



Empowering Direct Care Workers: Lessons Learned from THE GREEN HOUSE® Model

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ABSTRACT

The nursing home culture change movement continues to gain support from government, industry, and consumer groups. Many believe it holds promise for improving both the quality of care and the quality of life for people residing in long-term care settings. One of the challenges currently facing the movement is insufficient guidance regarding the specifics of both implementing and sustaining culture change. This article presents findings from a study of THE GREEN HOUSE® model, focusing specifically on the development of empowered direct care staff. Although the study was conducted exclusively in Green House homes, the findings have implications for any long-term care organization interested in empowering staff.

INTRODUCTION

The Institute of Medicine report on quality of care in nursing homes (IOM, 1986) and the resulting Omnibus Reconciliation Act (1987) initiated significant changes in long-term care. Government responses at the state and federal levels were substantial, resulting in greater oversight and increased public accountability (Weiner et al., 2007). At the same time, nursing home providers initiated sweeping reforms that were designed to transform both quality of care and quality of life for nursing home residents (Rahman & Schnelle, 2008; Weiner & Ronch, 2003). While not all providers have joined the movement, which is generally referred to as nursing home culture change, involvement and interest remain high (Lustbader, 2001; Rahman & Schnelle, 2008), resulting in a proliferation of varying culture change initiatives that are spreading across the country and internationally.

Despite many differences among the separate culture change initiatives (Weiner & Ronch, 2003), they share several core elements, including greater autonomy and choice for residents, more homelike environments, consistent assignment of direct care staff to a group of residents, and greater empowerment of direct care workers (Doty et al., 2008). One challenge to the culture change movement is inconsistency in how elements are defined and lack of clarity in how they are implemented. This inconsistency has also made it difficult to interpret research findings concerning the impact of culture change on resident outcomes (Hill, 2011; Kane et al., 2007). A better understanding of the variation in core elements and how they are implemented could improve the ability to predict the gains that can be expected from implementation and to inform organizations throughout their implementation efforts.

One core element common to culture change initiatives is empowerment of direct care workers. Even beyond the formal culture change models, providers have embraced the notion of empowering direct care workers (Campbell, 2003; McAiney, 1998;

Stone et al., 2002; Yeatts & Cready, 2007). In some instances, worker empowerment is seen as a means to better quality of care or better quality of life for residents. For others, empowerment is recognized as an important strategy for promoting worker satisfaction and retention.

Research has consistently documented the frustration of direct care workers in long-term care, particularly in the general failure to be recognized for their expertise and skill in managing their own work (Bowers et al., 2003; Broocvar et al., 2000). Many rate staff retention and resident quality of life as highly interrelated, as worker retention is necessary for consistency in assignments, which many believe is necessary to foster relationships between staff and residents. Relationships with staff have been consistently documented as important to resident quality of life (Flesnor, 2009; Medvene, 2005; Nolan et al., 2004). As with all the core elements, empowerment of direct care staff is often discussed, generally supported, and largely left undefined. Whether in the form of research or provider literature, published work has been largely silent regarding strategies for implementation.

As in other culture change initiatives, one of the core elements of culture change in THE GREEN HOUSE® model is the development of an empowered workforce. In The Green House model, the team of direct care workers in each Green House home set their own schedules, find replacements for absent staff, determine resident assignments, and decide how the work will be shared.

Past research suggests that nurses play an important role in supporting certified nursing assistant (CNA) empowerment and self-managed teams, including listening to CNA suggestions about work modification, providing consistent feedback, involving CNAs in decision making, and helping cover responsibilities while CNAs attend team meetings (Cready, Yeatts, Gosdin, & Potts, 2008). One of the challenges for culture change initiatives has been the integration of empowering direct care staff while maintaining the necessary oversight and participation

of the professional nursing staff. Several researchers have noted the tension created when this is not done effectively (Scalzi et al., 2006).

