with the staff members working at Woodland Park? How comfortable are you that they know your loved one well?

Question 7. 10 minutes

Is your loved one ever cared for by someone who does not know him/her? What are your concerns when this happens?

Closing 10 minutes

Thank you for sharing your thoughts and feelings with us. If there is anything else that you would like to add, there are sheets of paper _____ on which you may write your comments. The information you shared will be summarized and used to help make your loved one's stay in their

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new home as comfortable as possible. Your information will also contribute to the larger body of research about older adult.

Thank you!

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Post-Move Focus Group Script

Staff

Opening 5 minutes

1. Welcome the group and thank them for coming, introduce self and the project. Explain the purpose of the focus group.

2. Ask participants to introduce themselves.

3. Present the agenda for the meeting

Script: *Welcome everyone, and thank you for taking the time to join us. My name is ______ and I am a researcher at VCU, in the Department of Gerontology. This is one of a series of focus groups that is being conducted to gather information about people's thoughts about the Green House. We are interested in knowing how you feel about Green House now that a loved one is living in one. The information you provide will help VMRC make your loved one's stay in their new home more comfortable and also give researchers insight into your thoughts about Green House.*

A focus group enables people to come together and share their opinions about a topic. Each of you is representing your own opinion; you do not need to view your comments as a representative of all the others who are making the move to Green House. Please be as honest and open as possible in your responses. Your anonymity will be protected. No one at VMRC or at VCU will know who said what. You are free to withdraw consent and/or leave the room at any time.

We will move quickly through a series of questions and should be done in about an hour and a half. Let's start by introducing ourselves.

Warm up – 5 minutes – Introductions

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Question 1. – 30 minutes

Now that you've been working in Green House, how would you define it if someone were to ask you to? What is it like working in Green House? How is it different from working at Oak Lea? What do you like most about it?What has been most difficult

Question 2. – 10 minutes

What is different about how you provide care?

Question 3. – 10 minutes

Is your relationship with the elders different? Is the relationship with the residents' families different?

Question 5. 20 minutes

What was done to prepare you and the residents for this move?

Closing 10 minutes

Thank you for sharing your thoughts and feelings with us. If there is anything else that you would like to add, there are sheets of paper _____ on which you may write your comments. The information you shared will be summarized and used to help make your transition to Green House better. Your information will also contribute to the larger body of research about caring older adult.

Thank you!

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Focus Group Detail Sheet

Date of Focus Group:

Arrival Time:

Start Time:

Finish Time:

Facilitator:

Co-facilitator:

Number attended:

Summary:

1. What were the main themes, issues, problems, questions witnessed during the session?
2. What people, events, or situations were involved?
3. What were the main themes or issues raised?
4. What new hypotheses, speculations, guesses, or insights related to the focus group purpose statement arose during the session?
5. Are there implications for the next focus group?
6. What happened or was said that was unexpected?
7. What was puzzling?
8. Other comments, reactions, observations?

Note. Taken from Simon, J.S. (1999). Conducting Successful Focus Groups. With permission.

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Focus Group Demographic Information Residents Only

Please tell us about yourself. Check only one answer for each question below. Thank you.

1.)How long have you lived in a nursing home?

- o Less than 2 years
- o 2 years or more

2.)How long have you lived - at VMRC?

- o Less than 2 years
- o 2 years or more

4.) Highest level of education

- o Some High School or High School diploma or equivalent
- o Technical/Vocational School
- o Associate Degree or some college
- o College graduate - BS/BA degree
- o Graduate Degree (Masters or Doctorate)

5.) Gender

- o Male
- o Female

6.) Racial Category

- o American Indian/Alaska Native
- o Black or African American
- o Caucasian/White
- o Pacific Islander or Asian
- o Other or more than one race

7.) Ethnicity – check if you are

- o Hispanic

8.) Your age

- o Under 65 years of age
- o 65-74 years of age
- o 75-84 years of age
- o 85 years or older

THANK YOU!

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Focus Group Demographic Information Family Members Only

Please tell us about yourself. Check only one answer for each question below. Thank you.

1.How long has your loved one lived at VMRC?

- Less than 2 years
- 2 years or more

3.Are you the primary caretaker of your loved one?

- Yes
- No

4. How are you related to your loved one?

- Spouse
- Son or Daughter
- Niece or Nephew
- Grandchild
- Other _______

4. What is the highest level of education you have completed?

- Some High School or High School diploma or equivalent
- Technical/Vocational School
- Associate Degree or some college
- College graduate - BS/BA degree
- Graduate Degree (Masters or Doctorate)

5.What is your gender?

- Male
- Female

6.) Racial Category

- American Indian/Alaska Native
- Black or African American
- Caucasian/White
- Pacific Islander or Asian
- Other or more than one race

7.) Ethnicity – check if you are

- Hispanic

8.) Your age

- Under 35 years of age
- 35-44 years of age
- 45-54 years of age
- 55-64
- 65 years or older

THANK YOU!

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Focus Group Demographic Information Staff Members Only

Please tell us about yourself. Check only one answer for each question below. Thank you.

1.)How long have you worked in the nursing home industry?
- Less than 2 years
- 2 years or more

2.)How long have you worked at VMRC?
- Less than 2 years
- 2 years or more

3.)What is your role at VMRC?
- Administration
- Registered Nurse
- Certified Nurse Aide
- Shabazim
- Guide
- Dietary Aide
- Activities
- Social Services
- Housekeeping/Laundry/Maintenance
- Physical Therapy/Occupational Therapy/Speech Therapy ; including Assistants
- Other Role, please describe ____

4.) Highest level of education
- Some High School or High School diploma or equivalent
- Technical/Vocational School
- Associate Degree
- BS/BA/BSN
- Graduate Degree (Masters or Doctorate)

5.) Gender
- Male
- Female

6.) Racial Category
- American Indian/Alaska Native
- Black or African American
- Caucasian/White
- Pacific Islander or Asian
- Other or more than one race

7.) Ethnicity – check if you are
- Hispanic

7.) Your age

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- 18-25
- 26-35
- 36-45
- 45+

THANK YOU!

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Focus Group Demographic Information Family Members Only

1. How long has your loved one lived at VMRC? _______________

2. In what facilities at VMRC have they lived? (Check all that apply)
    - o Park Village (cottages)
    - o Park Gables (independent luxury apartments)
    - o Park Place (1 & 2 bedroom apartments)
    - o Crestwood (assisted living studio apartments)
    - o Oak Lea (long-term care/skilled nursing)
    - o Woodland Park (Green House)

3. Are you the primary caretaker of your loved one?
    - o Yes
    - o No

4. How are you related to your loved one?
    - o Wife
    - o Husband
    - o Daughter
    - o Son
    - o Niece
    - o Nephew
    - o Granddaughter
    - o Grandson

4. What is the highest level of education you have completed?
    - o Some High School
    - o High School diploma or equivalent
    - o Technical/Vocational School
    - o Associate Degree
    - o BS/BA/BSN
    - o Graduate Degree (Masters)
    - o Graduate Degree (Doctorate)
    - o Professional Degree (MD, DO, DDS, JD)

5. What is your gender?
    - o Male
    - o Female

6. What is your ethnicity/racial category
    - o American Indian
    - o Alaska Native
    - o Hispanic
    - o Black or African American
    - o Caucasian/White

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- Pacific Islander or Asian
- Other or more than one race

7. What is your age ________ and year you were born __________?

THANK YOU!

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Appendix D

Study Timeline

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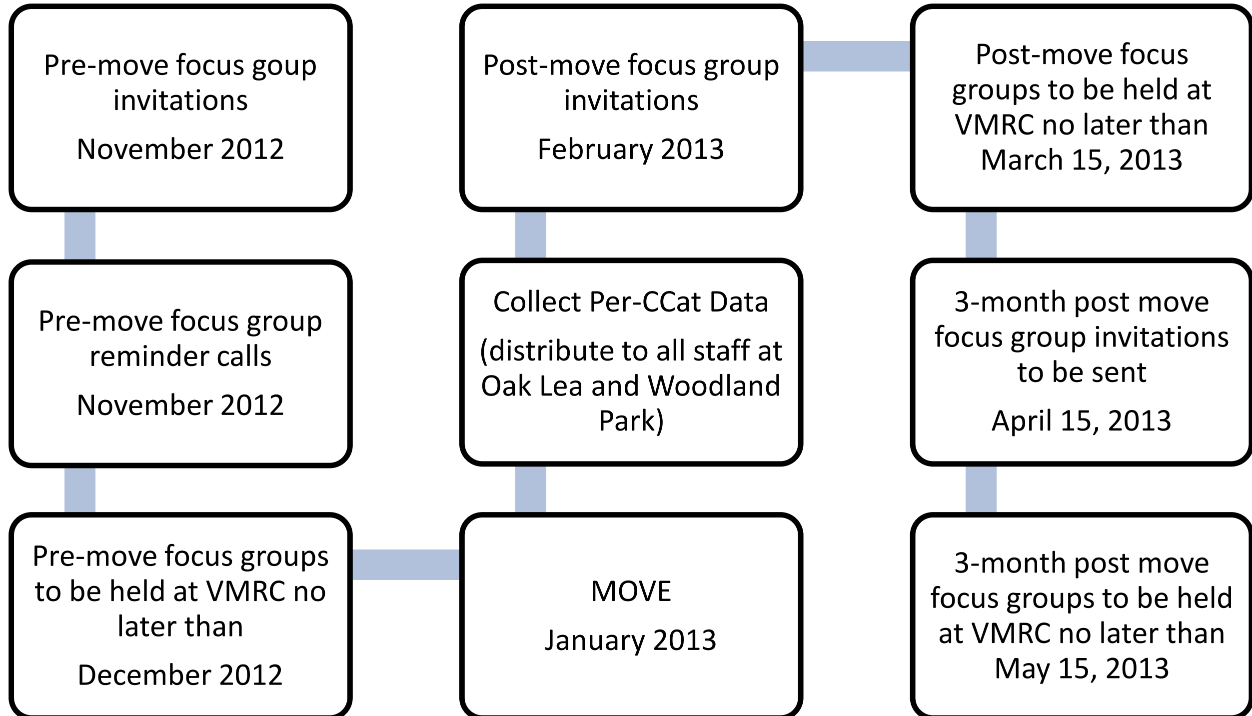
Study Timeline



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Appendix E

Tasks and Timeline

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Task and Timeline

Task	Date	Description
Set up focus group	September 2012	Email Melissa Fortner asking about possible dates
Prepare and submit IRB Forms	Completed November 2012	**Accepted**
Participant Lists	By November 21, 2012 ***Completed***	List to be given to VCU by VMRC. List to include names and addresses. **Follow-up if list has not been received.**
Prepare invitations/include response card (see focus group manual)	By November 27, 2012 ***Completed***	Invitation letter on VCU letterhead
Mail invitations	By November 28, 2012 ***Completed***	Mailed by VMRC
Call or e-mail VMRC to confirm room arrangements	December 3, 2012 ***Completed***	Speak to Melissa Fortner 540-564-3701 or mfortner@vmrc.org
Focus Group	December 17 & 18, 2012	Two to be held one day and the last one on the following day.
Transcribe focus group tapes.	December 19, 2012	Tapes will be given to transcriptionist in York PA
Pick up hard copies of transcription	December ????, 2012	Begin analysis Separate the transcriptions into three – send to Dr. Welleford and Ms. Pryor
Preliminary Analysis of focus group	December 20, 2012 – January 5, 2013	
Preliminary Summary of findings	January 10, 2013	Summary of focus group findings will be sent to Dr. Welleford and Dr. Cotter.
Preliminary Summary Report	January 12, 2013	Report to VMRC.
MOVE	January 15, 2013	
Data Entry: demographic data	Begin January 10, 2013	Data enter into SPSS-20
Continue Qualitative Analysis	Throughout January & February, 2013	Use Atlas.Ti

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Task	Date	Description
Inter-rater reliability	Throughout January & February, 2013	Split the data up between Dr. Welleford and Ms. Pryor so that they can code and compare.
Set up post-move focus groups	February, 2013	Email Melissa Fortner -include room arrangements and reminder to select participants. 540-564-3701 or mfortner@vmrc.org
Participant lists	By February 22, 2013	List generated by VMRC
Prepare invitation and response card (see focus group manual)	By March 1, 2013	To be mailed from VMRC
Per-CCat	By March 1, 2013	Mail to Melissa Fortner for distribution
Call or e-mail VMRC to confirm room arrangements	March 6, 2013	Speak to Melissa Fortner 540-564-3701 or mfortner@vmrc.org
Make reminder phone calls to participants		VMRC
One-month Post move - Focus Group	March 15, 2013	Two to be held one day and the last one on the following day.
Per-CCat pick-up		Christine
Transcribe focus group tapes.	March 17, 2013	Tapes will be given to transcriptionist in York PA
Pick up hard copies of transcription	March 21, 2013	Begin analysis Separate the transcriptions into three – send to Dr. Welleford and Ms. Pryor
Preliminary Analysis of focus group	March 21, 2012 – April 5, 2013	
Preliminary Summary of findings	April 8, 2013	Summary of focus group findings will be sent to Dr. Welleford and Dr. Cotter.
Preliminary Summary Report	April 11, 2013	Report to VMRC.
Data Entry – Per-CCat and demographic data	Begin by April 12, 2013	Data enter into SPSS-20
Per-CCat Data Entry Deadline	End by April 19, 2013	
Continue Qualitative Analysis	Throughout March and April, 2013	Use Atlas.Ti

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Task	Date	Description
Inter-rater reliability	Throughout April, 2013	Split the data up between Dr. Welleford and Ms. Pryor so that they can code and compare.
Prepare for May focus group	Select participants for May focus groups	Call Melissa to begin the process VMRC
Make room arrangements	April 15, 2013	Call Melissa
Mail invitations	April 30, 2013	VMRC
Three-month Post-move Focus Group	May 15-16, 2013	
Transcribe focus group tapes	May 18, 2013	Give to transcriptionist in York
Pick up hard copies of transcription	May 22, 2013	Begin analysis Separate the transcriptions into three – send to Dr. Welleford and Ms. Pryor
Preliminary Analysis of focus group	May 21, 2013 – June, 2013	
Preliminary Summary of findings	June 8, 2013	Summary of focus group findings will be sent to Dr. Welleford and Dr. Cotter.
Preliminary Summary Report	June 11, 2013	Report to VMRC.
Final report and dissertation	August, 2013	

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Appendix F

Person-Centered Care Attitude Test (Per-CCat) Version 5

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Person-Centered Care Aptitude Test (Per-CCatt) Version 5

The purpose of this survey is to measure care setting staff members' attitudes about person-centered care. In the statements below, the "elder" refers to a resident in a care setting such as a nursing home or assisted living facility. You may use pen or pencil to complete the survey. Do not place your name on the survey. If there any questions you do not wish to answer, you do not have to answer them. Thank you for your time.

