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Exploring the Challenges Non-Clinical Departments Encounter During Eden Alternative Implementation

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Abstract

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Keith George

MS, Strayer University, 2012

BA, Temple University, 2010

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

The Centers for Medicare and Medicaid Services recommends new guidelines that shift healthcare delivery in nursing homes and long-term care facilities from an institutional model to a person-centered care model. Although clinical outcomes are measured and tracked, there was limited literature about the challenges non-clinical departments face in a nursing facility during implementation of a person-centered model. The purpose of this qualitative study was to explore the challenges non-clinical staff experience while transitioning to an Eden Alternative philosophy, a person-centered care model. The theoretical foundation of this study relied upon Bressers' Contextual Interaction Theory. The research questions for this study focused on the specific challenges that affect non-clinical staff from a staffing, operating, and risk management standpoint. The research questions focused on the internal and external motivations for staff as well as whether or not identifying such challenges will allow a nursing facility to achieve full Eden certification. The researcher for this study utilized a case study approach to explore the responses of 15 directors of non-clinical departments across the United States. Semi-structured interviews, Eden Warmth Survey data, and Minimum Data Set 3.0 data were used to gather data from participants and facilities involved. After using open coding for data analysis, significant findings in this study included that directors needed corporate buy in, continuous education, proper staffing and financial funding in order to achieve and maintain compliance. The study implications for social change involves addressing non-clinical department challenges directly and thus creating fewer barriers when embracing person-centered care models, such as the Eden Alternative model, as an environment for aging, compared to institutionalized approaches.

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Dedication

This dissertation is dedicated to my father and mother, Sabu and Mini George and my two younger brothers, Josh and Nick. My parents sacrificed so much to bring us to this country for a better life. I want them to know how grateful I am for everything they have done. This dissertation took a large part of my twenties to complete so I lost friends along the way. It was not easy starting my own company and finishing this dissertation but I am so glad I was able to accomplish both concurrently. I am thankful for everyone I have met on this journey and I cannot wait to begin the next phase of my life.

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Table of Contents

Contents

Chapter 1: Introduction to the Study

The purpose of this study was to explore whether or not there were any implementation challenges of the Eden Alternative model for non-clinical departments within the nursing home industry. The present study was necessary given the incoming shift from the institutionalized model of healthcare delivery to the person-centered care model that heavily influences federal regulations that govern the entire industry (Bookman, 2008). According to the Centers for Medicare and Medicaid Services (CMS), not only do nursing facilities (NFs) need to successfully implement the Eden Alternative model but it must also meet regulatory standards in order to maintain compliance with both state and federal regulations (Caspar, O'rourke, & Gutman, 2009). The Eden Alternative model is an example of a person-centered care philosophy implementation process that NFs undergo when trying to shift from an institutionalized model of healthcare delivery to a person-centered care one (Yeung, et. al, 2016). I focused on the challenges that non-clinical departments face when implementing the Eden Alternative model and explored how directors were able to maintain compliance with both state and federal regulations.

This chapter is divided into various sections including the background of the study, the problem statement, purpose of the study, research questions, theoretical framework of the study and the nature of the study. Additionally, this chapter includes the definition of key terms, assumptions, scope and delimitations, and significance of the study. The background section includes a brief history of the nursing home industry and

explain how the CMS plays a significant role in how organizations construct policies and measure quality of care for the elderly community.