As in many of the culture change initiatives, there has been considerable adopter discretion in how Green House homes implement the model. While all Green House adopters express a commitment to supporting empowerment of direct care staff, not all have approached implementation in the same way.

The Green House Model of Culture Change

The Green House culture change model, which evolved from the Eden Alternative, is based on a belief that living in a family-like environment will result in both improved quality of life and improved clinical outcomes for residents compared to those living in more institutional settings. The philosophy is implemented through the creation of small homes of eight to 12 residents, with private bedroom and bathroom, sharing common spaces such as a large living and dining area. Consistent with the sense of intimacy, Green House homes are staffed by consistent direct care staff (“Shahbazim”) who work largely as a self-managed, small team in consultation with a team of clinical professionals, including nurses, therapists, dietitians, and Green House Guides. The Shahbazim are responsible for running the home, working together to schedule themselves, covering absent workers from among the staff to maintain consistency, and determining how the work will be divided among them. Rather than being assigned a group of residents, the Shahbazim work together to care for the residents in the home.

Initially, the focus of planning, training, and orientation for new Green House homes was on the Shahbazim. Nurses were much less involved in the orientation. In 2008, however, the national Green House program office changed the orientation for new homes so that nurses and Shahbazim could participate together throughout the orientation, which includes extensive discussions between them about how the model will work, how the roles of

each group will change, and how the two groups will subsequently work together.

In The Green House model, Shahbazim report directly to the Guide, who is generally not a nurse, as they develop their team collaboration skills, work out problems, and plan activities for the home. Nurses are not continually present in the home; they enter to pass medications, administer treatments, monitor resident conditions, and respond to requests from Shahbazim. Nurses do not oversee the daily tasks of Shahbazim, do not make resident assignments, and do not generally engage in problem-solving when there are conflicts among the Shahbazim. Effective operation of the model relies on an empowered group of Shahbazim who are responsible for the operation of the home, staffing, organizing, purchasing and preparing food, personal care, activities, and notifying professional staff of any medical conditions needing attention.

OVERVIEW

The study reported here is part of a larger research project conducted at 11 organizations that operate at least one skilled Green House home. The focus of the larger study was on understanding strategies for implementation, specifically the roles of nurses and direct care workers, examining variations in how the roles have been operationalized, the relationships between these two groups (nurses and Shahbazim), and the impact on care processes. This particular report focuses on how variations in nurse and direct care worker roles influence direct care staff empowerment. Although the study was not focused on empowerment, the interviews with direct care staff were replete with references to empowerment.

METHODS

The study was conducted using the grounded dimensional analysis methodology (Bowers & Schatzman, 2009; Schatzman, 1991), a qualitative methodology that is designed specifically to explore the perspectives of people participating in

the study (participants) and to understand how their actions are related to those understandings; e.g., in this study, the authors were interested in how the staff understood their roles and how their understanding influenced their actions, including strategies for implementation. This methodology is particularly useful for research questions about new areas of knowledge where little prior work has been conducted. In this study, the research team was interested in knowing how The Green House philosophy was operationalized, the variations in how it was operationalized, and the factors that accounted for that variation. Rather than beginning with a hypothesis or set of specific questions, this methodology begins with unstructured interviews, allowing the participants to describe the phenomenon (implementing The Green House model) from their perspective, explaining the strategies they use, and providing rationale for using those particular strategies.

Sample and Recruiting

A list of all 14 skilled Green House homes that had been in operation at least six months was provided to the research team by NCB Capital Impact (the national Green House project office). Guides were contacted at each of the 14 sites and invited to participate in an initial telephone interview. The research team was able to arrange phone interviews with Guides at 11 of the 14 homes. Site visits were made to eight of the 11 organizations. A total of 68 direct care workers (Shahbazim), 29 licensed nursing staff, and eight directors/assistant directors of nursing participated in interviews during the site visits, for a total of 116 participants. Some of the Guides were interviewed both on the phone and during site visits. For the site visits, interviews were conducted with Shahbazim and licensed nursing staff from all three shifts.

