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Nursing Home Culture Change and Social Work Practice

Priscilla Dawn Allen

Executive Assoc Dir LCAC, Long Fieldhouse Louisiana State University, Baton Rouge, LA, USA

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Corresponding Author:
Priscilla Allen,
Louisiana State University School of Social Work & Associate Director LSU Life Course and Aging Center, 311 Huey P. Long Fieldhouse Louisiana State University, Baton Rouge, LA, 70803-5501, USA
pallen2@lsu.edu

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ABSTRACT

The role of the social worker in the nursing home is vital in providing psychosocial services in a medical arena, yet experience, training, and education vary widely in the United States, and within the state of Louisiana. Workers are called to do more through rigorous behavioral and intentional documentation paired with advocacy recommendations to infuse higher attention to resident-centered care through federal changes in documentation and in the nursing home culture change movement. This multidimensional movement that aims to improve all aspects of life within the nursing facility, such as standards as care quality, satisfaction, and staff retention and commitment calls for a holistic method of practice. The purpose of this paper is to assess Louisiana's nursing homes in term of implementation of culture change and to assess if there is a relationship between implementation and social work education. The relationship between implementation with the level of training and education of social workers/social service designees is explored and descriptive statistics are provided related to level of implementation in the sample. Facilities with higher implementation rates in three of the six of the culture change categories were significantly related to social work education level: Staffing, Homelike Environment, and Activities.

INTRODUCTION

Nursing home social workers are key agents in maximizing the social, emotional, and psychological well-being of residents in long term care. However, the training and expertise of these workers spans a wide continuum, adding challenges for the workers themselves and the integrity of the profession as a whole. Added threats to quality social work practice in the nursing home includes lower numbers of students entering the profession in aging field during a time when gerontological focus is most needed [1]. However, this trend is beginning to enjoy a shift among scholars and educators putting financial incentives into gero-focused social work programs, such as certificate program at Louisiana State University responding to the need for more trained social workers in social work education. Sisco,Volland, and Gorin [2] and others urging dramatic reaction to the demographic elder tsunami citing National Institute on Aging's (NIA) call for a 43% increase for gerontological social workers by 2020. In the midst of the current state of undertrained nursing home social workers nationwide, the shift to promote a change in culture from a medical to a social model adds unique challenges to social work. This paper considers social workers as leaders in the movement while also taking an honest view of the concerns shared from the professionals related to yet a new role in the nursing home.

The Culture Change Movement

The culture change movement broadly represents a paradigm shift from an institutional, medical approach, where residents have traditionally been viewed as passive care recipients, to an active and collective experience where individuals' needs, preferences, and desires are met [3-6]. The Movement is based on the mission of the Pioneer Network, operating under the

executive directorship of Rose Marie Fagan at LIFESPAN in Rochester, New York [7]. In facilities embracing culture change, residents are true partners in the life of the nursing home. Meyers [5] describes the change as a philosophical one, from places to die, to places to live. Furthermore, Roth [8] views culture change as having cost saving benefits for facilities as staff retention and deficiencies are lower. Clearly, such vast structural, philosophical, and attitudinal change requires participation of all members of the nursing home team. Without question, nursing homes are not all created equal, nor do they all provide the same quality level of care. Some facilities are more traditional, rational, and medically oriented, while others are working to progress in the area of metamorphosing to a resident-centered place. The concept of culture change has been discussed and implemented throughout the US for the past three decades, yet the movement is still taking root [8].

Kossman, Lamb, O'Brien, Predmore, and Prescher [9] urge medical facilities to document the productivity and capacity of social work in a time where services are needed more than ever, but at the same time are threatened for sublimation into other departments, or worse, cut entirely. The authors remind us that in the 110 or so years that social work has existed, a dismal job has been done in documenting the efficacy and necessity of the profession's role [9]. Culture change may serve as an area to highlight the progression of facilities while urging the social work profession to take an active role to define best practices and measurable outcomes. Should culture change be linked to social work standards, it may provide a needed benchmark for the value of social work.