Background

For many years, researchers carefully examined the significance of the environment where older people live. A large number of researchers (Kayser-Jones, 1991 Lawton, 1970; Lawton, 1983; Lubben, 1988; Thomas, 1996; Thomas, 2003) observed the effects of an environmental setting on the older adult population. A movement to focus on the experience and quality of life of the elderly created a philosophy of nursing home care known as the Eden Alternative model. The Eden Alternative model focuses on including plants, animals, and children into the daily continuum of elderly care to improve the overall environment of a nursing home (Thomas, 1996). Dr. Thomas believed that the medical model that many current nursing homes are structured after creates a harmful environment for the residents of these facilities. The phrase *nursing home* misleads the public, as it does not reflect the feelings of being at *home*, but rather an isolating institution with strict, repetitive schedules with limited flexibility for personal preferences of the individual (Thomas, 2003). Limited availability for companionship, no opportunity to assist others, and restrictions in variety lead to loneliness, helplessness, and boredom. Dr. Thomas considered these as "plagues," and a traditional model is not structured or capable of combating "plagues" (Thomas, 2003).

The Eden Alternative model was successfully implemented in nursing home and healthcare facilities since its inception and has expanded to countries outside of the

United States (Thomas, 2003). Researchers who studied the Eden Alternative model implementation in nursing home settings conducted studies to measure the success of the Eden Alternative model by looking at patient satisfaction and employee retention (Barba et. al, 2002; Brownie, 2011; Kaldy, 2008; Koren, 2010); however, these studies focused on the patients and clinical employees responsible for direct care (certified nursing assistants, registered nurses, and licensed practical nurses).The researchers focused primarily on the administration of medications and other direct nursing practices. The researchers were not focused on the wide array of risk management or staffing requirements that an Eden Alternative certification required (Brownie, 2011).

The United States experienced significant growth in its elderly population during the 20th century. The number of Americans aged 65 and older climbed to 40.3 million in 2010, which is higher than the number in 2000 at 35 million and significantly greater when compared to 3.1 million in 1900 (Kumar & Lim, 2008). The baby boomer generation includes people born between the years of 1946 and 1964 (Kumar & Lim, 2008). As they grow older, the aging population trend will continue to increase. Between 2010 and 2050, the elder population is projected to grow to 88.5 million comprising approximately 20% of the total population (Vincent & Velkoff, 2010).

Early Nursing Home reform

As the population ages, elders and their families turn to nursing home care for assistance. Common concerns for nursing home leaders relate to the quality of care elders receive there. The measurement and identification of quality in nursing home care continues to be contested and scrutinized (Hughes & Mitchell, 2008). A significant

development in nursing home reform legislation entered the forefront upon the passing of the Omnibus Budget Reconciliation Act (OBRA) by Congress in 1987. OBRA enhanced the regulation of nursing homes and included various requirements on the quality of care, resident assessment, care planning and the utilization of neuroleptic drugs, as well as physical restraints (Hawes et. al., 1997).

In response to allegations of widespread neglect and abuse in nursing homes, Congress enacted the OBRA legislation in 1987 that requires nursing homes participating in Medicaid and Medicare to comply with certain quality of care rules. NF's "must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident by a written plan of care" (CMS, 2011, pg. 146). NF's , at a minimum, must comply with these regulations if they receive Medicare or Medicaid. It varies from state-to-state, but every facility is responsible for meeting these requirements. Minimal compliance means that elders are exposed to institutional, structured nursing care, which affects the quality of their end of life experience (Kapp, 1999).

CMS CMS is a federal agency that administers the Medicare program and works in connection with state governments to establish standards for Medicaid including changes in rules and regulations (CMS 2015). A Medicaid rule makes patient-centered care a requirement for home and community-based services, defines home- and community-based settings (HCBS). With these rules in place, there is a greater emphasis toward a person-centered approach to care for all aspects of regulations. Significant person-centered components lead to the creation of the new Life Safety Codes of 2012 (CMS,

2013). These new codes represent an industry that is moving toward creating environments that meet the needs of the residents rather than reflecting the institution. Every year, CMS requires skilled nursing home facilities (SNFs) and NFs to comply with the requirements established by CMS to receive payment under the Medicare or Medicaid programs.