The Guides at each Green House home were asked to assist with recruiting participants for the study. Flyers about the study were posted in each home. The Guides described the study to direct

care workers in staff meetings. Signup sheets were left in each home. Staff members who volunteered were interviewed. Each staff member interviewed was given a \$10 incentive. Many of the staff had been involved in The Green House culture change implementation from the onset, while others had come to The Green House subsequent to initial implementation, some only recently.

Most Shahbazim interviewed for this study had worked in traditional nursing homes settings. In most organizations, this was a requirement for The Green House staff position. In two homes, however, there was a mix of former nursing home CNAs and people with diverse backgrounds; e.g., a former primary school teacher, a bus driver, homemaker, child care worker. All Shahbazim had been through The Green House orientation program. Many of the nurses interviewed had dedicated positions in The Green House homes, although several also worked other shifts in the more traditional nursing home. Unlike with the Shahbazim, not all nurses had been through The Green House orientation program. Sometimes nurses were “pulled” from the nursing home, and some were even hired temporarily through agencies.

Site Description and Selection

All but one of The Green House homes had a more traditional nursing home on the same campus. Many of the functions, such as therapies, dietary services, maintenance, activities, etc., were shared between the traditional home and The Green House home(s). The number of Green House homes per campus ranged between one and eight.

Phone interviews with Guides were quite open, asking Guides to describe the implementation and current operation of the model. Guides were also asked specifically to describe the relationship between direct care workers and The Green House nurses, and between the Guides and the direct care workers. They were also asked to talk about how clinical decisions were made, and whether/how the interactions between nurses and direct care workers

were similar to or different from the CNA/nurse relationships in more traditional settings. Phone calls with Guides, averaging an hour in length, were recorded and transcribed for later analysis. Based on analysis of these interviews, eight Green House homes were chosen for follow-up site visits. The decision about which homes to visit was made to maximize the variation of difficulty implementing the model, degree of change in the model since initial implementation, variation in the relationships between direct care workers and nurses, differences in staffing patterns, and differences in size. In particular, the research team selected homes to allow comparisons of different nurse/Shahbazim roles and relationships.

Data Collection

Eight site visits took place over a six-month period, each lasting two to three days, with a research team of two to three members. During site visits, interviews were conducted with Shahbazim and nurses on all three shifts and with directors/assistant directors of nursing and administrators. Initial interviews were unstructured, allowing respondents to identify what they believed were the most important elements of The Green House model and to generally describe implementation processes. Subsequent probing questions followed the participants' line of thinking, while seeking the conditions relevant to their understandings, explanations for variations in understanding, strategies used to carry out actions, and the consequences as perceived by the participants. Informed by the ongoing analysis, subsequent questions focused on the role of direct care workers, the impact of implementation strategies on care quality, and quality of work life. Follow-up questions included an exploration of how variations in implementation influenced workers' sense of empowerment. The type of questions asked during this phase of the study included, "Can you tell me what it is like working in a Green House model?" and "How do you take what you learned about the model and use it as you do your work? As the

study proceeded, interview questions became more focused, following up on what the participants identified as most significant as well as lines of inquiry of most interest to researchers. In this particular study, because there were so many early references to differences among Green House nurses and how the nurses' approach influenced the work of the Shahbazim, interview questions were added that specifically focused on exploring these relationships in greater depth. Shahbazim were asked to provide examples of *how* the nurses influenced their work. Many of the responses were related to decisions Shahbazim made about their daily work.

ANALYSIS

Data were analyzed using a line-by-line dimensional analysis (Bowers & Schatzman, 2009; Strauss, 1987). This is an analytic process that maps the logic of participants, including the language and concepts they use to describe the phenomenon under study. In this case, references to empowerment, ability to make decisions or to be self-directed, and the conditions that influenced these things were explored in depth. In particular, the researchers examined how Shahbazim talked about being empowered, what they identified as the conditions influencing empowerment, and what they described as the consequences of being or not being empowered. This included references to when, how, and under what conditions the participants described being able to make decisions about their work and work life.