Care	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
1) I believe staff members should schedule meal times for elders.	5	4	3	2	1
2) I believe an elder in a care setting should have a choice to select food items from a menu.	5	4	3	2	1
3) I believe elders in a care setting should have a choice when and where they eat.	5	4	3	2	1
4) I believe shower times for elders in care settings should be scheduled based on staff workloads.	5	4	3	2	1
5) I believe an elder in a care setting should choose the days and times he or she showers or bathes.	5	4	3	2	1
6) I believe the use of anti-psychotic medication improves quality of life for elders.	5	4	3	2	1
7) I believe it is more important to help an elder manage his or her agitation rather than administering a drug.	5	4	3	2	1
8) I believe elders in care settings experiencing positive social interactions have decreased agitation.	5	4	3	2	1
9) I believe it is important to isolate an elder if he or she is being physically aggressive.	5	4	3	2	1
10) I believe elders with dementia are best served by staff members who express a preference to work with this population of elders.	5	4	3	2	1
11) I believe the physical environment of a care setting has little impact on elders' care experience outcomes; it is the care itself that matters.	5	4	3	2	1

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Communication	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
12) I believe in getting my work finished before I initiate conversations with elders in the care setting.	5	4	3	2	1
13) I believe in asking elders about their preferences in the care I provide.	5	4	3	2	1
14) I believe asking an elder a question is more important than waiting to hear the answer.	5	4	3	2	1
15) I believe that referring to an elder in a care setting by "honey" or "sweetie" is appropriate.	5	4	3	2	1
16) I believe that conversation with elders is not essential in order to complete my job duties.	5	4	3	2	1
17) I believe there is a need to carry on conversations with fellow staff in the presence of an elder.	5	4	3	2	1

Culture & Community	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
18) I believe knowing an elder's life story adds value to the care I provide.	5	4	3	2	1
19) I believe time spent with an elder's family member is not essential to learn about an elder.	5	4	3	2	1
20) I believe it is important to incorporate an elder's life story into care, conversation, meals, and activities.	5	4	3	2	1
21) I believe an elder in a care setting should bring items from his or her home.	5	4	3	2	1
22) I believe all elders' rooms in a care setting should be arranged uniformly for consistency.	5	4	3	2	1
23) I believe an elder in a care setting should have access to activity programs that are individually suited to their preferences.	5	4	3	2	1

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Culture & Community	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
24) I believe activities should be designed with an elder's past life story and past occupation(s) in mind.	5	4	3	2	1
25) I believe an elder in a care setting can choose if he or she wants to stay awake all night or "sleep- in" in the morning.	5	4	3	2	1
26) I believe involvement of the community is not important to an elder's quality of life in a care setting.	5	4	3	2	1
27) I believe creativity should be encouraged in interactions and activities with elders.	5	4	3	2	1
28) I believe activities should be conducted with a "no fail" approach.	5	4	3	2	1
29) I believe an elder in a care setting should have input on what type of activities are implemented.	5	4	3	2	1

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Climate	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
30) I believe most elders have similar needs.	5	4	3	2	1
31) I believe I am flexible in my daily routines.	5	4	3	2	1
32) I believe I am properly trained to meet the needs of a diverse elderly population.	5	4	3	2	1
33) I believe that a care setting should celebrate holidays that the majority of elders believe in.	5	4	3	2	1
34) I believe in learning new techniques and strategies to improve my relationship with elders in a care setting.	5	4	3	2	1
35) I believe it is important to follow ethical guidelines when interacting with elders in a care setting.	5	4	3	2	1
36) I believe it is important to work fast in order to finish my daily work responsibilities.	5	4	3	2	1
37) I believe my attitude towards work affects the care given to the elders.	5	4	3	2	1
38) I believe in increasing the independence of the elders.	5	4	3	2	1
39) I work with a team to provide top quality care to elders.	5	4	3	2	1
40) I feel overwhelmed with my workload.	5	4	3	2	1
41) I feel my daily routine in this care setting is repetitive.	5	4	3	2	1
42) I feel valued as an employee at this care setting.	5	4	3	2	1

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Please tell us about yourself. Check only one answer for each question below. Thank you.

1.)How long have you worked in the nursing home industry?
- o Less than 2 years
- o 2 years or more

2.)How long have you worked at VMRC?
- o Less than 2 years
- o 2 years or more

3.)What is your role at VMRC?
- o Administration
- o Registered Nurse
- o Certified Nurse Aide
- o Shabazim
- o Guide
- o Dietary Aide
- o Activities
- o Social Services
- o Housekeeping/Laundry/Maintenance
- o Physical Therapy/Occupational Therapy/Speech Therapy ; including Assistants
- o Other Role, please describe ____

4.) Highest level of education
- o Some High School or High School diploma or equivalent
- o Technical/Vocational School
- o Associate Degree
- o BS/BA/BSN
- o Graduate Degree (Masters or Doctorate)

5.)Gender
- o Male
- o Female

6.) Racial Category
- o American Indian/Alaska Native
- o Black or African American
- o Caucasian/White
- o Pacific Islander or Asian
- o Other or more than one race

7.) Ethnicity – check if you are
- o Hispanic

7.) Your age
- o 18-25
- o 26-35
- o 36-45

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- 46 -55
- 56 +

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Appendix G

Fact Sheet

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Fact Sheet

What is the purpose of this meeting?

Virginia Mennonite Retirement Community (VMRC) and Virginia Commonwealth University, Department of Gerontology (VCU) are working together to study people's feelings about the new Green Houses (Woodland Park) that are being opened in January.

What am I going to be doing?

You will be participating in a group discussion, known as a focus group, about your upcoming move to Woodland Park.

What sorts of questions will you ask?

We will be asking you about your feelings about moving to Woodland Park. We will not be asking you about anything that is personal in nature.

How much time will this take?

The focus group will take no more than 2 hours of your time.

Can I change my mind?

You are under no obligation to participate in the focus group and you may withdraw your consent to participate at any time. There will be no personal repercussions if you should decide to withdraw.

Will my statements be kept private?

The focus group session will be audio recorded, but no one will be indentified. The tape will be listened to by VCU research staff only.

How will this information be used?

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A report summarizing the information you shared will be developed by VCU research staff forVMRC to help residents who are making a transition to a new living situation. VCU will also use this information to help further research in the field of gerontology.

Who do I contact if I have any questions or concerns about the focus groups or the way in which the research is being conducted?

You may call J.James Cotter, PhD, Associate Professor, Department of Gerontology at VCU at (804) 828-1565 or the Office of Research at VCU at (804) 828-2521.

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Appendix H

Code Book

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Code Book

Code	Pre-move	Post-move 1 month	Post-move 3 months
Adjustment • *Challenges* *Prior to the move*, family had concerns about how their loved ones would adjust to the new routines and new environment. *At one month*, family reported that their loved ones had adjusted to the new environment reasonably well. Some residents were still getting used to the new routine. Family said of staff that they were still feeling their way. Staff members echoed this sentiment. *At three months* residents seem to have adjusted to GH living. One resident made a thoughtful comment about having to get used to other people's differences. A new family to VMRC commented that her husband was having a tough time adjusting to the new routines. While staff were still getting their "sea legs", they were optimistic that they would master their new coordinating roles. Nurses who had been in a supervisory role at OL were still accommodating to the flattened hierarchy. Likewise, the Shahbaz were making similar adjustments. No longer could they go to a nurse to help arbitrate a dispute; they must do it themselves.	***Family*** (a) Mother has been moved once in preparation for this upcoming move – concern about mother's ability to adjust to yet another change. (b) new routines	***Resident*** (a) I like it at [OL] because of the weather. It will be great when summer comes and I am allowed outside." This woman does like the living space at WP though. (b) One resident is wheelchair bound (younger man around 50 or so), so getting over to the main campus for activities is a real hassle." I want to do something, but I don't like loading and unloading [it's more work for the] staff." (c) The same gentleman as above said "everything was under one roof and it was easier." ***Family*** (a) I think he has done well (b) WRT Q RE adjustment: "I think it's just as easy because actually you can go anytime in the 24 hours. The parking is not difficult at the house". (c) "I spent the first 24 hours with him just so he would have a constant." (d) WRT husband ringing the call bell. He has mentioned that sometimes he must wait a long time before he gets any help. His wife commented that she didn't "know how much was his impatience or what it is …" Later she mentions, WRT to the same issue, "I don't know but that is another thing of needing to adjust and all." <u>about Staff</u>	***Residents*** (a) One resident talked about having to get used to living with people she is not used to living with. Each of us is "we're different". ***Family*** (a) This family is new to VMRC they had been at WP for about 4 weeks. "it's been such a short time and he does have a hard time adapting to new things so there are processes of adapting." ***Staff*** (a) "It seems like it is going ok. We still have our bumps that we come across and you know, we have to figure it out and then we know what to do when it happens again." (b) "We are still getting used to the management quality. The people that were in charge of management, I think we are still getting used to that stuff. And handling the <u>coordinator role</u>, but it's come a long ways. We are still in the period of adjusting. I think we have come a long way." (c) One staff member mentioned that the nurses (RNs and LPNs) are struggling with being in leadership roles that they didn't have at OL. And that CNAs are also struggling with being in leadership roles that they did not have at OL.
<u>Challenges</u>	*<u>Staff</u>*	(a)Feeling their way	*<u>Resident</u>*

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During the *pre-move* interviews, the staff expressed and expectation that working under a new care model will be challenging. This was a realistic expectation. Residents and family did not express this at one month. However at one-month and *three-months* post move, challenges were expressed by residents and staff. At *one-month* staff were finding it challenging to find coverage for their shift if they needed to call out. Other challenges included balancing the demands of needy residents, getting used to electronic record keeping, and taking on coordinator roles along with other duties. At the *three month* post move interviews one resident expressed that some tasks that the Shahbaz ask of him are difficult for him to do. Another resident found it challenging to accept that she must always walk with her walker and that she *may not* do certain activities like make her own bed. *Staff* were still finding it difficult to integrate resident autonomy into their care strategy and mindset. I think some of the Shahbaz still struggle with allowing resident choice over a schedule; none of the staff want to leave tasks undone. The coordinator roles also	Expect the new work environment to be challenging at first.	(b) "They are feeling their way too, just like we are. They know what works best and what doesn't." As part of this conversation other family piped in: "I would agree with that" & "They are still learning, yes they are." ***Staff*** "I think we are still transitioning and learning how to do our plans and all that fun stuff." (a) WRT visiting: "As far as getting there [to WP from the main campus], it's a whole lot harder for me because I don't think they took into consideration the privileges we had here [main campus] and having been a long way from Heritage Haven [independent living] up to Crestwood [assisted living. The GHs are near Crestwood, but not so near that a person with even a minor disability could walk safely.]" (b) This family member sums up the pros and cons: "Before, I could go over to his room and push his wheelchair to the auditorium and he could go to the barbershop and exercise, especially we could stop down and pick him up from exercise. Things like that which really felt like it was a great loss when he moved there [WP]. It's just a much nicer place to live, but not being able to get there as well as we could…I wish somehow they could have that kind of situation here to hook up with [referencing a way to connect all the	(a) One commented that he is sometimes asked to do things that he cannot do. (b) Another resident must use her walker all the time. It was/is a challenge for her to feel good about that. Also, the Shahbaz limit what she can do for herself. She wants to do for herself, but the Shahbaz will not allow it. ***Staff*** (a) The notion of autonomy does still create challenges for the staff because there are some residents who demand and/or require more help than others. (b) Coordinating roles remain a challenge. (c) Balancing care responsibilities along with coordinator roles is a challenge. ***Family*** (a) Lovely environment, but it is difficult to take residents to programs at the main building. One family member has stopped doing it because it is such an effort. This is a loss to this family "it really gave us something to do. We couldn't have a conversation with her but we could enjoy the program. Like I said, I probably won't bring her back. They were told that." ***Staff*** GH Ideology vs Reality (a) "You know, like, there comes a point where you have to look at the medical side of it and the feasibility within the house that we are not giving one-on-one care. (b) "But [residents] are misled the way we were

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continued to be challenging.		buildings as they are connected at the main campus]. (c) "I think it is a tradeoff. I think here they have so many buildings that are interconnected and so we've gotten used to it. Everything is at our fingertips and not having to go outside in the weather and its programs. There is a tradeoff". This family member goes on to explain that her mother's STM is impaired so having a conversation is impossible. She relied upon the programs to serve as a way that she could visit her mother. Both would enjoy the programs even if there could not be any discourse following. (d) "There are fewer to take care of him, but on the other hand, when they were taking care of him back there, they didn't do all the cleaning so…" (e) Not all of the sidewalks are wheelchair accessible. One family member had to take their mother out to the road before finding a dip in the sidewalk. *Staff* (a) "We're in charge of finding our own coverage if we call out. That's probably the biggest challenge. Especially with all three houses". (b) "One of the surprises was how hard it can be. We didn't think it was	misled about the way things are to go on here too. So I am not going to fault them. They are told one thing and in reality it's a whole different world."