Through an annual survey, CMS audits facilities to ensure regulations are met and outcomes of the on-site survey ensure whether facilities will continue receiving Medicare and Medicaid funding. According to CMS, facilities are designated a rating after an annual survey based on a 5-star grading scale regarding facility compliance in several areas (Elliot et. al, 2014). Federal regulations that govern long-term care facilities are known as F-Tags. Each state department of health and CMSuse F-tags survey quality of care provided to residents in such facilities (Allen, 2014).

State surveys and federal agencies determine facility compliance based on clinical outcomes. Clinical outcomes are recorded and publicly available to serve as quality measures that indicate the level of care one would receive if admitted to that facility (Lilford, Mohammed, Spiegelhalter & Thomson, 2004). Organizations and state surveys track clinical outcomes and monitor ratings as a result of state surveys since the public uses the same outcomes to decide what facility to select(Hawes et. al, 1997) . At the time of this study, I discovered that very few studies focused on the non-clinical departments in NF . The person-centered care implementation challenges for non-clinical departments were not measured or explored in depth during the philosophy implementation process.

Challenges of Person-centered Care Implementation

Policies and protocols are put into place within a NF organization and implemented through individual departments that are overseen by managers and directors. When a philosophy is implemented, policies and protocols shift, and new ones are formed (Kapp, 1999). The policies and protocols are established to comply with CMS regulations and ensure the organization is in compliance with federal regulations to continue receiving Medicaid and Medicare funding. The Eden Alternative model has a person-centered approach to care delivery and therefore shifts the focus of quality measurement from quantitative to qualitative. Clinical outcomes play a large role in the success of a facility's survey outcome and in order to deliver care efficiently, quantitative metrics are used to measure and assess clinical care coordination (Karon & Zimmerman, 1996).

Problem Statement

In order to comply with CMS regulations, NFs are in the process of transitioning to a person-centered model like the Eden Alternative model from the existing institutionalized medical model (Carman et. al, 1996). If facility leaders want to be Eden certified, the ownership must reach out to the Eden Alternative organization and an Eden Alternative associate is assigned to the nursing home to conduct an assessment and provide training and projects to expose nursing home facility leadership to the Eden Alternative way of thinking (Barba, Tesh & Courts, 2002). This is a long process that consists of months of meetings and seminars and nursing home leaders are asked to implement Eden Alternative changes while still providing day-to-day care. Throughout

this process the employees of the facility are oriented to the new philosophy, while they are still expected to provide a high level of care to elders (Barba et. al, 2002). Problems arise when staff are expected to abide by newly taught Eden Alternative Principles while delivering care with the established training and knowledge developed throughout one's professional career (Spratt, 2009).

The nursing home industry is heavily regulated; therefore, it is up to the owners and leaders of these facilities to interpret federal guidelines while carefully implementing the Eden Alternative philosophy throughout all departments (Kapp, 1996). Non-clinical departments are overlooked when measuring success; however, such departments could be held deficient during annual surveys if surveyors determine specific regulations are out-of-compliance (Mor et. al, 2003). Healthcare professionals and ownership of skilled nursing facilities can use the outcomes of the study to identify these challenges and barriers as it gathered thoughts, personal experiences, and reactions from non-clinical department leaders during an Eden Alternative model implementation.

Purpose of the Study

The purpose of this study was to gauge the preparedness of non-clinical departments in NFs to determine whether key elements of the Eden Alternative philosophy could be implemented while remaining in compliance with federal and state regulations. My goal for this study was to understand the philosophy implementation process of the Eden Alternative model as it took into consideration the characteristics of non-clinical department heads to reveal the challenges and barriers of successfully implementing the Eden Alternative model. I addressed the gap regarding the challenges

faced by non-clinical department and whether those challenges were addressed when trying to achieve a person-centered philosophy. It also elucidated whether a facility's leadership should go ahead with the implementation process if the anticipated challenges faced by non-clinical departments were unlikely to be addressed during the implementation process.