Transformative Care

Culture Change Pioneers focus on systemic nursing home changes with four broad categories as prominent areas of concern: 1) the transformation of individual and societal attitudes toward aging and elders; 2) the transformation of elders' attitudes toward themselves and their aging; 3) changes in the attitudes and behavior of caregivers toward those for whom they care; and 4) changes in government policy and regulation [10]. An institutional orientation to enhancing residents' functioning must penetrate interactions between residents and staff at all levels [11]. Fagan [10] posits that culture change is an organic, on-going process that has the potential for change, growth, and development. Residents must be empowered to participate and maneuver within their environments. While the focus is on improving residents' lives, the parallel focus concentrates on flattening the hierarchy of the interdisciplinary team. An area of achievement of facilities embracing culture change is to have communal neighborhoods with private rooms rather than divided nursing units with structured, medicalized procedures. Staffs are cross-trained to meet the needs of residents, permanent assignment of nursing staff is urged, and smaller neighborhood communities all serve as partial foci for transforming culture.

This study considers several dilemmas and dimensions related to social work in the nursing home setting and the challenges of culture change: The 1/demographic imperative of aging trained social workers and the lopsided numbers of persons entering the aging field, 2/the trend of culture change as a movement aligned with the values and ethics of the social work profession, and 3/the baseline results of one state's implementation of culture change, examining whether social work training is correlated with facility implementation across the six domains. It is believed those facilities with more trained social workers will be further along in the advancement of culture change.

Although the study did not individually survey the social workers themselves to see what their feelings, concerns and accomplishments are, some anecdotal information also is reported that a group of social workers shared in a learning circle at a national venue, The Pioneer Conference in Washington, DC, discussed later in the paper. The baseline data from the Louisiana Culture Change study provide a watermark of culture change penetration as well as identifying areas that may need the work of social workers to promote. Challenges to social workers and perceptions about working in long term care facilities also will have real outcomes for the profession. At the very least, the paper hopes to open the dialogue and the link between social work and culture change by reporting on both the state of culture change and the state of the nursing home social worker. Primarily descriptive baseline data are shown related to the implementation of culture change and bivariate outcomes are presented in terms of the implementation and the training of social workers. Clearly, Louisiana may not be representative of the entire nation, but it's a central place to begin with a long legacy of funding for institutional vs. home-based care.

Social Workers in Nursing Homes by Choice or Chance

Many social workers land in nursing homes by necessity, circumstance, or chance rather than choice. The dearth of social workers making nursing home practice a priority is not surprising. The pay is traditionally less than in hospitals, schools, corrections, and the caseload for a single social worker can bulge to 120 residents, not to mention the additional load of families, friends, legal representatives, staff and administration. While social workers may start out in the facility out of circumstance, they usually stay

because they have the heart and stomach for profoundly difficult, conflict-laden work, yet also enriching and meaningful work and how the residents impact them. The level of involvement with the interdisciplinary team, how administration views social work, as well as role appreciation are predictors to staying [5].

Social workers handle some of the most conflict-laden work in the facility [12]. They often have to fight the goliath grip of health care costs and restraints, are also experts on discharge planning and may be key agents in terms of assessing readiness, or appropriateness of placement. Therefore, not only are social workers essential in helping residents with adjustment, loss, care preferences, routine pleasures, depressive symptomology, but they also aid residents to return home when possible, coordinating complicated plans with limited home based resources. Social workers main focus is relationships, which also is the foundation of culture change, but a honest reflection of the state of social workers in the nursing home setting was expressed by Sandy Meyers in which she stated "Too often it seems our [social work] role becomes just getting answers to specific questions to complete documentation. We seem to have lost interest in listening to people's stories. Our jobs, too have often become mechanical and, therefore, monotonous [5].