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		going to be as hard as it was." (c) Some residents are demanding, so it has been a challenge for the Shahbaz to meet their needs as well as the needs of the less "squeaky" residents. (e) Other challenges include getting used to electronic documentation. (f)Doing all the coordinating role in there gets a little more challenging for me. (g) "At first it was more difficult because you had to get used to all of the responsibilities. (h) Now must do cooking, dishes, laundry, and cleaning. (i) "We have the role of being the nurse but we are home helpers now." Pros and Cons (a) Some residents have fallen since living at GH. (b) "Some have felt cut off from everything because they don't the same activities that they use to." (b) It is easier for family to visit at WP. "It is easier to get in here then it is over there because of health issues and it's easier for them to come here." (c) "Physically we share the burden [of caring for the residents]". (d) "…but I would say that mentally I burn out because you are constantly on the go from the time you in to the time you leave, and it's just like one thing after the other and you are trying to keep on with what you have to do.	
Attitudes	***Residents***	***Residents*** Toward GH	***Residents*** Toward Other Residents

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| *Attitudes, Feelings, Perceptions*
• **Toward GH .**
• Toward Parent
• Toward Elders
• **Toward Work**
• Elder toward Self

At the *pre-move* interviews resident and family spoke more about their expectations for Green House rather than their attitude towards it. Staff expressed specific attitudes toward Green House which ran the gamut from confusion about terms and "Doom and Gloom", to optimism. Among the five staff members interviewed, they all agreed that the setting seemed like it would be better for the residents, but that it will be challenging for the staff. Some staff likened the residents to children who must be on a strict schedule. Those that held that view had a hard time understanding how the GH care model would work.

At *one month* residents expressed satisfaction with the environment and with their caretakers. However, they would much rather be living in their own homes. Two residents decided to move back to OL because they felt too cut off from the main building (activities and conveniences).

Staff attitudes toward their work has shifted from having to get the list of tasks finished to one of having to get the work done to benefit the house. | Elder Toward Self per his daughter
(a) Defeated perhaps – "I am in the old folks home" and "I'm in the elephant graveyard".
Family
Toward loved-one
(a) frustration perhaps? "He is going to be this little buffoon".
Staff
Attitude Toward Green House:
(a) "Challenging at first until we get into a pattern and learn a little more about the residents and what their needs are".
(b) Confusing terms Seemed to me that CNA was saying that the terms are too pretentious.
(c) Doom and Gloom
(d) Chaos
(e) Optimism

Attitude toward work:
(a) sees work as a career
(b) finds meaning in work: "I just find it still fulfilling in some ways and hopefully it will be more fulfilling as I go on in my career."
Attitude Toward Elders
(a) Likens care of elders to that of caring for children.
(b) Retirement should be enjoyed, not tolerated.
(c) Put quality of life into residents' existence | (a) WRT Q: Do you like living here? "I guess, if you can do nothing but that, it's what you do. I think it's very nice." Others responded to the same Q: "Yeah, Yeah" & "I guess so".
(b) I wouldn't want to leave here and go to another one though, no way."
(c) "No I don't have much to do over at Oak Lea, because I need help and over there I don't want to ask them for help". **This is indicative of something, but I'm not sure just what.**

Attitude of Resident toward Staff
(a)WRT care: "Yeah, I do like it. Whatever they do is ok. I just keep on going as much as I can."
Staff
Attitude Toward Work
(a) "You sort of did your time, did your list, and did your thing. You did what you needed to there, but over here, you do what needs to be done for the house not for yourself."
(b) "It is a challenge, but it's not bad. You just do more and expand more than what you were."
(c) "That's what it is. I am stretching and I think we both are.
(d) See camaraderie
(e) "It's a lot more responsibility…there are things our supervisor used to do like quality control, things like documenting, flush throughs, etc. It's a whole lot more as far as that goes, but I think it balances out."
(f) "I feel like it's a lot to do, but I really have time | (a) "Friendly bunch".

Family
Observation/musings about OL staff attitudes toward WP:
(a) WRT staff at OL visiting a resident at WP: "I find it very interesting that the office staff don't want to and some of them have gone and then told me they've gone and it's almost like they are scared to go or reluctant to go." "It's like the interaction, it's like it's a totally separate country. |

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They have acknowledged that it has been a struggle, but that it is, for some, an opportunity for personal and professional growth. Some staff members feel overwhelmed by the GHs and prefer working at OL. WRT attitudes toward the GH model of care, the staff are in favor of it and would fight to keep GHs open if there were ever a threat to close them. Because the environment feels and looks like a home many of the staff prefer to work in the small house NH. At *three-month post move*, residents were still expressing positive attitudes toward GH. WRT residents' attitudes toward other residents and staff, they agree that they're living among a "friendly bunch". A family member noted that there seemed to be a separation between the GH and OL staff, more like an "us" and "them" feeling. Staff commented that they feel as if they are working as a team, they have each other's back, even though they feel frustration toward administration because of the staffing shortage.		to as a Shahbaz to do what I need to do." (g) WRT to going back to OL: "I like to do other stuff." (h) "It's a job. It's not the worst job, but I have to work, so why not do something I like." (i) In general I prefer working at the home [OL].It is just that when I am over there, there is going to be less shuffle. And a bad day over there is still better. This is just mental overloading. Attitude Toward GH (a) "I do think if we had to shut the doors down and can't do the green houses no more, what would y'all do? The answer is, we'd find a way to keep the doors open. We wouldn't go back." (b) "I appreciate having a smaller base setting where you get to interact with the residents a lot more." (c) "We feel it's better than a traditional nursing home." (d) "I like it here, I really do." (e) "…there is not much left that looks like a nursing home. It just makes you feel right at home."	
Culture Change *Living/Practicing Green House & Culture Change* Because the GH is both a working and living environment, I split culture into two distinct groups. Each does affect the stakeholders'		***Staff:*** (a) WRT coordinator role: "I think it has opened my eyes more to everything else that goes on and not just the resident care. I think it's made us realize some that it's not just	***Residents*** (a) "Yeah, they don't force you to do anything and you do what you want to do." Q: So that's different from how things were in Oak Lea when you were living in the

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perception of the environment. At one month, staff express not only a camaraderie among team members, but a realization and understanding of the complexities to running a LTC facility. This "light bulb" moment changed the staff's perception of their work. In spite of this, there was tension between the nursing staff and the Shahbaz as they explored their new roles in a flattened hierarchy. By the third month follow-up, all stakeholders had developed a perspective of living and working in the GH. Residents feel that it is less regimented than OL, and also feel it is more comfortable. Residents are expected to do some things for themselves and for some though this is a challenge; for others it is welcome. Family members feel tension in the environment, the culture of the house does not evoke calm. Staff are still learning how a flattened hierarchy works and thus there is confusion about roles. Family members feel that the homes are understaffed, which creates a harried atmosphere. The staff are stressed by the lack of manpower, and the sometimes unrealistic and selfish demands from a minority of residents. When residents are displeased, they call their family, who in turn lodge complaints. These combine to create		resident care. There is so much more about this to make this work. It's a challenge." (b) While at OL: "The nurses decided that we weren't doing our part and they wouldn't ask for our input. But after all the pushing and pulling they kind of took our input. Even though we aren't necessarily in the nursing part they do." {Tension. Perhaps turf issues, role issues}	nursing home? The experience there was different from here? A: 'I don't think they are the same really." Q: For you it is, it feels different? A: Yes. Q: Would you say that you think it's less regimented here? A: Yes, that true. It's a little more comfortable. Q: Now you said that you have been here long enough to know what you like and what you don't like, and so what don't you like? A:I like it's less regimented. I can do what I want to do. But they expect you to do a certain amount of things. Some things I can't do. {I didn't press for any information because I didn't want him to think that I was prying or being insensitive.} ***Family*** WRT GH atmosphere from family perspective: i. "I guess I echo some of what has been said here is that the Shahbaz are really overwhelmed and sometimes they were running around and so there is not this calm confidence that really sort of calms the people, you know. What you need or want is the Shahbaz to be calming, confident and 'I can do what I need to do'. And so there is a sense of underlying anxiety that I am not going to get it done, I am not on top if it and that has exacerbated [my husband's] adjustment." ii. To the above family, it feels as if the nurses (RNs and LPNs) are detached. "…the nurses being as detached as they are means they can't

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an atmosphere that feels anxious and harried. Overall, the stakeholders prefer this environment to the traditional NH.			nurse…'This is the Shahbaz's house', and I thought that is sort of a waste, if the nurse could be more engaged and also provide some consultation and support" especially when the Shahbaz are overwhelmed. iii. There is not a team, I mean you think about all of it, a team kind of approach, but that is certainly not the impression one got when one heard the girls speaking. She was not a part of the team…" iv. The nurse: "This is the Shahbaz's house, I do medicine, but it's not my house." iv. "I have felt strange with more than one nurse". "One nurse is very aloof". v. from same family as iv. "it might be a territorial thing you know like 'you don't need to do this, we're fine, we are the Shahbaz here and you're the nurse." ***Staff*** (a) Workplace culture is influenced by the residents: "And that's the one that you have when he says 'do it', you have to do it. And it's not fair to the other nine, but you get dictated the ways it's going to be. You have to do what they say." (b) Workplace culture is also influenced by family members: "And if it doesn't happen, the family member gets called, and you get called with 'Well, I think he should get put to bed right after breakfast'. Ok, well I feel like other people should get to eat their

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			breakfast first. You know.”
<u>Choice</u> *Living/Practicing Green House & Culture Change* The *Pre-move* interviews revealed that most <u>family</u> members deferred to their loved-ones wishes about moving. Two family members made the choice for their parent. Some of the <u>aides</u> were skeptical about giving residents the right to choose when they awaken, eat, bathe, etc. Their skepticism was related to scheduling issues, not the desire to control every aspect of the residents' life. Their only frame of reference was a traditional nursing home, so it was difficult for staff to envision a loose schedule or one that would develop naturally from the rhythms of the individual. At *one-month* <u>residents</u> were pleased to have their own room, but they were displeased with the lack of transportation to the main building. This lack made the residents feel cut off from the larger VMRC community. In fact, two residents moved back to OL. At *three months* <u>residents</u> agreed that the schedule is less regimented and that they could do what they wanted when they wanted. There were restrictions to what a resident could do. If there was a risk that a resident might get hurt, then the	***Family*** (a) “So, he is kind of okay”. Daughter gently coerced her father into making the move.	***Residents*** (a) WRT schedules: “We do what we want to when we want to.” (b) One resident liked to help with chores such as setting the table. She also liked making her bed. “Yeah, keeping it straight.” ***Staff*** (a) “We keep the gate open when we're out [on the patio] and sometimes we open our doors then. They [residents] can come in and out. We can go over there, you know.” (b) “The people want to do more for themselves over here. They feel like they can and are more independent.” ***Family*** (a) “He was very interested to move”. (b) of the same gentleman in (a) WRT independence, choice, self-determination: “To him getting some exercise is very important and I guess he still hopes he can walk again sometime, but at least if he can get up and walk with the walker at his pace it makes him feel a lot better. So I am not exactly sure.”	***Residents*** (a) Liked that they have some freedom to do what they want to do when they want to do it, but there are restrictions. For example, one resident is not permitted to walk around without using her walker, residents cannot help with cooking, draw their shades or make their beds (for fear of falling related injuries).

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staff wouldn't permit the resident to do it. <u>Staff</u> reported that residents were free to go outside onto the patio and to visit with residents in the other house. Staff noted that residents were trying to do more for themselves, which sometimes resulted in injury.			
<u>Camaraderie</u> *Living/Practicing Green House & Culture Change* At the pre-move interview some staff members were optimistic about their ability to make the change and handle the work because they would draw from each other. And, there was affirmation of the concerns expressed by other staff about the level of level of care needed by the residents. By the one-month follow-up the staff agreed that they support each other, work as a team, and have a better understanding of the roles that each plays in the working of the house. By three-months, the staff seem to have grasped the humanistic underpinnings of the GH model.	***Staff:*** (a) "I think us being brought together as a unit and as a team we can draw from each other's strengths…" (b) Peer affirmation of concerns: "I can see her point, yes, especially with total care elders."	***Staff*** (a) "Like over there [OL] work changed [you didn't always know with whom you would be working], but here we know we are stuck with each other and we stick together". (b) "I feel like we have probably a stronger team than we had when we were working over in OL. It not only comes together and, you know, just generally agreeing, we also care for each other a lot more." (c) "We, as a group, are pleased with this. We balance stuff between us because we have a lot to do." (d) "It opened my eyes and I have more respect for what they do. She schedules all the aides, all the nurses." & "It gives you a new aspect of what does it take to run a traditional nursing home." (e) "We work well as a team. We just make sure that it's all done and it all works out." (f) We work together and I think you [to the RN] are very good about listening to what we have to say [compared to] over there [OL]having to go through this whole thing [the chain of command].	***Staff*** (a) One staff member said of another: "And she is one of our greatest assets for on call people. I mean, if you need anything [she] is the one that dayshift knows and we appreciate you, we really do. Without you, I don't know what we would do, you know? (b) "They are like you mean you guys have to do that, are you serious? Wow! I mean we are all good because we work together and [the residents] come and talk to you what is happening in their lives and you are like Green House is a very good idea".

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Commitment *Attitude, Feeling, Perception* At the one month interview with staff, staff members expressed their commitment to the GH model. But the tune is a little different during the three-month follow-up. The staff seem more committed to each other and the residents than to the idea of GH. I believe that by the time of the three-month follow-up the staff members were overwhelmed by staff shortages and so the model doesn't have the same luster as it did in the beginning.		***Staff*** "I do think if we had to shut the doors down and can't do the green houses no more, what would y'all do? The answer is, we'd find a way to keep the doors open. We wouldn't go back."	***Staff*** WRT commitment to teammates: "If it weren't for my teammates I would really walk. I don't have the heart to walk out on them because I am one of them." Another aide said," I love my people. I could not walk out on my people or my coworkers".
Communication *Living/Practicing Green House & Culture Change* There is an understanding that in order for this model to work to everyone's benefit it will be necessary for there to be good communication. By the *one-month* follow-up <u>staff</u> were sharing clinical knowledge, and solutions to problems. Staffing levels effect the quality and quantity of the information exchanged between each other simply because many of the substitute staff members were part-timers pulled in from OL. At *three months* the staff have been able to smooth out some of the communication glitches. They recognized that graveyard shift miss the meetings and have worked out a plan that	***Staff:*** (a) "…especially us all communicating together we can work out a schedule without saying" I don't want to work this day and I don't want to work this date" because we are all one unit.	***Staff*** (a) "I feel that she [the RN] knows way more than me. I learned more too because we are able to communicate more and they are able to explain situations better.…Now if we have questions we can go to them and they can answer it. (b) "We only have eight [staff members] I believe. We had ten and we are trying to work back up to ten people and even before we would all communicate pretty well, but for the part-timers it's hard because you aren't here and you didn't get all…but I think we all are pretty good."	***Staff*** (a) Communicating with each other has helped to smooth out some of the initial bumps. Initially there were problems with the team meetings. (b) Night shift staff often miss the meetings (and thus the chance to hear and be heard) because the meetings are held during the day. They have developed a solution "One [staff person] comes in one week and then the other the next week."

