



Meeting: NURSES INVOLVEMENT IN CULTURE CHANGE  
Opportunity for Improving Residents' Quality of Care and  
Quality of Life (Funded by the Commonwealth Fund)

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Topic: Professional Nursing Practice Models and Culture Change

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Professional nursing practice models are defined as systems that support registered nurses' control over the delivery of nursing care and the environment in which that care is delivered (Hoffart and Woods, 1996). These systems are composed of structures, processes, and values. An important structural element of a professional nursing practice model is shared governance. This is operationalized by nurses being included in decision making about the hiring of nursing staff, staffing plans and practices, budget decisions, and the development of policies and procedures that reflect evidence-based practice. A key value in professional nursing practice models is professional development. This is operationalized by the provision of relevant continuing education, staffing modifications to support educational activities, and a process for professional recognition and advancement. Professional practice models are "site-specific innovations that RNs design, implement, and sustain to address the particular health needs of patients or residents in the organizational context of their workplace" (Lyons, Specht, Karlman and Maas, 2008, p. 219). Thus, professional practice models are relevant to settings at every stage of the culture change process.

From their comprehensive review of professional practice models, Lyons et al (2008) identified the following commonalities among initiatives: "resident-centered care with a focus on excellence, an articulation of a shared philosophy or values statement, employee-friendly personnel policies, lifelong learning, interdisciplinary collaboration, community involvement, participatory leadership, and quality improvement" (p. 220). Thus professional nursing practice models are consistent with and supportive of nursing homes' efforts to transform their practice and their environment. As stated in the Culture Change Coordinator Manual, nurses are the "logical discipline to coordinate culture change activities" (Eliopoulous, 2008). In fact, professional nursing practice and culture change share many common components. This provides an opportunity for nursing to address both simultaneously.

Although there are multiple points of synergism between professional nursing practice models and the components of culture change, registered

nurses have often been perceived as resistant to culture change. Reasons for resistance to organizational change in general in nursing homes and best practices for addressing this resistance have been summarized by Compas, Hopkins and Townsley (2008). These best practices include: “the use of a specific, measurable mission or goal statement; the use of multidepartmental and multidisciplinary involvement; the need for further education and resource materials; the use of a reward/incentive program; the need for internal and external stakeholders to be identified along with a project champion; and the process of feedback and outcome measurement.” (p. 209).

Rather than focusing on organizational culture change in general, this paper will focus specifically on the Artifacts of Culture Change (CMS, 2006) as comprising the fundamentals of the culture change movement. The Artifacts of Culture Change Tool was developed by CMS in 2006 to help nursing homes gauge their progress with implementing culture change initiatives. ([www.paculturechangecoalition.org/resources/cms-artifacts-tool.htm](http://www.paculturechangecoalition.org/resources/cms-artifacts-tool.htm)). The 79 items on this self-evaluation questionnaire are grouped into the following components: care practice artifacts, environment artifacts, family and community artifacts, leadership artifacts, workplace practice artifacts, and outcomes. These major categories will be addressed as they relate to professional nursing practice. This paper will not address the specific forms that the interpretation of these culture change artifacts might take, for example Greenhouses.

Using these Artifacts as a framework, this paper will delineate some of the points of synergism between professional nursing practice models and culture change, as well as potential causes of the perceived resistance to culture change. A premise is that because many of these components overlap with professional nursing practice, some of the same factors that underlie resistance to culture change also underlie resistance to nurses practicing within a professional practice model. This paper will also raise issues that need to be addressed to overcome this resistance and will suggest areas for future research.

Care practice artifacts that offer residents choices in their scheduling are consistent with the underlying philosophy of nursing which is to encourage person’s independence and autonomy and with nursing care that is person-centered rather than task centered. However, the implementation of resident autonomy could be perceived by nurses as hindering them in fulfilling their responsibilities and tasks. For example, if residents choose when they sleep and eat, and what they eat, nurses may perceive a conflict with their routines of giving medications according to prescribed schedules or their responsibility for residents’ adherence to prescribed diets. “I” format care plans may also be foreign to nurses who were not educated to develop care plans in the voice of the resident or have never worked in a facility with such care plans. In addition, the use of the MDS as the sole source of information for care is insufficient to provide

resident- centered care. For example the resident's work history, interests, and preferences become important data for the nurse to collect.