Getting our Hands Dirty

Some social workers simply do not want to do the dirty work that nursing homes in general require, and those adopting culture change promote. In the age of privatization and specialization, a general model of broad based practice where all hands are on board such as promoting neighborhood models and responding to call bells is met with scoff. *Feeding and changing patients is not what we're trained to do*, one social worker frankly shared with members of the profession at a recent Pioneer Network conference, the preeminent venue to spread grass roots efforts to get culture change cemented nationwide. The reaction at the Pioneer Network conference isn't an isolated one. Brennan, Brancaccio & Brecanier's [13] study spoke precisely to the curious reluctance among social workers. In their facility-wide evaluation on culture change, it was the social workers who had the hardest time adopting and engaging principles. In fact, 100% of the social workers, all seven (an increase in hiring during the study), departed in the study period (p. 229). This seems to be a cautionary tale that something isn't working with nursing home social workers and culture change. Perhaps social workers feel more of an afterthought than the architects of the model even though the basic premises seem to echo precisely the core values of the social work profession. Given the history of social work not being as legitimized in the nursing home setting to the same degree as nurses, some social work professionals may feel unsupported to lead the movement, particularly in homes with higher resistance. Another reason for reluctance may be the profession's increased specialization and clinical vs. macro/generalistic practice due to many forces, not the least of which is the pressure of insurance companies and the privatization, and the preferences of social work students to envision hanging a shingle rather than to promote social justice in an organizational setting– leaving a notable gap in our care.

Rothman [14] suggests a root cause of clinical, silo minded vs. macro/structural minded social justice workers is the reality that so many students come to social work school fresh out of a psychology program with more of an individual/pathological focus. Perhaps social workers adopting culture change principles fear they will become invisible and less unique in the facility. Also, if 30% of nationwide nursing home social service workers do not hold a degree higher than a high school diploma, workers may feel thwarted in taking on leadership positions in culture change. Or maybe not – it may, in fact, be those social workers who feel so uniquely trained in a psychotherapeutic model, who are more reluctant to run an activity group or help a resident to the bathroom. More investigation into the role of social work and culture change is merited, and into the reluctance of students to enter the aging arena in general.

Along this line, nurses and other professionals in the Brancaccio & Brecanier's [13] study had an easier time than social workers tending to tasks that were normally outside of their domain, such as working in a kitchen or providing some clean-up, toileting, or assistance with laundry or housekeeping. This seems counterintuitive for the social work profession based on the premise that the environment determines and influences wellness. Using a holistic perspective may require workers to dirty hands when the call bell rings. The noted round-table discussion in Washington, DC among social workers provided a forum where seasoned and new social workers were very frank about the real resistance of taking on the flattened tasks that culture change calls for. It may make sense why more social workers who boast credentials aren't flocking to nursing homes, and those facilities where seasoned and credentialed social workers are aren't necessarily farther along the culture change road. A partial explanation may have been unearthed in a study by Kane et al., [15] wherein these nursing home researchers study staff perception over the quality of life of residents in nursing homes. Those who felt they had the most influence over quality of life were consistently were the Certified Nursing Assistants (CNAs), and those least likely were the physicians.

Social workers consistently fell under the mean rates of the CNAs. The authors felt that it was personal contact and relationships with residents, not the position or status of a staff member that showed a relationship between perception of improving a resident's quality of life. This is one of the major foundations of permanent assignments of staff in the culture change model. Those who have a more personal responsibility, and more intimate involvement with residents view their role as more rewarding and more influential. The fact that social workers are spread across so many domains with up to 120 clients solely assigned to one social worker may impact the degree of alienation from residents and from perceived influence over quality of care and quality of life. Hence, more recognition of the social worker's unique role, more mentorship, and further attention to the measurable contributions of these essential workers seems not only merited, but crucial in upholding the psychosocial skills in long term care. It seems we may be at a critical turning point, where social workers can take on a more central role in culture change, but with infused opportunities for the profession, yet without exploiting or making nursing aides out of trained social workers. Solomon [16] suggests that mentorship is an essential key toward social workers feeling fulfilled and supported in their roles. Career ladders for social service designees where social workers may be part of the neighborhood leaders in a culture change facility is another avenue to bolster and celebrate the hard, but rewarding role of social work.

Certainly, there are social work heroes who practice, research, and advocate for the roles of nursing home social workers, and a developing cadre of experts from across the country is becoming more mobilized. Champions for social work roles include such established scholars including Rose Dobrof, Rosalie Kane, Joan Zlotnik, Kelsey Simons, Ellen Netting, Ruth Huber, Renee Solomon, Cheryl Zimmerman, Roberta Greene, Mercedes Bern-Klug, Colleen Galambos, and Betty Vourlekis, to name a few. In fact, the Centers for Medicare and Medicaid Services (CMS) have supported the efforts of the collaborative movement under the tutelage of Robert Connolly and Sonya Bowen, and their special edition journal related to psychosocial needs and realities in nursing homes serves as a testament to their concern. The spirit of such efforts echo Rosalie Kane's philosophy about social work infusing "a good life" into the daily routine of nursing home residents.