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will allow staff to be present for the meetings.			
Concerns *Adjusting* • Staffing • Safety • Transportation Overwhelmingly and at all three time points residents, family, and staff voiced concerns about staffing levels. Residents were concerned for their own safety, family were concerned with the quality of care (including ability of staff to prepare meals) and safety, and staff were concerned for their own safety and that of the residents. At one month staffing concerns continued with very specific examples of how overwhelmed the Shahbaz were. Staff members reported feeling burned out with one revealing that she would like to quit. At the three-month interview family and staff members said that the GHs are understaffed. Specific examples barriers to do their job were provided by staff members: some do not have a key to get into the house, the washers are low capacity and are not at waist height, Shahbaz must leave the house to get chart information on a new resident. Staff also mentioned concerns about the sustainability of the GHs. VMRC LTC residents are not choosing the GH, but	***Residents*** (a) Staffing level One gentleman remarked that he can't see how one aide is going to be able to transfer him from bed to his chair.{The plan is to have only one aide to lift because there is a new lift attached to the ceiling that is supposed to make it possible for one person to transfer a resident. (b) Cost (c) Adjusting to the change ***Family:*** (a) staffing levels. (b) loved one's safety. (c) will staff be good cooks? (d) how are staff going to manage care duties along with cooking and cleaning? (e) The video about Green House showed elders who were quite mobile and pretty sharp (not suffering from dementia or other cognitive problems) very different from her mother. {Video not realistic to their lived experience}. ***Staff:*** (a) Team work (not used to relying upon others in this way). (b) General concern because it [Green House] is new. (c) "I have to go along with the team to confront the issue and work the issue out and that is not a position I totally enjoy. I mean I can speak up, but I am not comfortable speaking up." (d) "One of my greatest concerns is that there is just one CNA there at	***Residents*** (a) "But you know, as far as helping us, some are good, some are bad. And they don't have enough help. That's really the thing, you know, having enough help to, you know to be right at your beck and call. And I believe that that is terrible and they try." This same resident continues: "I mean they work harder, but I just mean that they really need more working in this nursing home {Notice, she didn't call it a house} ***Family*** (a) "I think staffing was one of the concerns I had. It's still one of my concerns especially at night when they have only one person to a house." (b) "The one thing that I noticed when my mom was in the nursing home is that anytime she went in the walker, they would have the belt around [her waist] they would be holding onto her. When they moved over to WP, I think because it's more of a home atmosphere…I noticed that maybe a week or so later that they were walking her in the walker but no belt and not even hands on and I was thinking she might fall because she was really wobbly." "I don't want to see safety given up because it's a home. (c) "A thing that my husband complains about is that sometimes he needs to ring the bell and the light comes on and he	***Family*** (a)WRT staffing: "I feel like the staff sometimes is a little understaffed." (b)Still not certain who is in authority. (c)Still no consistency with placing staff pictures and names out. So, the family member doesn't know who is on that day. (d)Transportation ***Staff*** (a) WRT barriers to work: Part-time staff do not have a key card. They often must wait several minutes on the patio for someone to answer the door. This makes the staff member late for her shift. (b) The houses are equipped with washer and dryers. The linens are done by the laundry service on site, but the residents' laundry is done in the house by the Shahbaz. The washer and dryer are small capacity machines and furthermore they are front loaders without a platform. "…you have to get on your knees…it's like down on the floor and you got to get on your hands and knees and the opening is this big around (demonstrates small size with hands). It breaks your heart. You can put in like two pairs of pants and three shirts and the thing is full." (c)At OL there was a white board with important facts about a resident including likes and dislikes. It was easy to go over and check it. There is nothing like that

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rather wish to stay at OL because of staffing concerns. They believe that staffing levels are inadequate. At the *three month* time point staff questioned the compatibility between the resident and the environment especially under current staffing levels; the acuity level of the residents is too high for two staff members to provide adequate care. The demands of the residents seemed to be unrealistic, but staff didn't blame them. Residents said that they were told that they'd receive more attention. But on the other hand it sounded to me as if sometimes the residents were not courteous of the others. Staffing shortages, the Shahbaz say, put them at risk of injury because it is expected that one staff member will transfer a resident. Also, they fear for the safety of residents in an emergency.	night to take care of people because sometimes you need two to handle residents." (e) Concerned for personal safety. Some residents are very strong and resist help at times. This is especially so among the AD residents because they have little control over their behavior. (g) Concern for safety of residents.	has to wait a long time, but that happened in the nursing home also." & "Well at certain times he says he has rung and nobody has come yet." (d) WRT exercise/walking independently: "PT said they should walk him with his walker, but he is not supposed to walk by himself [even] with the walker, and they should walk him to and from meals. But at mealtime is their most busy time getting everybody there and serving up the food and all. To him getting some exercise is very important and I guess he still hopes he can walk again sometime, but at least if he can get up and walk with the walker at his pace it makes him feel a lot better. So I am not exactly sure. ***Staff*** (a) staffing levels – one Shahbaz in particular was burned out from pulling double shifts. One of her team members quit. When the staff were pressed for a little more information about why a staff member quit, the reply was that they were leaving for personal reasons, not because they disliked working in the GHs.	at WP so a new resident is really an unknown. If Shahbazim want to know about the new resident they must "go pull that chart and you've got to look. So you have to physically leave this place." <u>WRT demands from residents:</u> (a)There is a sense among the Shahbaz that the residents are not being realistic and that some are selfish. i. "two recent move-ins are expecting a lot of stuff; "I was told this and I was told that"., and it's like really?" ii. "I understand the residents have rights and I have no problem with resident rights, but they go way over and beyond. They think that they are the main…'Those other people, I don't care. I pay to be here and this is my house. You guys are supposed to do for me.' OK, but there is no people to help, 'I don't care, that's not my problem.' " <u>WRT sustainability of GH</u> (a) One staff member mentioned that current WP residents are coming in from other facilities because those living in OL do not want to move to WP because of the staffing issues (and related concerns about safety and quality of care). "We can't get other people from long term care, their families don't want them over here because they feel like there is inadequate staffing.…I heard this from actual family members, so I'm not just saying." This staff

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			member goes on to say that the family love the concept, but they are afraid for their loved one's wellbeing. <u>Resident & Staff Safety</u> (a) The residents who have gone to bed early will often awaken in the middle of the night and need assistance. Sometimes there are as many as three people at one time needing help and there is only one staff member on shift overnight. (b) "And when things do go wrong, like having somebody combative and taking you down, and then you are the only one there." (c) Staff members go on to describe the strength of one gentleman in particular who is suffering from advanced AD. He has been violent and injured staff. Sometimes he can be calmed and an incident is avoided, other times he cannot. (d) One gentleman is particularly heavy and the staff cannot imagine having to roll him over on their own: "Like he hurts my back just with the tow of us." (d) Volunteers and part-timers are very appreciated by the full-time staff members; however they are not as familiar with the routines of the house or the residents. So, for efficiency, the full-timers do all the patient care which is intense work. "…that is where a lot of that feeling burned out is coming from because you can't get the easy job to

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			give yourself a break or your back.…I had a resident dropped on me yesterday and it just feels like you, for two nights now, I have had this terrible spasm in my back. You can't give your physical body a break…" (e) One resident has been known to fabricate stories to get his own way (implicating staff in wrong doing, making accusations of verbal abuse). The staff feel they need to have another person around to serve as a witness. (f) "We are still understaffed". (g) Volunteers, while they are appreciated, cannot be of much help because they are not permitted, nor do they have the training, to do care tasks or cooking. (h) "I think we are understaffed". This Shahbaz goes on to say that there should be two people in on the overnight shift "I mean heaven forbid that something catch on fire and… (i) "That is one aid in a house of ten people and one nurse between three houses [if there were a fire] I would be in a panic." (j) The Shahbazim all told "horror stories" of residents "tanking" at the same time (residents crawling out of bed, becoming combative, having delusions and hallucinations) and the nurse being tied up in another house dealing with an emergency. (k) "We have no resources to call in at a moment's notice" so

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			when things tank it gets very overwhelming. The family members get upset.
Confidence *Attitudes, Feelings, Perceptions* There seemed to be confidence in the leadership among a few families pre-move. With that said, only two families commented on their confidence in leadership. At three months post-move two family members (the wife and sister of the resident) did not feel confident in the Shahbaz. I'm not sure that this can be generalized to the other families though. While the family members have commented on their concern about staffing levels, they have not said that they do not have confidence in the Shabazim.	***Family*** (a) "So far I haven't heard any complaints from them [CNAs]. I tried to talk to them and say 'OK how is it really going?' " Response: "It's great and we had another class today and it's good." {Not sure if this is a truthful response. It could be that the training is great, but the question asked had a double entendre which was, what do you think about this Green House idea now that you've had training, is it doable? I think the answer to the question is a cautious one because family members are not "safe" people with whom to discuss doubts, fears, or concerns.} (b) Family perception that leadership is confident about the change, "I am ready let's go now". (c) Confidence in leadership – this family member feels confident that the leader will choose staff members who will "pull their share of the load." "I think it will be a good combination."		***Family*** (a) A new family to GH expressed feeling less confident in the Shahbaz than she did when her husband was in a traditional nursing home. She said that she senses their discomfort and stress.
Creating Place *Living Green House and Culture Change* *Theory* Even *before the move*, family members were beginning to think about how to make their loved-one's room more like home. One family member was planning on taking her father back to his home so that he could pick out furniture to put in his room. Other family	***Family*** (a) "I am going to bring furniture from home and put it in his room, which I think will make a big difference [since] we haven't had a chance to do that here.…We have gone through the process of cleaning out the house and getting it ready to sell, and what have you, and just decided that some of these pieces belong in his room." (b) familiar belongings	***Resident*** (a) One resident was unhappy that her bed had not yet been made. I think this was speaking to a few things: (1) wanting to keep her space neat; (2) not having control over tidying her space (the Shahbaz will not allow her to make her bed because she is a fall risk); and (3) a need to adhere to home-like routines. ***Staff*** (a) "…there is not much left that looks like a	***Resident*** (a) One resident has ornamental geese outside her bedroom door. She dresses them in holiday themed outfits. In fact, her bathroom guide rail holds an entire wardrobe of outfits for her "goose children". The geese are outside her door, so perhaps it is symbolic of a boundary – pushing out her space. It is an expression of herself too. (b) Resident is concerned about the dining room

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members were purchasing new furniture for their loved one (making it a gift) At the one-month follow-up residents said that the GH was beautiful and they liked all of the rooms, but that their own room was their favorite. One resident was taking control of her space by wanting her bed made and the room kept tidy. She also contributed to the running of the house by setting and clearing the dishes during meals. Participating in meaningful work (and a strong desire to do it) serves several purposes: (a) it is a contribution to the community; (b) it is an out word expression of belonging to a place; and (c) gives personal satisfaction to the doer. During a later visit *(3 month follow-up)* two residents showed us their bedrooms. Again, this is an expression of their belonging to this place and having their own space to which they can invite you or not. Another expression of belonging or ownership comes from wanting to keep the furniture nice. One resident fretted over the table. The table is special to her and she wants it cared for properly. This table is not hers, but belongs to the community. She assigned meaning to the object. In addition, this same resident has "goose children" which she placed outside her bedroom. Perhaps a	(c) making space home-like (d) fulfilling filial duties (by selling parent's home and retaining some of his/her furniture) (d) reuniting elder with cherished possessions (e) aiding in reminiscence	nursing home. It just makes you feel right at home."	table. She fears that it will be ruined because residents spill food and drink on it. She feels as if the table does not get cleaned properly the finish will be ruined. This resident returned a number of times to this topic. (c) residents enjoy the sunroom and the hearth, but like their own rooms best.