Analysis included participation in a larger research team that provided ongoing feedback on whether the analysis was grounded solidly in the empirical data, ensuring that questions asked by interviewers were not leading, and continually checking the logic of interpretations. This process served to ensure that researchers did not impose their a priori assumptions on the analysis. Member checking was also used extensively to both validate interpretations and to add depth to the analysis. This highly disciplined analysis process prevents the research team from

imposing preconceived understandings onto the data and from guiding the interviews in the direction of the researchers' interest or assumptions. The end result is a conceptual mapping of participant understandings and actions and the relationships between understandings and actions.

FINDINGS

Although The Green House model of culture change is a coherent model with a clear set of core elements, there was considerable variation in how the model was implemented and the consequences for direct care worker empowerment. The findings from this study have implications for implementing The Green House model as well as other culture change initiatives that are attempting to develop an empowered direct care workforce.

Many of the Shahbazim expressed satisfaction with their new level of responsibility and decision making authority, feeling much more empowered than they had in traditional nursing home settings. Some Shahbazim, however, saw no difference from traditional nursing home work. Significantly, there was a high level of consistency in feelings of empowerment among Shahbazim working with the same nurse; i.e., Shahbazim tended to connect their sense of empowerment to their interactions with the nurses they worked with.

When questioned about the responsibilities for which they had new decision authority, Shahbazim talked primarily about the daily routines, the timing and sequencing of activities, interactions with family members, determining the division of labor among staff in the home, and scheduling shifts.

Selecting Workers/Implications for Empowerment

An issue that was raised repeatedly was the attitude of the nurses and the ability of new Shahbazim to "fit in" and to work within the model. There was considerable variation in how direct care workers were selected to become Shahbazim. In most homes, either the director of nursing alone or a group of

managers had selected staff for the initial Shahbazim positions. Very few homes had included direct care workers in the selection process. At the time of the study, several of the organizations were including Shahbazim in the hiring of new Shahbazim. The nature of their involvement, however, varied across organizations. In a few organizations, Shahbazim were active participants in the process of selecting new workers. In some homes, the Shahbazim were included more peripherally but felt they were listened to and that the criteria for selection were appropriate. Still, others allowed the Shahbazim to participate in the interviews although the Shahbazim felt they had little influence on the final decision. In one organization, the director of nursing alone selected Shahbazim by taking people in the order they applied, wanting to give everyone an equal chance.

Shahbazim had clear beliefs about the criteria that should be used to select new workers. They consistently identified flexibility, reliability, ability to work out conflicts with other team members, and ability to work in a team rather than independently as the most important attributes of a co-worker. Managers, including directors of nursing, tended to use somewhat different criteria to select new Shahbazim. Most managers identified ability to work independently, attendance, and punctuality as the most important attributes.

Both Shahbazim and managers identified absenteeism as important, while Shahbazim who had been working in The Green House model for some time saw punctuality as something that could often be worked with. Recognizing the often complex and poorly resourced lives of their co-workers, some of the more experienced Shahbazim saw histories of poor punctuality as easily addressed through scheduling flexibility; e.g., allowing mothers to work split shifts so they could pick up children from school, take them to after-school care, and then return to work was a solution used in one home. In another home, one of the workers left to pick her children up from school and brought them to The Green House

home, where they played outside until their mother's shift was over. Shahbazim also provided many examples of workers with previous poor records for attendance and punctuality who responded positively to group pressure to be on time.