Social workers in the culture change movement have been at the forefront of organizing for years. Pioneer, Carter Williams a leader in the Pioneer Movement, and social worker has coordinated roundtables and learning circles with social workers at the Pioneer conferences. Dr. Wendy Lustbader was a key player in a learning circle back in 2008 to discuss the role and activism of social workers, when there was a mist of fatigue about the role of social work and the invisibility perceived in the movement. One person, a progressive and insightful social worker and leader in the area of elder care and culture change shared the following disappointment: "We [social workers] should be spearheading the movement, yet I don't see social workers in the program lineup and here we are on the final day, gathering in a back room as if an afterthought."

It may not be snobbery of social workers to stay in their respective treatment silos, but downright fatigue. Social workers are often called to be marketers, admissions directors, discharge planners, room change technicians, grief and bereavement specialists, conflict resolution experts, advocates, counselors, Minimum Data Set coordinators, activities helpers, lost and found workers, and handlers of vast mountains of paper work. It is no wonder that some facilities were mourning the loss of social workers, who once prepared artful, helpful social histories, as one example: "We used to do that, until we realized they went in the back of the chart and were almost always left unread."

Culture Change – Getting Back to Social Work's Roots

In many respects, the Culture Change Movement parallels the efforts of the Settlement House Movement (SHM) from a century ago. The profession's heroine, Jane Addams, the first woman to be awarded a Nobel Peace Prize, for momentous gains in the SHM with partner, Ellen Gates Starr after adopting the models used in Toynbee Hall in London. Addams and Star changed the ways in which the impoverished and vulnerable – those lacking access to housing, food, education, social welfare, childcare, skilled labor, were treated. Instead of being removed from clients, Addams lived among the residents, empowering the citizens to gain skills, power, and access to rights during the Progressive Era. There was little or no specific division of labor among the social workers, despite the fact that perhaps no one else made as profound an impact on the professionalism as Addams. Although not a panacea for implementing culture change, getting back to our roots may provide a replenishing retro movement into implementing culture change. Several have noted the degradation of social work as silos in a privatized world where the profession has almost unanimously adopted the psychoanalytic micro-perspective model of clinical practice, when almost nothing works when we don't embrace the environmental perspective.

The correlation between facilities embracing culture change having higher trained social workers is

admittedly intuitive; those facilities that are more progressive in advancing care to be less medical, more individual and care-driven would likely hire social workers with legitimate social work background and credentials. The study doesn't portend to illuminate the chicken or egg dimension of whether social workers are leading efforts resulting in higher implementation rates of culture change, or whether facilities that are more progressive have better trained social workers. In any case a correlation is indicative of resident-centered places with better trained social workers, inarguably a good partnership representing places that are more humanistic, holistic and with better psychosocial services.

Culture Change Stages

Experts through the Action Pact Institute [6] describe facilities in four stages, 1/Traditional, 2/Transformative, 3/Neighborhood, and 4/Household. The majority of all facilities currently, in the year 2008, are still at the traditional level, yet with movement toward transformative practices. Norton [6] describes traditional facilities as embodying the bureaucratic, efficient, medical model. Transformational stages represents when the facility is moving toward resident-centered care where choices in bathing and dining are happening. In the Neighborhood stage, facilities are restructured into smaller units where residents and staff work collectively to expand choice and growth. The Household model is an advanced stage where home is maximized through all levels of care, choice, activities and authority. Although the Louisiana Culture Change study doesn't seek to assess the 4-stage model that Action Pact introduced, there are some parallels between implementation and traditional as noted below.

1. Traditional: Not Familiar/Not Considering
2. Transformation: Under Discussion – moving in the right direction
3. Neighborhood: Implemented
4. Household: *Implemented at much higher level usually incorporating structural changes.