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subtle way to push her space boundaries a bit further out.			
<u>Connecting</u> *Living/Practicing Green House, Culture Change* Staff members at both the pre-move interviews and the three-month interviews expressed an understanding of the importance of having privacy. There was an acknowledgment that residents get lost in the task oriented environment of a traditional NH. In general, the aides were open to learning more about the residents in their care so that they might connect with them. One resident in particular expressed her gratitude for the staff because they understand when she doesn't feel well and they do not push her to do more than she can.	***Staff*** (a) "It's a place to go where it's your space. I value that in my lifestyle." <u>Empathic Care</u>: (a) "So the resident is the one that gets caught in the shuffle and quality care gets lost because you are busy worrying about getting a lot done as opposed to getting it done well."	***Resident*** (a) "I have a bad back so they know it and if I want to go sit down, take an aspirin, whatever, I can do it. They understand it."	***Staff*** (a) "We sit down and talk to them about things and find out why they are the way they are, why they don't like the walker and why they don't want in the bath for a while and little things like that, and you just understand where they are coming from."
<u>Enjoyment</u> Outcome		***Resident*** (a) The evening is great. I like the food. It's a lot warmer. (b) birthdays and holidays are celebrated. (c) play games (d) watch tv (e) enjoy visitors (f) enjoy their rooms	***Resident*** (a) good food (b) play cards (c) watch tv (d) enjoy visitors especially children and family. (e) enjoy TV/baseball games
<u>Expectations</u> All stakeholders cited privacy as one aspect of GH that they were looking forward to (for the residents that is). Staff were also expecting to have time to get to know the residents and to create closer relationships with residents. However,	***Resident*** (a) privacy (b) own bedroom and bath ***Staff:*** (a) "actually have time to sit down and speak to the resident like they are a person." (b) "It will be nice to actually sit down and connect." (c) "Closer relationship with elders there and	***Staff*** (a)That you will each pull your load: "If you work together and you are fully equal that way, you are going to have a good day. But if your partner is not pulling his/her own weight, you wear yourself out in a short time…"	***Staff*** (a) WRT expectations of residents: "But [residents] are misled the way we were misled about the way things are to go on here too. So I am not going to fault them. They are told one thing and in reality it's a whole different world." (b) There is an undercurrent of

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not all staff were expecting a smooth transition. Two were quite certain that chaos would ensue due to the lack of structure. At the one-month follow-up expectations for staff shifted to work related issues, such as team members pulling their own weight. At three months staff expressed frustration with residents' expectations and their own training. Staff feel that the residents were promised a certain level of care that the Shahbaz cannot deliver. Because staff did not receive training in any of the coordinator roles, the burden of the learning curve and care duties is overwhelming. So the expectations that staff would be able to cultivate relationships by baking, playing games, etc. is not being realized (in some of the GHs, not all).	getting to be one-on-one instead of the hustle and bustle. (d) "I'm not sure what to expect." (e) "I would have a one-on-one bracket where I would listen to them, read a story, bake cookies." (f) "Involving more of the family and the nurses and whole staff just participating in individual care." (g) CHAOS: "…thing I really struggle with is the way VMRC does the resident centered care. Like they are turning around telling everyone they can get up when they want, they can eat when they want, they can do this,…for me working with the type of residents that we are moving to WP I see absolutely total chaos."		disappointment. The staff were shown videos about GH in which the elders were higher functioning than the majority moving into WP. The staff members looked forward to getting to know the residents and to being able to interact with them on a more personal level. However, the acuity of illness among the elders coupled with the new responsibilities has simply overwhelmed the staff. (c) "Green House is to be more like home care…" The acuity level in the Green Houses is so high that this staff person believes that the residents would be better off at OL where this is more staff and more structure.
<u>Family</u> *Outcome* Family members were actively involved in the move either by weighing in on the decision to move, or in helping with the move. Staff have noted that residents' family and friends come more often to visit since the move to GH. They believe that the environment and the ease of access to the houses has helped. One family have had to hire an aide to come in an sit with their father	***Family*** <u>Filial duties</u> (a) closing and selling parent's home, (b) making or contributing to decision about moving parent to GH, (c) visiting, (d) monitoring care. (e) helping to move parent's belongings to the GH. (f) "So, he is kind of okay". Daughter gently coerced her father into making the move. (g) Information seeking coping style (gathered as much information as he could) when considering moving his mother to GH	***Staff*** <u>WRT Family Involvement</u> (a) "We see family members that weren't coming as much over there that are coming a lot more over here and a lot more in the evening. There is nonstop flow." <u>WRT visitors</u>: (a) It is the perception of the Shahbaz that the residents are visited more often. "It's enjoyable over here. They have their own private room and they have the hearth room and the sun room, they can go outside, so they definitely feel more comfortable.	***Family*** <u>Involvement</u>: (a) Family members visit frequently and have observed that the houses seem to be understaffed and the environment feels stressful. (b) One family's daughter has paid for an aide to come between 11:00 a.m. and 7:00 p.m. to give her father one-on-one attention. (c) One family member comes on Sunday to take his mother to church. He feels that if he didn't take her she wouldn't go. "It's not a problem because I come and take her, but if I didn't come here she wouldn't go. She needs

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because he requires a lot of assistance. Family want to be and are involved in their loved-one's lives. The four or five family members who have consistently participated in this study are clearly different from the family who did not participate.			somebody to physically take her. She needs somebody to physically taker her."
<u>Feelings</u> *Attitudes, Feelings, Perceptions* • Feelings about environment • Fears/worries During the *pre-move interviews* <u>staff</u> mentioned that they were worried about the move. They had the ideology from training tapes, but they didn't really know how GH was going to work out. <u>Residents</u> were afraid of the change too. But they were excited for the opportunity to have their own room and to be in a new and bright setting. <u>Family</u> members too were excited for their loved ones to move out of the institutional setting and to be living in a home-like environment. At the *one-month* follow-up <u>residents</u> said that they liked the environment better than OL; however there was one resident who said she wasn't sure that she liked it there. She felt cut off from the rest of the community. During the same time frame <u>family</u> expressed satisfaction with the living environment, and some disappointment with	***Staff*** "A little scary not knowing where it [Green House] is going."	***Residents*** (a) "Well, I think most of us are really appreciative of where we are [now]. (b) "I liked it better down there [OL]. This is a nice place, but I am so limited. I don't know if I like it" (c)I am happy here. You are so at home, living here." (d) Yeah, I'm happy here, but I would like to be at home." ***Family*** (a) During this interview one family member became emotional when describing staying with her husband for the first 24 hours after his move into WP. (b) Same woman as above shared with us a description of the WP GHs that one resident offered her: "one of the other residents said, 'this is an old, old house that they fixed up; it was a plantation estate." (c) "…[Mother] likes the programs, when they bring children and have programs for them, so she is missing some of that. She doesn't realize she is missing it, but I do and I know…" (d) "In comparison [to OL}, think about it, he might spend the rest of his days in this half of a	***Residents*** (a) WRT living at WP: "I guess it is alright". This woman continued to talk about making adjustments (not caught on tape because she was soft spoken.) (b) WP is beginning to feel like home. (c) WRT having to use a walker: "I don't go out by myself. They won't let me go anywhere alone and I have to have that darn thing with me all the time." ***Family*** (a) The way I feel if mom wants to eat spaghetti and pizza and ice cream every night, let her have it. (b) There are some inconveniences but to have such a nice place to live, it makes my husband feel a whole lot better and makes me feel a whole lot better. To think of him being in oh just half of a hospital room…It's really, I think, a plus." (c) "I think it [WP] was planned for the physically [able]. I mean it's not to say that I am not glad he's there, but I am happy that he is over there, but I do think they are understaffed." (d) New family reported that loved one was

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the decreased access to the main buildings. For one family in particular this was a barrier to interacting with their mother. She felt the loss for herself and for her mother who enjoyed listening to the music and seeing the children's programs. Staff expressed positive feelings about working in the GHs, even though it was a difficult transition and continued to be. In spite of the difficulties in adjusting to new roles, some said that they wouldn't want to go back to working in a traditional NH. At the *three-month* interviews residents still held positive feelings about the GH. Some were still adjusting to the other residents with whom they lived, and others felt as if this was home. One resident wanted very much to help around the house, but felt frustrated by restrictions that policy had dictated. Family members were still pleased with the GH environment and felt that while it is inconvenient to be separated from the main building it is worth the trade-off. Staffing level concerns continued to be a main topic of conversation. Some staff members are less enamored of GH than they were at the outset. Staffing levels continued to be a problem that influenced the aides' feelings about working in the GH setting. One commented that she didn't feel that the aides		hospital room like before". ***Staff*** (a) "it was really hard" (b) "I love it. I would not ever go back to a traditional nursing home." (c) "I think we both like it like this." (d) WRT confronting a coworker: "I don't want the conflict, I just want to do it [the work] and get it done. I don't want my work or anybody else's work not being done and put on the next staff coming. I don't feel good about that and I don't feel comfortable and I don't want conflict so I am not policing and saying anything. I feel like we are adults and we should know better." (e) Staff reported that some residents say "I hate it [here – WP] because they need more structure."	looking forward to moving into the GHs. ***Staff*** (a) Report feeling overwhelmed. (b) Report that GH model does not work in their house: It's not [working], but it might be working in other houses.[paraphrased] (c) "It's just a lot of responsibility and I don't even really think it's worth the pay increase. (d) I just want to be a CNA.

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were compensated commensurate with the degree of responsibility that they have. Another wished that she could just be a CNA and not worry about all the coordinating stuff.			
<u>Green House/Ways to know GH</u> *Living Green House & Culture Change* • Green House Characteristics • Pros and Cons to Green House • Ideology vs. Reality • Living GH, being • Comparison GH vs OL Pre-move, most residents, all family, and all staff members could give a definition of the GH model of care. Family had expectations about the GHs. There was an expectation that the environment would be more calming (this is an expectation, but was part of this woman's definition of GH). Family recognized that aside from privacy their loved-ones would be cared for in a less regimented environment and would have the opportunity to engage in social activities. Staff could also give a definition of GH. Some of the staff members were excited about the change, while others were less excited. I think that there is some fear of the unknown. But in addition there may be an inability to or a	***Residents*** <u>Green House Characteristics</u> WRT Residence: Some understood completely where they were moving and the philosophy of care. Others seemed clueless. ***Family*** (a) "I think it's going to be a calming effect on the residents that will be there." (b) "Your know, their main focus is on the residents and they will take care of them first and then whatever else needs to be done, laundry or whatever, that can be done at another time". (c) flexible (d) home-like (e) private room (f) more like a family situation (g) mom will be able to participate in food preparation (h) Connecting with nature (i) Stimulation (j) "will probably have something for them to look at [father is in corner room]. (k) "will probably have flower gardens or put up bird feeders there." ***Staff*** (a) "…it is a place for LTC and where we are overseers in a house setting as opposed to institutional, where you sustain and protect and nurture and it's kind of a	***Resident*** *Residents WRT <u>comparison of GH to OL</u>* (a) "It was dark, a gloomy place [OL]. It was maybe a little sad, a little depressed and you come over here and "on go the lights', and everyone gets along real well and there is something to do all the time." ***Residents*** (a) WRT <u>Meaningful work</u>: "But I like it a lot and I like helping. I get to help, my job is the dishes. I set the plates, the placemats, and the meal s, and clear the table. (b) "We do the jobs they ask us. It's a lot of walking to and from the kitchen, but I always get everything on the table ready. I use my cart, I have a tray that goes on it and I can collect orange juice in the morning. I do what I can. " ***Staff*** <u>Green House Characteristics</u> (a) "…there is not much left that looks like a nursing home. It just makes you feel right at home." ***Family*** (a) "…but it was so much nicer being there and he has his own room and it's house-like around." (b) "It's much more pleasant to go into and we	***Resident*** <u>WRT nature</u>: i. "You'd be amazed, there are daisies growing out there. You can see them through the windows. In the daytime I can see the daisies." Q: are their animals back there too like squirrels and rabbits? A: Yeah, yeah. There are squirrels and the birds too. They feed the birds but the squirrels eat it up. The squirrels eat berries and nuts." ii. One resident commented that she liked to look out her bedroom window because of the view (trees, flowers, birds). iii. Watches the birds and squirrels iv. Another resident said that she has a view of the trees from her room. She said, "It's like at home a long way away." <u>Reminiscence</u> i. This (item iv) lead to a question about where she had lived, which was Texas. It so happened that one of the other residents has children living in Texas. So there followed a bit of reminiscing about children, work, husbands, and grandchildren. (Could also go under Personhood) ii. Later we were invited to see a resident's room. He spent time telling us about the paintings on his

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<td>resistance to move beyond what is traditional, to move away from how one was trained.
I also got the sense from one aide in particular that the vocabulary of GH might be a bit too pretentious or high minded.

At one month residents reported being pleased with the environment. They all agree that it is pretty and bright. However, many feel cut off from the main building and especially the activities. Transportation is not frequent or consistent. Family agree. Some family worry about their loved-one's safety because the elders are trying to do things for themselves which is putting them at risk for falls.
At one-month staff feel that the concept is good, that the environment is better, but they feel overwhelmed by the new roles that they have had to take on. In addition, the residents are far more disabled than those portrayed in the training video.

By three-months residents are settling into a rhythm, seem to be happy to be in this environment, would not want to move back to a standard NH, but do realize that they've needed to work through an adjustment period. That is, getting to know new people, waiting for help, having restriction upon what they can do.</td>
<td>personal reflection on the residents."
By Contrast: "…a lot of the folks are thinking Green House being a place you grow plants and things like that" and "I don't use the term Shahbaz because people are like "what in the world is that?". I am just a CNA. For me I look at it in a different way."
Christine: maybe the terms are too pretentious?
(b) home-like
(c) "more like a home than as institution".
(d) "long-term care with a home setting. It has a lower ration of staff as to elders"
(e) "It's easier sometimes to have that other person there to kind of help me with it [an issue] because that's her position to do that and I feel like people respect authority when they are in authority, but we understand in class and have been taught to come together as a team in dealing with issues is a necessity".
(f) "I look at it more one-to-one relationship with the elders involving more of the family and the nurses and whole staff just participating in individual care."
.</td>
<td>can move about, we can stay in his room privately and have privacy, or we can move out and often other family members come because in his room it's kind of crowded and so we have other little spaces to go and visit and it's just more homelike."
Staff WRT comparing GH to OL
(a) Work preference OL or WP? "My preference is exactly where we are. Here."
(b) Much more difficult to have functions for/with the residents when they were at OL. In the GHs it is much more manageable.
(c) WRT visiting at OL: "Yes, and it wasn't like home and you could hear everything on the other side of the curtain."</td>
<td>wall and what he liked most about his room.
Resident WRT Community:
(a) Enjoys eating at the table with the other residents. Also enjoys being among the other rather than staying in bed.
(b) Likes helping to set the table, etc. It is not only meaningful work for this person, but also contributes to the house/the community.
(c)Preservation of the dining table seems important to one of the residents – perhaps it is to keep it nice for current and future residents.
WRT Meaningful work:
(a) Well one of my main jobs that I do is that I do the tables. I set the table, I fix the orange juice, I put the napkins and the plates and the silverware out. I go to the pantry for things they might need. That sort of thing. And I don't feed anybody, I just supply whatever they need.</td>
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Family agree that it is a lovely setting and that they would not want their loved one living at OL again. However, they are still concerned about understaffing, resident safety, and the lack of access to the main building. Residents are missing out on the programs. At three months some staff agree that they would not want to go back to OL whereas others wish that they were a regular CNA again. The work roles and level of resident acuity continue to be a struggle for the aides. Understaffing also continues to be a problem given the level of disability among the residents and the additional work responsibilities.			
<u>Hopes</u> *Expectations*	***Staff*** (a) "It would be actually nice to sit down and give a resident a hug and let them know they are enjoyed as a person and not just another object that you have put on a list that you took care of today." (b)"Instead of working around a nurse's schedule, we work around their schedule. With the smaller setting we are hoping to have time to fulfill the hours for the residents on their terms a lot more than what is going on in the institution." ***Family*** (a) "They are not going to be in their room all the time either. They want	***Family*** (a) [Administration] is hoping to have more [shuttle] service later."	