Selecting the licensed nursing staff for Green House work was generally not something that Shahbazim described having input into. Although the nurse's approach to Shahbazim had a considerable impact on the nature and quality of Shahbazim work life, none had an expectation of involvement in the selection of the nurses. There was considerable inconsistency across homes in opinions about the attributes nurses need to work effectively in Green House homes. Many of the managers interviewed saw nurses as relatively interchangeable, often stating that any competent nurse could work effectively in The Green House model. How nurses worked and how they interacted with other staff was consistently viewed by many managers as less important than these attributes were for the Shahbazim to the operation of The Green House model. This view was not shared by the Shahbazim who described the nurses as having a significant impact on the quality of their work lives and the effective operation of The Green House model. An important finding from the study was the management's generally insufficient appreciation of the impact nurses had on direct care staff empowerment and the difficulty of implementing the model without the support and understanding of the nurses working in the home.

The Meaning of Empowerment

Although references to empowerment often include authority overscheduling and decision making about daily routines, the Shahbazim interviewed in this study consistently identified one of the most positive consequences of the empowered model as "not having someone telling me what to do." In particular, Shahbazim were pleased that Green House nurses, who they believed understood the model, rarely asked Shahbazim to do things that Shahbazim were already planning to do and that were part of their

everyday routine, such as vital signs or baths. There was no one at the end of the shift asking them if they had done these things. This was considered Shahbazim work not requiring oversight by licensed staff. As one Shahbaz stated, "Why wouldn't I do it? I have done it every day for years!" Shahbazim also appreciated the absence of someone deciding for them what was a priority at the moment, pulling them away from something they were doing to attend to something else, possibly less of a priority for the Shahbazim; e.g., prioritizing cleaning up a mess to spending time with a resident in need of comfort was a decision they could make without worrying about being interrupted and redirected by the nurse. As one Shahbaz pointed out, they are in a much better position to know how to prioritize these things. Many Shahbazim offered this lack of oversight or "checking up on them" as an example of the greater respect nurses had for Shahbazim and the greater independence they had in their daily work. This was one of the most important aspects of the empowered model of care for many of the Shahbazim.

Shahbazim also described talking directly to families about resident care as an important aspect of empowerment. Shahbazim in most homes were quite accustomed to initiating contacts with families, either during family visits or by telephoning them. Shahbazim were comfortable initiating contact with families to discuss end-of-life care, involvement in activities, relationships with other residents, food preferences, etc. In some cases, it was the Shahbazim who contacted families to alert them to changes in a resident's condition. As an important source of empowerment, Shahbazim talked about their ability to initiate contact and engage in conversations with family members about resident care and condition. While all who had been CNAs in the past had interacted with families, it was quite unusual for any to initiate conversations with families about care issues or to make telephone calls to families. That had always been something the nurses would do. None of the Shahbazim in The Green House

homes initiated contact with physicians or discussed medications with either families or physicians. They clearly identified this as a role of the nurse.

The Challenges of Empowerment

From the perspectives of direct care workers, some aspects of empowerment were more challenging than others. Probably the most challenging, confirmed repeatedly by Shahbazim across Green House sites, was addressing conflicts among co-workers. While nurses frequently identified the loss of responsibility for managing these conflicts as a significant benefit of the model for the nurses, many of the Shahbazim did not feel adequately prepared to deal with interpersonal conflicts. This was an observation made by both nurses and Shahbazim who participated in the study. The most common co-worker issue described by Shahbazim was the failure of a co-worker to function well as a team member, work independently rather than as an effective team member, and accepting responsibility only for “their” group of residents. Direct care workers who were accustomed to having “their own” residents to care for, rather than working as a group, sometimes had difficulty approaching the work of the house collaboratively, finding it difficult to let go of being accountable for only “their” residents. Shahbazim in the home often found it quite difficult to confront the staff member who continued to work independently. Instead, they organized their work to accommodate and not rely on the more independent worker, undermining the collective approach to the work of the house. This was particularly significant in that the ability to work independently was a common criteria used by managers to select Green House workers. While some “independent” workers were able to make the shift, others were not, creating considerable anxiety and increased workload for the other Shahbazim in the house.