METHODS

In the fall of 2006, facilities in Louisiana were invited to participate in a survey to assess the level of readiness and implementation of culture change. The survey was adapted from the Culture Change Scale introduced in Promoting Excellent Alternatives in Kansas Nursing Homes Education Initiative (PEAK-ED). The study was administered through the Louisiana Governor's Office of Elderly Affairs Long Term Care Ombudsman Program. Local Ombudsman assisted in the collection of the surveys, which likely was a favorable detail in terms of higher response rates. Data collection and entry occurred over several months, most facility surveys were received between September 2006 – January 2007, with 72 of the 151 facility reports entered. A final set of data were received in January of 2008 and entered between February and March of 2008. The response rate was 52% (151) of the total operating nursing homes at the time of final data entry. Most often a person in an administrative role completed the surveys. The following is a report of the key findings, related to implementation rates of culture change reported by facilities. Analysis of variance (ANOVAs) were run to measure mean differences between rates of implementation by social work education. Education was operationalized in seven categories – High School Diploma, Associates Degree, Bachelor's Degree in Social Work, Bachelor's Degree Other, Master's Degree in Social Work, Master's Degree Other.

Many challenges have existed in Louisiana, not the least of which were two epic Hurricanes, Katrina and Rita. It is possible that culture change may have less of a head start here as there was a statewide initiative held just prior to Hurricane Rita, yet in retrospect, many said that recovery post disaster was in many respects mirrored culture change with all-hands-on-deck and a can do spirit to help the residents and to maximize the team spirit of the workers. The six domains reviewed included: Resident Control, Meals, Staffing, Community, Activities, and Home Environment. An abbreviation of the survey is referenced as the RCMSCAH.

RESULTS

There was a significant relationship between social work education and facility implementation in three of the six domains of culture change: Staffing, Homelike Environment, Activities, i.e., those facilities farther along the culture change road had social workers with BSWs or MSWs rather than social service designees with degrees other than social work. One-third of all of the social service workers possessed only a high school degree. Older and disabled persons deserve to receive psychosocial treatment from qualified professionals, and the workers with less experience and training deserve to have support that fosters their individual growth. Talk about professional career ladders for CNAs has been occurring for some time, but the crucial role of social work is just beginning to gain momentum. Certainly implications as to how social work measurable impacts care is required, and this study is a first step in terms of highlighting both the practice realities and professional reluctance in a field that is riddled with difficult role strain as well as less prestige and pay.

Resident Control

Five of the six sub areas were implemented in more than 50% of the facilities. Personal routines, bathing preferences, restraints minimally used, special programs to reduce loss of items, and residents regularly attended care plan meetings. Medication times adjusted for the individual was the lowest, reported as implemented in 47.5% of the facilities [Table 1].

Meals

Meal choices and options are essential features of culture change. Facilities farther along the culture change implementation have incorporated maximum choices and dining options. Three of the eight categories: Variety of snacks offered, Outings arranged, and Food preferences beyond special diets are accommodated were noted as implemented in more than 50% of the facilities [Table 2].

Staffing posed some culture change challenges in terms of implementation seven of the fifteen areas were noted as implemented in 50% or more of the facilities. It is encouraging to see that a permanent assignment is noted as implemented in 74% of the facilities. Whether this (and other ratings) is an accurate reporting rate is something that could be verified through ombudsman staff [Table 3].

Table 1. Percent of Resident Control Implementation

	Not familiar	Not considering	Under discussion	Implemented
Routine	0	.8	22	77.2
Bathing	0	1.6	27.9	70.5
Medication	3.3	20.5	28.7	47.5
Restraints minimized	.8	1.6	23.0	74.6
Special programs	5.7	1.6	27.9	64.8
Res attend care plan	1.6	.8	22	75.6

Table 2. Percent of Meal Implementation

	Not familiar	Not considering	Under discussion	Implemented
Variety of meals	2.5	3.3	17.4	76.9
Menus offered	3.3	23.3	35.0	38.3
Facility arranges outings	7.4	13.9	27.9	50.8
Expanded meal times	4.1	18.0	36.1	41.8
Buffet	3.3	36.6	45.5	14.6
Family style	12.6	33.6	29.4	24.4
Food preferences	5.0	4.1	26.4	64.5
Residents involved in establishing menu	6.5	26.0	41.5	26.0