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	them out in the social area so that is going to be different." (b) "bring the resident out a little". {Not sure if she means out of themselves, or simply out of their room} (c) "I think it's just going to be a very calming peaceful setting. At his age I want him to be comfortable. So we will keep our fingers crossed." (d) **Hoping Green House will be a place where [mother] thrives.** (e) Hopes father will reconnect with world affairs "he is out of touch with what is going on in the outside world". (f) Daughter is anxious to see if dad takes up some old habits such as watching TV, reading paper, following stock market. (g) hopes mom will get out of wheelchair more often		
<u>Improvements</u> *Outcomes* Improvements in health status and quality of life were noted by residents and staff: food is warmer and this is more variety, the environment is pretty, cheerful, bright. There is more opportunity to get to know other people. The staff recognized changes for the better in residents such as, eating and sleeping better, walking more, and socializing more. Staff believe that the residents are getting more visitors now too.		***Residents*** (a) Food is warmer (b) More food variety (c) Prettier environment (d) Opportunity to meet new people "I met a few people here, and l like meeting people. ***Staff about Resident*** (a) "I actually do see a change in some of the status. That is we did have people who did have a fear who couldn't walk by themselves or you know didn't feel very well and then they come over here and they start walking, they start getting better…" (b) Residents are being drawn out of themselves. "She wouldn't hardly come out of her room for a meal and we can't keep	***Residents*** (a) "easier to get help" (b) more freedom (c) meeting different people (d) get to go outdoors more. (e) More opportunities to be social. Some have made friends. (f) receive more visitors and more often.

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		her in the room now. She would go around and encourage people to and she was up doing things." (c) "One resident wouldn't even talk, and now, over here, she is talking, she is actually walking, she is actually eating more than she did. It's definitely an improvement in everybody. One used to always want to stay in his room, eat in his room and now he comes out for games, sits at the table with everybody. There is definitely an improvement." ***Family about Loved-one*** (a) "In general…I think they are really caring and are trying to take care of her and I think she seems to be eating better. She is talking a little bit more and they tell me that she is walking better."	
Job/Work *Adjusting* ***Theory - Environmental Press*** • Elements of the job (both positive and negative) • Training • Work Coordinating Staff are struggling with the coordinating roles. They are **having** difficulty balancing those duties and their care duties. Staff feel unprepared for the coordinator roles. They feel that they were not trained to take on managerial tasks and that CNAs should have had the opportunity to visit a GH.		***Staff*** Training (a) "We were prepared until we walked through the door and started doing it." (b) "We had a lot of ideology and lots of training and so we had an image in our mind of what it was going to be like.…the residents can sabotage that because they want everything right away." (c) "In the video they made it look like it was just one big assisted living people." & "They made it look like people you could communicate with and there are hardly any." (d) "I sort of wished we would have went and visited another group home. I kind of wish we could see how they are	***Staff*** Training WRT going to an already existing GH: "…just so I can see the way someone else does it to see the type of resident they have. I want to talk to the workers there myself because when they sent all of those people to the model homes they sent people who were office staff, they did not send people who do our jobs. They saw it from the surface level, they did not see just like now, with our guide, she doesn't see what goes on behind those doors or the things that are going on." (b) a lack of experiential training, or reality based training. (c) "I still have all these underlying things, like

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		doing like cooking a meal and doing the work. I would have liked to go for a night and see what they do." (e) WRT being prepared: "Like I didn't know, and some of the others didn't know that you had to do all of these little things that we never even knew about. I am just now learning about some of the things that we should have been doing". Work ***Staff*** (a) "I struggle with having enough time for certain things. Like the care coordination scheduling without giving overtime. I don't envision you can do it because we can't take care of someone when we have stuff to do on the floor [in the house]. (b) "They [the coordinator] take care of the team meeting, resident meeting, resident counseling and things like that. They keep the birthday cards and things like that.…Our full timers each have a care charge and the coordinator is in charge of all the scheduling and that person is in charge of housekeeping."	coordinator roles, that we have to do and for me, I don't feel like I've been trained sufficiently to do any of them. We had training before we opened but it was very minute. And as far as training on how you are supposed to do it, I haven't no clue". Teamwork (a) "You need teamwork for cleaning the place, and so on." ***Staff*** (a) Coordinating roles: dietary, housekeeping, nurse scheduling coordinator, care coordinator, and team coordinator. "We rotate but it's like three months on and then a four month break."
Lack of *Adjusting to GH*		***Residents*** (a) Transportation from WP to OL to attend church, go for physical therapy, have a haircut, go to the gym. (b) Convenience and access to programs.	***Staff*** (a) From the interviews, I got the sense that the staff felt a lack of i. support from leadership, ii. understanding iii. experiential training iv. manpower
Leadership *Attitudes, Feelings, Perceptions*	***Family*** (a) Confidence in leadership.		***Resident*** (a) "The lady who runs this place is very nice" ***Staff***

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			(a) WRT to Guide: The staff are somewhat disappointed with their Guide. "We have no guidance when it comes to issues like [defusing a combative resident]. She is not a nurse and is assigned only part-time to the houses so she doesn't have a lot of time to dedicate. Moreover, she doesn't comprehend or understand the aides. She comes into the houses periodically and it is usually in the morning after the residents have breakfasted and everything is calm. So, she doesn't see the chaotic times of the day. (b) "We have no resources to call in at a moment's notice." I don't think that this is being understood when we try to assess what's really going on because we can't talk with her (the guide)". I don't mean anything against her but she needs to come into our house frequently and see what is going on on a regular basis and someone who really we can go to and say this is our issue and they are going to comprehend our issue." (c) Guide does not give ample time during team meetings for hearing about the issues and working on solutions. The CNAs feel unheard.
Optimism/Enthusiasm *Attitudes, Feelings, Perceptions* Pre-move, one family member commented that a member of the team, Lisa, was enthusiastic about the move.	**Family** (a) Leadership enthusiasm is contagious "I think her [Lisa] enthusiasm is going to spill over." **Staff:** (a) "I like the concept. I think it is going to be great for the resident and once we get,		

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However, while no other family members said specifically that they were enthusiastic or optimistic, it was clear that they were excited for this opportunity. Staff members were also excited about the move. To be specific, three in particular were excited about the concept/ideology and felt optimistic that they would be able to do the work, that everyone would adjust, "get into a groove".	as they say "our groove" as a team working with the residents I think it's going to be really good." (b) "I am excited and concerned." (c) "I think it's great that they have free choices and I think it's exciting that they have choices about food because food is a big entertainment." (d) "I am excited about the [Green House] and I think it's going to come together fine and I think us being brought together as a unit and as a team we can draw from each other's strengths." (e) Looking forward to meeting and working with new people. (f) "With everybody coming in every unit being positive, it may take a second, but I think it's gonna work…"		
<u>Perceptions</u> *Attitudes, Feelings, Perceptions* • Work load • Miscellaneous At one-month residents perceived that the nursing staff were more laid back. However, one resident did note that the staff have more on their hands. Another resident noted that the staff seemed like ducks out of water. Another said that the staff are still working out the bugs. With regard to the GH model, one resident said that he hadn't expected it to be as radical a change as it was. I didn't get the sense that this was a negative comment either. Family members' perception of the move		***Resident toward Staff*** (a) "…the nurses are kind of more looser in my opinion, and over [at OL]. They work with you…" (b) "I can see they have more on their hands than what people think they do. You know, they [residents? administration?] think all these people [staff] are maid workers." & from same resident: "I think for the amount of people that they have to wait on, they don't have enough workers, they should have more workers. If they had more workers they could give the residents more attention and I just think it would be better all around. I am not business person, so I don't know." (b) WRT staff transition: "The staff, like everyone	***Resident*** (a) WRT Transportation: Q: Has the transportation issue been addressed to your satisfaction? A: "It seems like it's worse, but we have to put up with it." But another resident commented that he "thought that it was better." (b) WRT visitors: Maybe visitors come more often because of privacy. "I believe it's the fact we have more private room to see them." (c) When asked about a favorite room, most residents said that their own room was their favorite. "I like my own room better than here. This is shared." (d) "Now there are several ladies that have to be fed and the nurses' aides do

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was that it went fairly easily for their love one. Staff on the other hand said that the change was very hard indeed. This was not the case for all Shahbaz though. One commented that it went smoothly in her house. There is a perception among some staff that the organization cares about them. Most agree though, that they could use more staff because it is difficult to do the care tasks as well as the coordinator roles. Some aides agreed that residents seem to be getting more company than they did while at OL. At three months one resident did not perceive a difference in the transportation issues; although, another did. Most believed that they see more visitors because there is more privacy – a nicer way to receive guests. It was interesting to me that one resident, in spite of the setting, still perceived herself as a patient. She refers to herself as a patient. Family perceived the transition as going pretty well. One resident did find the change scary; however, she has adjusted and likes the staff. Another family member commented that the chaotic atmosphere has made it difficult for her husband to adjust (he is new to WP). Family have made some observations of staff: some staff do not enjoy		else were afraid of change.…when they were first over here they were like a duck out of water. They didn't know quite what to do because everybody didn't train to do everything, but it took a while to work the bugs, and they are still working on this." <u>Resident toward GH</u> (a) "I did not expect the change to be as radical as it was." ***Family*** <u>Transition</u> (a) "I thought that it was very well planned for my husband's move.' (b) "He [husband] was looking forward to the move very much." (c) "It went pretty well, I think." "By the time [Mom] got to WP everything was ready for her. It was a nice experience and less confusion and not "what are you doing with my furniture and what are you doing with my clothes."" {Mother can become paranoid so to avoid triggering this, one family member took Mother out and about while the other moved Mother's belongings to WP}. ***Staff*** <u>Transition</u> (a) "It was really hard." "It took a while to get used to the work load as opposed to the workload at OL. Just getting in a routine like that." (b) "I think in this house it went pretty smooth for the most part." (b) "They [administration] care about us too. We have a life, where at other places they help the	that, I don't do that. I don't <u>because I am a patient</u> and I am not allowed to do a whole lot." (e) While we were interviewing another resident was moving into the house. Undoubtedly there will be another period of transition/adjustment while the staff get used to the new resident and the residents adjust to the new person. (f) "Thy are all private rooms here. I have a very nice room. Fact I think it's nicer than the room in the other building." (g) Q: has the staff been consistent, that is are they the same people? A: "They are all the same and you get to know them very well." ***Family*** (a)<u>WRT transition</u>: i.Relatively good transition. At first it was different and scary for mom, but she got used to it and now she seems very content there and she likes the staff. (b)<u>WRT to staff</u>: i. I like the way the staff is interacting with her and they seem to be providing for her needs very well. ii. I feel like they are often pushed to a mental limit. iii. Some of the staff seem to not enjoy the cooking part so much. Maybe they haven't been trained. iv. "I guess I echo some of what has been said here is that the Shahbaz are really overwhelmed and sometimes they were running around and so there is not this calm confidence that really sort

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cooking (a perception), staff are pushed to a mental limit, seem overwhelmed, lacked a calm demeanor, and did not radiate calm. There does seem to be a difference in stress level across houses. Could be the patient mix or the personality mix of all. Family members perceived that, for the most part, their loved ones enjoy living in this environment. One family member noted that her husband seems much happier, especially since he can look out his bedroom window and see all the flowers. Another required a private aide to help him get through his day. Family perceive a lack of professionalism among the staff members. Perhaps they are getting too relaxed? Part-time Staff members perceive one of the houses as being the nut house. It seems that they are always in crisis mode.		residents and don't care about us." (c) "The residents seem to be getting it all figured out for the most part. It's more ideal so when you look at that the residents are happy as they could be there." (d) "Too overwhelming sometimes." (e) WRT to work: "I feel kind of like a fish out of the water." (f) WRT visitors: It is the perception of the Shahbaz that the residents are visited more often. "It's enjoyable over here. They have their own private room and they have the hearth room and the sun room, they can go outside, so they definitely feel more comfortable. (g) Feels that two staff members is not enough, but they have someone that "we can call or holler. We can't push too much so…"	of calms the people. You know what you need or want the Shahbaz to be calming, confident and that I can do what I need to do and so there is a sense of underlying anxiety that I am not going to get it done, I am not on top if it and that has exacerbated [my husband's] adjustment." v. Maybe it's like we're stuck in this old hospital, like were talking about, but the nurses provided a sense of confidence that there was somebody in charge and there is somebody we trust to know the whole picture, and it just gave me a sense of when I'm seeing certain nurses' care outside I am 'phew, she is on for the night', and I think the nurses being as detached as they are [here at WP] means they can't nurse. vi. There appears to be some inconsistencies. For example, a resident needs Tylenol. One Shahbaz might administer it while another won't. {I wonder if this family member is getting the RNs/LPNs confused with the Shahbaz}. (c) <u>WRT to loved-one</u>: i. "He seems to enjoy being there more because in his room he can look out at the flowers that are so pretty. All that seems to me he enjoys so much." (d) Family hired an aide to give husband/father individual attention. "He is one that really needs it". His wife goes on to say that her husband was not put to bed as early as she would like "and he would also at night be up

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			a lot and create problems for the Shahbaz and it was one person working during the night and she would have to devote her time to him." (e) WRT GH: I believe that [administration]came up with this project for assisted living more so than [for those]who need full care because, I think they are understaffed and under pressure because of being so many guidelines that they have to meet…" WRT GH Philosophy of Care: I think family members are still struggling with the idea of a flattened hierarchy. They want to know who is in charge, they do not care for the casualness of the staff members towards them and the residents. Seems to lack professionalism. Because of this confidence in their [staff's] abilities is low. Both families and residents feel less safe. "Then there is a lowering of professionalism which then is going to make the residents have less a feeling of safety." ***Staff*** WRT difference among houses: (a) There seems to be a difference in stress level by house. One staff member who floats between the houses said of the Green colored house that "this [house] in my honest opinion is the nut house". The red house is much calmer. She noted that the staff had time to sit down with their residents. And the blue house is up and down. But the green