Sharing responsibility for the work of the house was, for some Shahbazim, even more difficult when it involved non-resident care work, such as cleaning up messes that might have been made by another

staff member or completing work that was not completed by workers on another shift. In the several homes where sharing responsibility was described as working well, direct care staff saw the work of the house as a collective responsibility. This meant that they were generally willing to back each other up, finish work that a co-worker had left undone or that had not been completed on a previous shift, even clean up someone else’s mess when they perceived it as unavoidable or as the consequence of care decisions that would benefit a resident; e.g., when a staff member sat with a resident who was depressed or there was a birthday party for one of the residents, some of the work from the evening shift was left for the night shift to complete. Staff from both shifts saw this as reasonable and did not generate any resentment about the shift in work. Shahbazim described how they would communicate to the incoming shift about why work had not been done, rarely experiencing negative responses. Shahbazim described this as different from what they had experienced as between shift tensions in more traditional settings. Shahbazim described how it had been difficult to learn to collaborate and to see work as a collective when it spilled across shifts, however. Several accounts of how they learned to do this were provided during interviews. Learning to see multiple shifts as a team was longer in coming than was a sense of collective work on a single shift.

While Shahbazim generally appreciated the absence of someone “looking over my shoulder,” directing them, and determining their priorities, this also meant they needed to determine these things on their own or in collaboration with co-workers. For many, this involved acquiring new skills in organizing, prioritizing, multitasking, and shifting focus quickly as priorities changed.

Empowerment of direct care staff requires them to possess a range of skills, including sophisticated interpersonal abilities, time-management skills, ability to manage complexity, and to reprioritize quickly as situations change. It also requires that workers have a wider range of skills such as cleaning, food

preparation, activities planning, and management that direct care workers are unlikely to have learned in their roles as CNAs, skills that many of the Shahbazim did not have as they began their work in The Green House homes.

Benefits of an Empowered Worker Model

Learning to work as part of a team was a challenge for some Shahbazim. These were not skills they needed in their prior work as CNAs. In more traditional settings, CNAs are generally assigned a group of residents for whom they are responsible. While they might back each other up, they generally work quite independently. Shahbazim were generally patient with new workers, allowing them time to absorb the new expectations and learn to work collaboratively while also making suggestions and offering assistance to the new Shahbazim. The role of mentor, which more experienced Shahbazim took on, provided them an opportunity to develop teaching and mentoring skills. Many had never had such an opportunity before and were extremely pleased with their personal development. As Shahbazim were in charge of both purchasing and preparing meals, they were forced to learn to plan and follow a budget. This was also a new experience for many of the workers interviewed and one many were quite proud of.

Finally, several Shahbazim talked about the joys of bringing special skills and talents to their work, such as baking, craft-making, musical ability, clowning, juggling, photography, etc. As Shahbazim planned their work together, special talents and interests were allowed to surface and were generally appreciated and acknowledged. In addition to the more obvious skills required for universal workers in a self-managed team, Shahbazim also developed many important life skills that could be transferred to their personal lives; e.g., under the tutelage of a Guide, Shahbazim with limited social skills learned to interact with a wide range of people, increasing their comfort level in social situations and improving their

overall repertoire of abilities. As they learned from more senior Shahbazim and dieticians, others with no cooking experience were able to become skilled cooks with a significant knowledge of nutrition.

Sources of Variation in Empowerment Implementation

Not all organizations approached empowerment in the same way. Significantly, variation was greatest between the homes that had been involved in The Green House culture change prior to the change in orientation that integrated nurses and those that had implemented the model subsequent to that change, and between homes that included Shahbazim in selection of new Shahbazim and those that did not; i.e., the homes that had joined most recently and the homes that included Shahbazim in the selection of new Shahbazim experienced more consistency in implementation strategies and a greater sense of empowerment of the direct care workers.