Table 3. Percent of Staff Implementation*

	Not familiar	Not considering	Under discussion	Implemented
CNAs attend care plan meetings	3.3	5.7	45.1	45.9
Permanent staff assignments	1.6	5.6	18.5	74.2
Management	4.1	15.4	21.1	59.3
Staff schedule	9.8	56.9	17.9	15.4
Career ladder	7.3	16.3	29.3	47.2
Health insurance	2.4	24.9	21.1	31.7
CNA contact	8.1	37.1	24.2	30.6
Family knows CG	0	3.2	21.0	75.4
Mentoring	3.2	6.5	27.4	62.9
Incentives	1.6	17.9	16.3	64.2
Staff response	1.6	1.6	22.1	74.6
Staff training	4.9	10.7	27.9	56.6
Staff employed	11.5	24.6	26.2	37.7
CNAs leader	3.3	18.7	30.1	48.0
Nontraditional	3.2	28.0	24.0	44.8

*Category showed a significant correlation with social work education

Community

Community showed a promising representation of implementation with seven of the ten areas reported at 50% of higher [Table 4]. Family councils are still lagging in Louisiana. The common response is "we've tried it before and people aren't interested in attending."

Activities

Areas related to culture change implementation in activities were reported as highly implemented. All but one of the categories (activity schedule offering several options at the same time) were implemented in 50% or more of the facilities [Table 5].

Home Environment

Three of the eight categories were recorded as implemented by more than 50% of the sample facilities. Neighborhoods are less familiar and not considered by 30% of facilities, with 24% noting neighborhoods established. Nurses stations minimized ore redesigned is implemented by a reported 35% with 24% of those not considering. Areas of concern are potential areas for advocates to work toward, such as in the key areas of home environment which represents higher level of transitioning toward culture change. [Table 6].

Table 4. Percent of Community Implementation

	Not familiar	Not considering	Under discussion	Implemented
Welcome wagon	4.9	4.9	48	42.3
Grieving process	4.0	8.1	33.1	54.8
Family rooms	2.4	13.7	20.2	63.7
Cross-generational programs	12.4	8.3	24.8	54.5
Internet access for residents	4.0	35.2	38.4	22.4
Volunteer programs	1.6	4.1	22.8	71.5
Visiting pet program	.8	4.8	24.2	70.2
Resident council	0	1.6	11.4	87.0
Family council	2.4	14.6	57.7	25.2
Outside activities	0	5.6	14.4	80.0

Table 5. Percent of Activity Implementation*

	Not familiar	Not considering	Under discussion	Implemented
Schedule offers rooms for maximum choice	4.0	5.6	16.9	73.4
Schedule offers multiple concurrent options	2.6	16.9	37.9	42.7
Outside entertainment	0	1.8	13.7	83.1
Non-group activities	2.5	2.5	16.7	78.3
Space for nontraditional	2.5	47.5	23.8	52.5

*Category showed a significant correlation with social work education

Table 6. Percent of Home Environment Implementation*

	Not familiar	Not considering	Under discussion	Implemented
Nurses' station decentralized	8.1	24.2	24.2	34.7
Seating	.8	3.2	15.2	80.8
Bathroom	4.0	16.8	47.2	32.0
Furniture	6.4	11.2	18.4	73.6
Animal interaction	2.4	5.6	18.4	73.6
Neighborhoods established over time	8.9	21.0	44.4	25.8
Neighborhoods in place	9.2	24.2	42.5	24.2
Housekeeping participation	9.1	32.2	24.8	33.9

*Category showed a significant correlation with social work education

Limitations

Clearly, there are limitations to this study in terms of making a case between increased educational levels and culture change at only a bivariate level may only unearth rudimentary realities of facilities facing harsher challenges with budget constraints, new bundling under Medicare, and increased MDS protocol, more focus of CMS and others on re-hospitalization as well as dementia care - some may question why the relationship is visited at all – however, the case remains relevant – with more and more expectations and a growing elder population and the obvious need for trained social workers, the relationship between social work and outcomes is valid for investigating to further the field and most important, to build a better system for our present and future residents.