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			house staff are constantly on the go. (b) There seems to be a difference in the residents' needs by house. Perhaps the green house has many higher needs residents. (c) In the green colored house there seems to be some drama that centers around two residents. (d) "I am just learning how things seem less dark out here." ***Resident*** ***(a)Refers to herself as a patient even though she has been living at WP since it opened. I think this is significant.***
Person-environment fit *Environmental Press* **Theory** PE fit and EP were not evident at first, with exception of one staff member who noted that some people are going to be stronger at one role than another. By the one-month follow-up this construct became more evident. Staff commented that the GH environment was detrimental to the well-being of one resident and thus she was transferred back to OL. At three months, PE fit and EP are concepts that the staff are questioning. For example, they wondered about the wisdom of transferring a resident to WP who required three aides to walk with him. Also there was disconnect between the training video and the lived reality of GH at WP. Residents	***Staff*** Environmental press: "There are people who are stronger at one role than another. How are you going to mix all those roles together and rotate those roles, each one has a learning experience?"	***Staff*** about a Resident Person-Environment Fit (a) Green House environment was believed to be detrimental to the wellbeing of one of the residents. She felt cut off from the community at Oak Lea (OL). As a result she felt desperately unhappy, so she moved back to OL. Staff said they were afraid that she would die if she stayed at WP. (b) WRT to knowing which residents were moving: "Well they [administration} just picked and we helped and if the family member didn't want them coming down here they wouldn't move off the floor and the people that wanted to go were welcome. So we kind of had a bit of an idea."	***Staff*** Person-Environment Fit (a) an elder is moving into the one of the Green Houses (from OL) who requires three people to supervise him when he is walking. One behind him and two flanking him. This is a recommendation made by Physical Therapy. This is impossible for the Shahbaz to do. It is not a realistic expectation while he lives in the GH environment. (b) "We recently got a gentleman too who is the perfect person. The only thing you really have to help him do is help with his cath bag and assist him with showers". Another staff member responds, "See that is the kind of people that were here when two people would be good." In other words, a higher functioning elder would be easier to care for under the current staffing structure. And another staff member pipes in

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portrayed in the video were higher functioning than those who moved into WP. Not all the residents are high needs though. A gentleman who had higher cognitive function and less disability recently moved in to WP. The Shahbaz said that he is the perfect candidate for this environment, especially under current staffing levels. Among staff there is a perception that the guide is not well suited to her job. While she is a very bright individual, she does not have a nursing background and thus has a difficult time connecting to the Shahbaz (that is, really understanding the Shahbaz).			"and he's got his mind, you can talk to him and have conversations with him. He can have engagements with other people…. Most of [the residents] we have to engage the entire conversation. (c) "I am not trying to be ugly about this, but I think that there should be more strict stipulations of who is accepted to live here because there are some people who on the model Green House, they don't fit the model Green House." (d) "It is not beneficial over here for them, it hurts them more than helps them. It really does. I mean you meet people who can barely walk, there is more structure at OL, but here…. (e) "They aren't in the right place physically or mentally. It helps so much when they can be part of it. It's just hard you know." (f) WRT the guide: perhaps the role that this person has taken on is not a good fit for her. She may not be adequately trained or she may not like this aspect of her work.
<u>Personhood</u> ***<u>Making Connections</u>*** Living/Practicing Green House & Culture Change	***Staff*** "I would say that the thing that stands out the most to me is the private rooms. There is nothing greater than your own space, and when somebody is in your space it takes away your rights to be your own person."	***Resident*** (a)Similar to (g): "They tell you sometimes you have to wait in the bathroom, but I know they can't really help that." (b) "At first they would sometimes walk in the room without knocking. I didn't like that. I wouldn't say they were disrespectful, but the door is your door. They shouldn't walk in	***Residents*** (a)O ne resident had an especially lovely view from his window. He invited another resident to come to his room to see the squirrels. ***Resident*** a) One resident had an especially lovely view from his window. He invited another resident to come to his room to see the squirrels.

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		unannounced. I like it though. Not having a roommate." (b) All residents liked having their own room. (c) Most residents agreed that their favorite room is their own room. (d) WRT privacy: "We have privacy in many ways in the building, you know…"I say most people take advantage of it and do enjoy it." ***Staff*** (a) Staff plan activities, some are spontaneous. One afternoon following a snow storm one of the houses had a snowball fight in the tub room. "I don't know how it started, but we had fun." & "You all did the bubbles one day and sit out and have milkshakes. And one of you decided to do the Easter baskets. We did it as a group you know, like a family. " (b) One house in particular is called the party house. They celebrate birthdays, Valentine's day, Easter, and they had a Superbowl party. (c) "They [other residents in WP] come over here for Bible studies. We keep the gate open when we're out and sometimes we open our doors then. They can come in and out. We can go over there, you know." (d) This environment has drawn the residents out and has, for better or worse, put them at some risk for injury because they want to do more, to be more mobile, to engage in meaningful activities. "She tried to do	(b) We were invited to lunch with one of the residents. (c) Q: has the staff been consistent that is are they the same people? A: "They are all the same and you get to know them very well." ***Family*** (a) One family told us that one nurse in particular was able to calm her husband during a particularly stressful event. One morning the fire alarm sounded (it was nothing of consequence, just a glitch), but the fire department had to come and there was the fire truck and fireman traipsing through the house making all kinds of noise and disrupting the morning routine. The Shahbaz were running around trying to take care of and calm residents. One nurse (RN) had come over to distribute medications and seeing that the resident was distressed she took him along with her on her rounds. This was very comforting to him. ***Staff*** (a) WRT making connections with the residents: "Here you have more interaction with[the residents] and you can talk to them about things they enjoy doing and their family. You get really like friends being with them daily." (b) "We sit down and talk to them about things and find out why they are the way they are, why they don't like the walker and why they don't want in

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		so much and we're not watching her 24/7 and she fell. But even now she still comes out and you know when she is feeling good trying to do things. It's a huge change in her." (e) WRT visitors: It is the perception of the Shahbaz that the residents are visited more often. "It's enjoyable over here. They have their own private room and they have the hearth room and the sun room ,they can go outside, so they definitely feel more comfortable. (f) One of Shahbaz is making arrangements for one of the WP residents to attend her son's baseball game. "He sees the children come and he likes to go watch them play, so as soon as I get my schedule I am going work it [baseball game] out." (g) WRT to ways in which a person's personhood may not be fully acknowledged, not intentional, but as a matter of circumstance: "To him getting some exercise is very important and I guess he still hopes he can walk again sometime, but at least if he can get up and walk with the walker at his pace it makes him feel a lot better. So I am not exactly sure. (h) WRT to above (g): this gentleman has walked on his own even though he is not supposed to. (Risk taking as part of living?) (i) Another family member told us that her mother would get herself ready for bed. She would	the bath for a while and little things like that, and you just understand where they are coming from." (c) In this setting, staff members have been involved in shepherding an elder and his/her family through the dying process. The staff grieve the loss of one of their elders.

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		get into the bed by herself.	
Policy Research Question **I think more questions should have been asked about this issue. To what degree/extent is policy hamstringing the CNAs from doing their jobs as they were expecting to do them (through the training videos)?** **The other thought about this is to what extent is policy interfering with residents' ability to fully enjoy what the GH has to offer. Why can't an able resident help cook dinner if they choose to? Why can't an able resident fold laundry, make their own bed, go out onto the patio alone?**		Institutional and health policies versus GH ideology. (a) For example, one Shahbaz must stay in the kitchen when the stove or oven is on. Elders are not permitted to come into the kitchen when the stove or oven is on. Thus, an elder who is capable of helping to prepare a meal is not permitted. (b) "No, they don't let you do any cooking. They do all that. We can't help, but that doesn't mean we don't want to help."	***Staff & Policy*** (a) WRT feeling overwhelmed and understaffed: "One of the things I keep wondering is if it's not policy because once that one person starts cooking in the kitchen they can't leave as long as there is food boiling. They can't leave. You know, somebody has to be there to keep an eye on that kitchen to make sure nobody goes in there and opens and oven and reaches in without a mitt…technically we are supposed to watch [the cooking/baking] so technically that leaves one other person to watch all ten people and the theory was that when we all came here we thought we only had five people to take care of and you got all that other stuff falling down on you and you might not be there to answer that constantly ringing door bell and answer the phones and amongst all the other stuff". (b) When family members have to wait outside they sometimes get "nasty and get mad at ya. One actually called the phone and said, 'I'm outside the door'." "Yeah, I'm in the bathroom with your loved one, we'll be there as soon as we can." Question: What would be the problem if the primary family members had a key card? Answer: "She works here and can't even get a card". ***Family***

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			With regard to requirements: i. "I think the requirements they have to meet with the housekeeping, sometimes it seems to take priority and they really don't have a lot of time to spend with the residents other than feeding them, bathing them, getting them up in the morning and dressed and then ready for bed." ii. One family member explained that there are so many standards to meet such as the laundry water must reach a certain temperature and likewise the dryer – so they need to measure the temperature every time they do a load of laundry. When a resident has finished eating, his/her plate must be removed immediately from the table so that another resident does not eat from it. Then there is a diabetic resident who will eat another resident's dessert if she is not being watched.
Push and Pull Competing responsibilities *Adjusting (to flattened hierarchy, to new routines, new roles).*		***Staff*** "Like the other day I was in care planning and one of my coworkers got stuck on the floor [the house] by herself and she was in a resident's room and the doorbell was ringing, the phones were ringing, a resident bells were going off and I constantly had to leave the care planning meeting to go take care of stuff.	***Family*** (a) Turf issues between RNs and Shahbaz ."This is the Shahbaz's house." ***Staff*** (a) "So you neglect one person feeding them because the one wants to go lay back down, but he's already been up and had his breakfast. But you can't get the other one up to feed their breakfast because you are dictated to and we have that in the evening too." Another staff member replies, "I believe it too". (b) Trying to maintain a professional balance when one has been caring

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			intimately "it is very easy to grow fond in a professional way and in a private way, and you have to maintain that balance because in the friend role it is like, 'why are you doing this, why are you treating me like this'?"
Problem Solving *Outcomes* During pre-move conversations with the staff, one staff member anticipated problems, but also offered solutions.	***Staff*** (a) Pep Talk: "…come on now, we used to have ten residents by ourselves…y'all don't have to worry about picking up 2,3, or 4 because someone didn't come in or someone had to leave early." (b) Anticipatory problem solving: "So, what I can do is about planning. It's gonna take a while but two or three weeks you will be seeing, Okay Mrs. Jones' schedule is the same when I give her a bath and when I get her up, so these ones [other residents] we could go ahead and fit them to another schedule." (b) Shahbaz team will be more responsible for problem solving, working out whatever the issues are in the house and you have to be a team, and I am good for being a team player but to have to step up and be a little more dominant [confrontational – knows she will have to take on this role]. (c) WRT a snack in the middle of the night: "If I am able to stop and fix it, yeah…The concept is to go ahead and fix it for them…[I will] try to as close to giving them what they want as possible or coming up with a way to give them what they want so they understand and if	***Resident*** WRT finding a way to help and elder participate in meaningful work: (a) "It's a lot of walking to and from the kitchen, but I always get everything on the table ready. I use my cart, I have a tray that goes on it and I can collect orange juice in the morning. I do what I can. "	***Family*** (a) WRT staffing: i. "…if I could make a suggestion…and I understand that people cost money…if they could even have somebody running between the three houses" to help during the busy times of the day (wake up, meals, bedtime). "Anything they can do to kind of fill in and take a little bit of pressure off". ii. One family decided to hire extra help. Their loved one has advanced AD and required a lot of attention. iii. "They have all these rules they have to go by and so it just seems to me that if they have a person that is a housekeeper and she does all the cooking and cleaning and everything and then the Shahbaz can go around the table and feed people and they would have more time for [residents]. I think they need one housekeeper and the two Shahbaz could do it with just the one housekeeper." This family member goes on to explain that after a resident has finished a meal they want to get up and leave the table, but most cannot go on their own, they need assistance; however there are still residents who have not been fed their meal as

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	it gets to a point where it gets too technical then the Shahbaz team works together and we look at coming up with a solution to try to meet that need.”		they require help to be fed. iv. family suggested a memory book with pictures of current and past residents. ***Staff*** (a) WRT solving the staffing issues (and reducing stress): “I think three [staff members] in the morning, three in the afternoon, and three on night shift. I think that would make a heck of a lot of difference.” Another goes on to say, “It wouldn’t even have to be for the whole shift.” (b) WRT when VCU was conducting focus groups there were additional staff on hand to help facilitate that: “I think it was like when we had three yesterday, it was good feeling”. (c) I think in the evening because, I don’t work evenings over here, but I think that they need three because everyone wants to go to bed at the same time, everybody wants to go early.” (d) “My husband and I are planning, this sounds really stupid, for our family vacation, we are planning on making a trip to one of these model homes that is already up and going just so I can see the way someone else does it, to see the type of residents they have. I want to talk to the workers there myself because when they sent all of those people to the models they sent people who were office staff, they did not send people who do our jobs. (e) You have to have that third person. At least that

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			way you can still have that one that can run the kitchen and maybe they'll do breakfast, and the other can tag team and go in and do lunch just so that everybody can kind of rotate around and give your physical body that break…" (f) WRT defusing a situation: "If there was two on the night shift it would be good because one person could just easily step away and have the second person step in. So with one person you don't have that option. Like now if that person steps away…you're doomed."
Procedural	***Family*** (a) "I told him we would have to move regardless because they are going to close down the section that he was in…and then find out that that one is going to close down and you are going to have to go to another house." *This is a procedural code but could also be categorized as gentle coercion, choice made for convenience so as to minimize the number of changes this person would have to undergo (and thus the number of times his daughter would have to move him too).*		
Quality Care *Attitude and Outcome*	***Staff:*** (a) "Sometimes I've been told I'm slow, but it's not that I'm slow, I want to be thorough. I want to know that I have met all of the needs and done my best". Contrasted: "…sometimes in this profession, in an institution, it's easy to lose that [empathic care/quality care] because		***Family*** (a) There is a concern that there is a lack of professionalism among the team members. Shahbaz are too casual in their interactions with residents and each other.