When researchers explored the nature and sources of these variations, the consistent response from the longer-term members, particularly from Shahbazim and nurses, was that they had had minimal guidance in determining how to empower the direct care staff, particularly as it influenced Shahbazim working relationships with The Green House nurses. Thus, the source of the greater variation among longer-term Green House members appeared to be, at least in part, attributable to the initial absence of guidance on just how to approach the implementation of this core element. On the other hand, more recent members in The Green House model identified the recently implemented national curriculum and ongoing input from the national office as the source of guidance for empowering Shahbazim, likely accounting for the greater consistency and greater sense of empowerment. Bringing nurses and direct care workers together for The Green House orientation program was identified as particularly helpful. The opportunity for direct care workers and professional nurses to discuss the nuances of implementation, how their roles might change in relation

to each other, and what was expected of each were described as important in guiding transformation of staff roles and the development of direct care worker empowerment.

Maturing of a Model

One of the more interesting findings from this study was the clear difference in implementation of an empowered direct care worker model as The Green House program matured. Bringing nurses and Shahbazim together from the beginning, allowing them to discuss what empowerment means and how it relates to the roles of Shahbazim and nurses in The Green House homes resulted in greater comfort and satisfaction with the model from the perspectives of both Shahbazim and nurses. This evolution highlights the importance of clarifying the assumptions and actions connected to a philosophy such as empowerment.

Limitations

Several important study limitations should be acknowledged. First, the study was initially conducted for the purpose of examining the relationship between nurses and Shahbazim in The Green House model. It was not a study specifically of empowerment. Consequently, there were no doubt opportunities to pursue experiences of empowerment and conditions influencing empowerment. Second, the study used a single site visit to each Green House home participating in the study. Since the study was not longitudinal, it was not possible to actually observe the implementation of the model and the Shahbazim experience related to empowerment as the model evolved. Finally, while site visits included both observation and interviews and included each shift, the researchers were not immersed in the setting and therefore had to rely on reports from staff. Thus, reluctance to share and failure to remember correctly could both influence findings.

CONCLUSION

One of the most common elements of nursing

home culture change initiatives is to increase the empowerment of direct care staff. There is almost no guidance, however, in existing research literature on the strategies that promote empowerment of staff, the challenges faced by empowered staff or, for that matter, what empowerment actually means. The study reported here offers some insight into direct care staff empowerment as experienced in The Green House model of culture change. As culture change models vary, not all the insights from this study will be relevant to all other culture change models. In particular, this study has implications for skill development among direct care workers prior to expecting them to embrace greater responsibility for managing their work lives. The authors have little empirical data regarding the extent or distribution of these skills in the current population of direct care workers, either in Green House or in other culture change models. It is also clear that empowerment has many components and that many of the discussions concerning empowerment proceed without clarity of definition. This study helps to provide some insight into how direct care workers in one culture change model, The Green House, implemented an empowered direct care worker model, including both the benefits and the challenges.

Comparisons between the earlier and more recent Green House homes demonstrate the importance of addressing the specifics of implementation, going well beyond embracing an idea or philosophy. In this case, direct care workers and nurses are now being prepared for the changes in roles and exploring how the changes affect their own and other workers' roles. Direct care staff and guides are also now engaging in educational sessions designed to improve direct care workers' skills at teamwork and conflict resolutions, two apparently vital skills for an empowered direct care worker in The Green House model.

The greater consistency of implementation following more intensive, timely, and inclusive educational programs for Green House staff pushes both sponsors and implementers to examine what the implementation of an idea actually entails, how it can actually

be done, and how it can be sustained. As the culture change movement continues to mature, no doubt there will be more insights provided concerning how implementation is achieved, the preparation of staff, the support of managers, the policies connected with implementation, clearer guidance on implementation, clarifying associations between culture change elements and related outcomes, and increasing the chances for a significant impact. The authors believe this beginning look at implementing empowerment has implications as well for implementing other culture change elements, as it highlights variability that can be expected when organizations attempt to implement a philosophy or idea without clear structure or guidance.

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ACKNOWLEDGEMENTS

The authors gratefully acknowledge support from the Robert Wood Johnson Foundation and NCB Capital Impact.

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