Conclusion and Implications

There is a wide variety of implementation and it may further require exploration into what is not being implemented as it seems curious with high vs. extremely low numbers of implementation and may impair the integrity of the data. What may be more interesting is what facilities are saying they are not doing. The definition of culture change in some respects may have diminished facilities' potential to highlight practices implemented without the formality of the culture change. The barriers most notably suggest that there lacks a clear understanding of both the nuances and realities that regulations play into the equation.

Although some cautionary realities have been discussed in this paper, the linkage between social work education with one-half of the domains is promising. The researcher expected the domains to be more aligned with what seems more social work focused, i.e., Resident Control, Meals and Community. However, the correlations between facilities that employ higher educated and trained social workers have a relationship toward self-reported implementation levels in 50% of the domains is a step toward showing a relationship with best practice facilities. It is a beginning to showing that facilities with social workers with advanced training have higher levels of resident-centered care, which is what the core value of self-determination, one of the hallmarks of social work serves. The research also analyzed whether facility deficiencies were negatively correlated with reported culture change levels (i.e., facilities with higher implementation rates of culture change had fewer Department of Health and Hospital deficiencies), yet there was no relationship found between rates of findings and culture change. A flaw in the study is that the rates are facility reported and may not be actually reflecting what's happening inside of the facility. Also inter-rater reliability would be impaired as usually only one person responded to the questionnaire. More exploration into the relationship between culture change and deficiencies also seems merited. For one reason, facilities still feel that they would be breaking compliance in areas such as medication passes and optimizing choices in dietary options for those on restricted diets, or with demanding medication oversight. Using ombudsman staff to what may be really occurring in facilities vs. what facilities say is occurring or report cards such as *Nursing Home Compare* [accessible on www.Medicare.gov] are avenues to potentially assess the status of culture change. There is little question that aging Baby Boomers will require facilities where choice driven care is paramount. Culture change may still be in its infancy, but activism is becoming more mobilized as Boomers place aging parents and consider their own long term care options.

Stone [17] proposes that given the tremendous variation in the characteristics in nursing homes, it is likely that each organization will have to adapt the features of the model programs to meet its own unique needs. Stone outlines the following elements that should be in place to ensure that culture change not only occurs, but also continues to evolve: 1) top leadership must be committed emotionally and financially to culture change; 2) commitment must exist at all levels of the organization; 3) systems of accountability must be built-in at all organizational levels; 4) the clinical and work culture dimensions must be integrated; 5) the dimensions of culture change must be codified and applied systematically and 6) sustained culture change requires ongoing feedback about failures as well as successes.

What seemed counter-intuitive was the relationships between those categories seeming at face value most aligned with social work values and direct intervention, particularly involvement with community and especially resident control were not significant. It would seem that social workers with more training would advance levels of culture change in their respective facilities – but the inconsistent findings may have more to do with the role strain of more clinical social workers not doing the yeoman's work of a macro social worker and change agent. How can we do both – advance culture change in facilities while requiring more training and skills among workers without betraying, exploiting, or jettisoning the social work professionals themselves?

The practice of facilities hiring under trained social workers is certainly not the sole blame of the nursing industry; the challenge also lies in the dearth of social work students looking to secure field placements and professions with older persons. We are making strides, since the data collection, however, where at LSU,

supported by the JAH Foundation and CSWE to improve and infuse aging content across the curriculum and to offer a gerontological certificate, we have seen an influx of interested social work students sign on. Likewise, the reluctance of some facilities to embrace culture change may have myriad reasons, some express that it is simply another passing fad and that regulators aren't signed onto, feeling the surveyors may find ways to sanction facilities that don't uphold rigid-medical model tendencies of the past. The buy-in is not simply one discipline, the organizational change must be a societal change where the pressure is real and the necessity crucial, not just in the wings of some felt-agenda of a few advocates. Nursing homes are changing with more opportunities for social workers to advance the resident centered models of culture change. Exposing social work students, educators, policy makers and practitioners in multi-arenas to meet the unique socio-emotional needs of nursing home citizens also must follow suit if we are interested in advancing care and treatment of older persons. For the good of our 1.6 million (and growing) residents and the need human service professionals to meet the needs of those most vulnerable, the time to change the culture – not only in the nursing home, but also in the social work and medical arena – is now.

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