The majority of RNs practicing in nursing homes are from associate degree and diploma programs in which there was little preparation in geriatric nursing. When RNs are not well prepared for their role as geriatric clinical expert, they tend to be more comfortable with institutional like care routines and a more authoritative form of interaction with both residents and staff. Thus resident-directed care can appear threatening to their sense of control, as well as their sense of fulfilling their task-oriented job responsibilities.

The environment artifacts are also consistent with nursing's philosophy of maintaining patient's dignity and autonomy. However, they may be perceived as affecting the traditional role of the nurse by removing the traditional nurses' station. The structure of the nurses' station has provided a symbol of the central role of the nurse and also provided a location where the nurse could be seen as "doing her job" and legitimizing their role. Many nursing home nurses have become "desk" or MDS nurses and the removal of the nurses' station could be psychologically threatening.

The family and community artifacts are consistent with nursing's philosophy of the important role of the family in care. However, some nursing homes have become somewhat closed systems in which family members are seen as interfering with care or frequently complaining about care. The family and community artifacts represent the opening up of the system and more visibility to the community. Again this could be perceived as a loss of nursing control.

The leadership artifacts are perhaps the area in which there is most potential conflict with nursing. The lack of leadership training or training in a leadership/supervisory style that are primarily autocratic could mean that nurses are not comfortable with self-directed work teams, cross training and the involvement of CNAs in resident care conferences. In addition, the education of RNs in leadership often does not embody the newest knowledge about supervision and management that is reflected in the concept of self-directed work teams. It also does not incorporate information about coaching skills and listening skills such as those in the Coaching as Supervision program of the Paraprofessional Healthcare Institute.

The workplace practice artifacts that focus on consistent assignment are in keeping with nursing's philosophy of patient centered care. The artifacts related to job development and career advancement are also in keeping with essential elements of professional nursing practice models. Artifacts that may be difficult for nurses to accept are the self-scheduling of work shifts and the cross training of staff. Part of nurses' control of their practice is related to their control of the work schedules of staff. Thus turning this control over to CNAs may be

difficult. If CNAs are doing nursing related activities, in addition to activities related to housekeeping and dietary, the nurse may not be in the position of only supervising a portion of the CNA's activities.

The issues that confront professional nursing in nursing homes are also embedded in those facilities involved in culture change. There is a lack of clear differentiation between the role of the LPN and the RN and often indiscriminant substitution of LPNs for RNs. There is also a lack of willingness to take responsibility for supervising direct care workers and, when supervision does occur, it is often autocratic and authoritarian and based on power differences and punitive approaches, and characterized by a "we/they" approach, rather than respectful and inclusive.

RNs have often assumed non-nursing tasks such as scheduling and been reluctant to engage in direct care. Culture change requires that RNs become clinical care partners and serve as role models, teachers, and mentors for staff. It requires that they are gerontological nurse experts and have the leadership skills to build care teams. It requires that they relinquish control over non-nursing tasks and be responsible for the clinical care. It appears that many of the areas where nurses have been seen as resistant to culture change overlap with the areas in which they have not yet achieved the common components of professional nursing practice.

Some important questions to address related to nurses and culture change are:

1. Why do nurses feel marginalized in culture change initiatives?
2. What are the major areas of resistance to culture change?
3. What are effective strategies for overcoming these areas of resistance?
4. What skills and knowledge do nurses need to be leaders of culture change?
5. What set of leadership skills are most consistent with the principles of culture change?
6. What is the role of the advanced practice nurse in culture change?
7. How can the RN retain responsibility for clinical care while simultaneously promoting a team of unlicensed staff?
8. What is the appropriate level of nurse staffing in a household model?
9. How are nurse hours calculated for CNAs that have non-nursing responsibilities?
10. Are all components of culture change consistent with both long-stay and short stay residents?
11. Are nursing sensitive resident outcomes different in facilities which have adopted the artifacts of culture change?

Addressing these questions and others would provide insights needed to better engage professional nursing in culture change. A better understanding by

nurses in long-term care of the principles of professional nursing practice models, the principles of culture change, and the overlap of these two sets of principles would serve to decrease perceived or real resistance of nurses to culture change. The intentional inclusion of these two sets of principles in nursing education programs is also important.

References:

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