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	you are on a schedule because everything is done at a certain time and you got to get it all done." (b) "make time to give a nice tub bath." (c) "nourishment" (d) "not [allowing an elder] to sit around bored, lonely, and depressed". (e) "to interact [with an elder] and make their day something to speak of." ***Family*** (a) One CNA "doesn't take 'no' for an answer". {One CNA in particular is proactive and gets the residents to participate in social events. She simply tells the resident that they are going. I coded this as gentle coercion because the intention was to increase socializing, not to bully.} (b) Having staff who know the residents. (c) Having staff who know the family and family who know the staff. (d) Letting the elder know that their call has been heard. (e) Cleanliness (f) Treat mom with respect (g) Do not be short (h) Proactive staff to draw a person out. (I) Facility responds quickly to family's questions or concerns. (j) Staff having access to what they need to do their jobs. (k) Expects that a job well done will be reflected by the happiness of the resident.		
Quality of Life *Attitude and Outcome*	***Staff*** (a) "Quality of life to me is being happy and being fulfilled where I am at."	***Resident*** (a) WRT Stimulation: "We gab, we play games, dominos, cards, whatever we can do. I have lots of	***Residents*** (a) WRT Stimulation: "We just got all the new trees since I've been here and the flowers. We do

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	(b) "The physical and spiritual [needs] are being met." Family: (a) Reunion with cherished belongings ***Family*** (a) "to me it bothers me to see them always sitting in lounge chairs and sleeping." (speaks to the lack of stimulation, her own values, and a judgment about the NH environment).	company. Like today we had a big birthday party." (b) "Yeah, we have fun. We help with the cooking and preparing. We make cakes, pies at night."	most anything, we play cards, list to the TV a lot. We just like to watch TV and some of the men like the baseball games, and I think every room has their own TV, I'm not sure."

Note. Taken from Gendron and Welleford. Department of Gerontology at VCU.

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Appendix I

Frequency Table of Per-CCat Items

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Frequency Table of Per-CCatt Items

Care	Total N	Agree N (%)	Disagree N (%)	No Opinion N (%)	Missing N
1R. I believe staff members should schedule meal times for elders.					
	86	21 (24.4)	48 (55.8)	17 (19.8)	0
2. I believe an elder in a care setting should have a choice to select food items from a menu.					
	85	81 (95.3)	0	4 (4.7)	1
3. I believe elders in a care setting should have a choice when and where they eat.					
	86	74 (86)	5 (5.8)	7 (8.1)	0
4R. I believe shower times for elders in care settings should be scheduled based on staff workloads.					
	86	14 (16.3)	58 (67.5)	14 (16.3)	0
5. I believe an elder in a care setting should choose the days and times he or she showers or bathes.					
	86	74 (86)	1 (1.2)	11 (12.8)	0
6R. I believe the use of anti-psychotic medication improves quality of life for elders.					
	85	20 (23.6)	32 (76.5)	33 (38.8)	1
7. I believe it is more important to help an elder manage his or her agitation rather than administering a drug.					
	84	63 (75.0)	6 (7.2)	15 (17.9)	2
8. I believe elders in care settings experiencing positive social interactions have decreased agitation.					
	84	74 (88.1)	1 (1.2)	9 (10.7)	2
9R. I believe it is important to isolate an elder if he or she is being physically aggressive.					
	86	24 (27.9)	47 (54.7)	14 (16.3)	0
10. I believe elders with dementia are best served by staff members who express a preference to work with this population of elders.					
	86	68 (79.0)	5 (5.9)	13 (15.1)	0
11R. I believe the physical environment of a care setting has little impact on elders' care experience outcomes; it is the care itself that matters.					
	85	16 (18.9)	62 (72.9)	7 (8.2)	1
Communication	**Total N**	**Agree N (%)**	**Disagree N (%)**	**No Opinion N (%)**	**Missing N**
12R. I believe in getting my work finished before I initiate conversations with elders in the care setting.					

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	Total N	Agree N (%)	Disagree N (%)	No Opinion N (%)	Missing N (%)
	85	6 (7.1)	72 (84.7)	7 (8.2)	1
13. I believe in asking elders about their preferences in the care I provide.					
	86	80 (93.1)	0	6 (7.0)	0
14R. I believe asking an elder a question is more important than waiting to hear the answer.					
	86	8 (9.3)	70 (81.4)	8 (9.3)	0
15R. I believe that referring to an elder in a care setting by "honey" or "sweetie" is appropriate.					
	86	52 (60.5)	10 (11.6)	24 (27.9)	0
16R. I believe that conversation with elders is not essential in order to complete my job duties.					
	86	79 (91.9)	2 (2.4)	5 (5.8)	0
17R. I believe there is a need to carry on conversations with fellow staff in the presence of an elder.					
	85	52 (60.5)	8 (9.3)	25 (29.4)	1 (1.2)

Culture & Community	**Total N**	**Agree N (%)**	**Disagree N (%)**	**No Opinion N (%)**	**Missing N (%)**
18. I believe knowing an elder's life story adds value to the care I provide.					
	86	74 (86.1)	5 (5.8)	5 (5.8)	0
19R. I believe time spent with an elder's family member is not essential to learn about an elder.					
	83	1 (1.2)	77 (92.8)	5 (6.0)	3
20. I believe it is important to incorporate an elder's life story into care, conversation, meals, and activities.					
	83	73 (87.9)	2 (2.4)	8 (9.6)	3
21. I believe an elder in a care setting should bring items from his or her home.					
	84	74 (88.1)	2 (2.4)	8 (9.5)	2
22R. I believe all elders' rooms in a care setting should be arranged uniformly for consistency.					
	82	11 (13.4)	58 (70.7)	13 (15.9)	4
23. I believe an elder in a care setting should have access to activity programs that are individually suited to their preferences.					
	84	82 (95.4)	0	2 (2.4)	2
24. I believe activities should be designed with an elder's past life story and past occupation(s) in mind.					
	84	71 (84.5)	3 (3.6)	10 (11.9)	2
25. I believe an elder in a care setting can choose if he or she wants to stay awake all night or "sleep-in" in the morning.					

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	Total N	Agree N (%)	Disagree N (%)	No Opinion N (%)	Missing N (%)
	84	76 (90.5)	2 (2.4)	6 (7.1)	2
26R. I believe involvement of the community is not important to an elder's quality of life in a care setting.					
	84	2 (2.4)	75 (89.3)	7 (8.3)	2
27. I believe creativity should be encouraged in interactions and activities with elders.					
	84	79 (94.0)	1 (1.2)	4 (4.8)	2
28. I believe activities should be conducted with a "no fail" approach.					
	81	37 (45.6)	19 (23.5)	25 (30.9)	5
29. I believe an elder in a care setting should have input on what type of activities are implemented.					
	84	80 (95.2)	1 (1.2)	3 (3.6)	2

Climate	Total N	Agree N (%)	Disagree N (%)	No Opinion N (%)	Missing N (%)
30R. I believe most elders have similar needs.					
	84	31 (36.9)	46 (54.7)	7 (8.3)	2
31. I believe I am flexible in my daily routines.					
	83	74 (89.2)	2 (2.4)	7 (8.4)	3
32. I believe I am properly trained to meet the needs of a diverse elderly population.					
	83	69 (83.1)	2 (2.4)	12 (14.5)	3
33. I believe that a care setting should celebrate holidays that the majority of elders believe in.					
	83	69 (83.1)	1 (1.2)	13 (15.7)	3
34. I believe in learning new techniques and strategies to improve my relationship with elders in a care setting.					
	83	76 (91.6)	0	7 (8.4)	3
35. I believe it is important to follow ethical guidelines when interacting with elders in a care setting.					
	83	76 (91.5)	0	7 (8.4)	3
36R. I believe it is important to work fast in order to finish my daily work responsibilities.					
	83	12 (14.4)	57 (68.7)	14 (16.9)	3
37. I believe my attitude towards work affects the care given to the elders.					
	83	79 (95.1)	1 (1.2)	3 (3.6)	3
38. I believe in increasing the independence of the elders.					
	82	74 (90.3)	2 (2.4)	6 (7.3)	4
39. I work with a team to provide top quality care to elders.					

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	83	76 (91.6)	1 (1.2)	6 (7.2)	3
40R. I feel overwhelmed with my workload.					
	81	27 (33.3)	36 (44.5)	18 (22.2)	5
41R. I feel my daily routine in this care setting is repetitive.					
	81	26 (32.1)	36 (44.4)	19 (23.5)	5
42. I feel valued as an employee at this care setting.					
	80	57 (71.3)	10 (12.6)	13 (16.3)	6

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Appendix J

Revised Person-Centered Care Tool

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Revised Person-Centered Care Tool

Person-Centered Care Attitude Test (Per-CCAT) Revised

The purpose of this survey is to measure care setting staff members' attitudes about person-centered care. In the statements below, the "elder" refers to a resident in a care setting such as a nursing home or assisted living facility. You may use pen or pencil to complete the survey. Do not place your name on the survey. If there any questions you do not wish to answer, you do not have to answer them. Thank you for your time.

Resident Autonomy & Care Philosophy	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
1) I believe an elder in a care setting should have a choice to select food items from a menu.	5	4	3	2	1
2) I believe an elder in a care setting should choose the days and times he or she showers or bathes.	5	4	3	2	1
3) I believe it is important to help an elder manage his or her agitation rather than administering a drug.	5	4	3	2	1
4) I believe elders in care settings experiencing positive social interactions have decreased agitation.	5	4	3	2	1
5) I believe in asking elders about their preferences in the care I provide.	5	4	3	2	1
6) I believe an elder in a care setting should have access to activity programs that are individually suited to their preferences.	5	4	3	2	1
7) I believe an elder in a care setting can choose if he or she wants to stay awake all night or "sleep-in" in the morning.	5	4	3	2	1
8) I believe creativity should be encouraged in interactions and activities with elders.	5	4	3	2	1
9) I believe an elder in a care setting should have input on what type of activities are implemented.	5	4	3	2	1
10) I believe in learning new techniques and strategies to improve my relationship with elders in a care setting.	5	4	3	2	1

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Resident Autonomy & Care Philosophy	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
11) I believe my attitude towards work affects the care given to the elders	5	4	3	2	1
12) I believe it is important to follow ethical guidelines when interacting with elders in a care setting.	5	4	3	2	1
13) I believe in increasing the independence of the elders.	5	4	3	2	1
14) I believe knowing an elder's life story adds value to the care I provide	5	4	3	2	1
15) I work with a team to provide top quality care to elders.	5	4	3	2	1

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Social Interaction & Community	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
16) I believe elders in a care setting should have a choice when and where they eat.	5	4	3	2	1
17) I believe the physical environment of a care setting has little impact on elders' care experience outcomes; it is the care itself that matters.	5	4	3	2	1
18) I believe that conversation with elders is not essential in order to complete my job duties.	5	4	3	2	1
19) I believe knowing an elder's life story adds value to the care I provide.	5	4	3	2	1
20) I believe time spent with an elder's family member is not essential to learn about an elder.	5	4	3	2	1
21) I believe it is important to incorporate an elder's life story into care, conversation, meals, and activities	5	4	3	2	1
22) I believe an elder in a care setting should bring items from his or her home.	5	4	3	2	1
23) I believe all elders' rooms in a care setting should be arranged uniformly for consistency.	5	4	3	2	1
24) I believe involvement of the community is not important to an elder's quality of life in a care setting	5	4	3	2	1

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Work Culture	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
25) I believe staff members should schedule meal times for elders.	5	4	3	2	1
26) I believe shower times for elders in care settings should be scheduled based on staff workloads.	5	4	3	2	1
27) I believe it is important to isolate an elder if he or she is being physically aggressive.	5	4	3	2	1
28) I believe in getting my work finished before I initiate conversations with elders in the care setting.	5	4	3	2	1
29) I believe it is important to work fast in order to finish my daily work responsibilities.	5	4	3	2	1

Work Climate	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
30) I believe I am flexible in my daily routines.	5	4	3	2	1
31) I believe I am properly trained to meet the needs of a diverse elderly population.	5	4	3	2	1
32) I feel overwhelmed with my workload.	5	4	3	2	1
33) I feel my daily routine in this care setting is repetitive.	5	4	3	2	1
34) I feel valued as an employee at this care setting.	5	4	3	2	1

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Vita

Christine Harrop-Stein lives in York, Pennsylvania with her husband, Jonathan Stein, and their two daughters, Hannah Claire and Abigail Lois. Formerly from Philadelphia, Pennsylvania, she earned her Bachelor of Arts degree in psychology from La Salle University in 1987 and her Master of Science degree in health education from St. Joseph's University in 1994. In August, 2014, Ms. Harrop-Stein completed her doctoral studies in Health Related Science with a focus on Gerontology in the School of Allied Health Professions at Virginia Commonwealth University.

For over ten years, Ms. Harrop-Stein worked at Fox Chase Cancer Center (Philadelphia, PA) in the division of Population Science and later in the Family Risk Assessment Program as a health educator. She left the cancer center in 1999 to move with her husband to York, Pennsylvania.

Currently teaching Health in the Later Years, The Sociology of Health and Illness, and Death and Dying, Ms. Harrop-Stein works as an adjunct professor in the department of Behavioral Sciences at York College of Pennsylvania. She is a member of the Gerontological Society of America, is an advocate for grieving children, and also volunteers as a companion at Olivia's House, A Grief and Loss Center for Children. Ms. Harrop-Stein's research interests include nursing home culture change; long-term care paradigms and quality outcomes; attitudes toward and beliefs about aging and the aged; health disparities; and health behaviors and decision making. In her free time, she enjoys gardening, cooking, traveling, and reading.

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