Research Questions

The research questions that guided this qualitative research study were :

1. What are the specific challenges that affect non-clinical staff from a staffing, operating, and risk management standpoint when implementing the Eden Alternative model?
2. Will identify the challenges of adopting the Eden Alternative model from a non-clinical perspective determine whether complete transition achieves Eden Certification?
3. What are the internal and external motivations that influence non-clinical departments, if any, to commit to new philosophy implementation?

Theoretical Framework

I used the CIT as the framework for this study. When discussing philosophy implementation in a healthcare organization, the implementers (corporate team and administration) cannot employ a simple process that focuses on quick fixes to create rapid change in an implementation network (Bressers, 2007). The introduction of quick fixes without evaluating challenges and barriers in all healthcare departments will fail to produce long-term behavior change (Bressers, 2007).

Bressers discussed the contextual interaction theory when assessing water governance, policy and knowledge transfer between two different nations (Bressers, 2007). Bressers (2007) acknowledged that two different entities have established policies and philosophies that determine whether the implementation can move forward successfully. In Bresser's water management study example, once a policy transfer is in place, like water management based at the river basin scale (an incoming entity with new policies and philosophies) will be met with an existing governance regime (an established entity with policies and philosophies (Bressers & de Boer, 2013). CIT provides an analytical framework that helps to assess whether a policy transfer contributes to or damages conditions for successful water management (de Boer, Bressers, Ozerol & Vinke-De Kruijf, 2013). CIT has been used most commonly for other water management case studies and land redistribution (Boer, 2012; Edelenbos & Teisman, 2013; Ross, 2012; Van Der Zaag, 2010). An important element pertaining to the CIT that is mentioned in the water governance study is that if the existing arrangements undergo change there is no guarantee that the ideas that worked so well in the originating context will contribute to the quality of water governance procedures in the new context in which they are being applied (Bressers & De Boer, 2013 p. 36). Those who have studied CIT and apply it in policy change cases break down some of the key elements that make up the theory (Bressers, 2007, Bressers & de Boer, 2013, Owens & Bressers, 2013).

Policy processes are the first aspect of CIT and are not considered mechanisms, but rather social interaction processes between a set of actors (people, organizations (Bressers, 2007). This means that applying a step by step implementation process to

different situations will not yield the same results simply because the implementation process is organized step by step because it is dependent on the people involved in the process. Policy transfer processes and project realization fall under the category of policy processes (de Boer, et. al, 2013). Many factors can influence the activities and interactions of the actors but only because and in as far as they change relevant characteristics of the actors involved (de Boer, et al., 2013). The factors involved include the motives that drive actions, cognition that is the information held to be true by members of any given field of expertise, and resources that provide capacity and power by key actors responsible for acting out these changes within organizations (de Boer et al., 2013). The characteristics of the actors shape the process but are also influenced by the course of and experiences within the same process therefore gradually can change during the process of a new philosophy implementation.

A basic assumption of the CIT is that the course and outcome of the philosophy process does not only depend on the inputs of an incoming philosophy implementation such as the tools, resources, and guidelines that an established group or team must follow, but also the characteristics of the team members involved: motivation, information, power, and interaction (Bressers & de Boer, 2013). The characteristics of team members can significantly influence the philosophy implementation process to determine whether it is considered successful or not. The measure of a successful implementation of the Eden Alternative philosophy is based on clinical outcomes and resident satisfaction (Barba, et. al, 2002). Each department consists of staff and leadership that must synchronize the completion of tasks and responsibilities with other departments in the

facility. It requires a complete buy-in to implement policies otherwise; undesirable results will occur (Bressers, 2007).

I used key elements of the Eden Alternative model, such as the belief that residents should be able to request meals at any given time as opposed to a scheduled delivery of food, to highlight the differences between a person-centered approach and an institutional model approach. Other elements included the introduction of children and plants into the environment to achieve an "edenized" atmosphere. Each department's role in the process of implementing these key elements were questioned to assure the element is introduced successfully (Thomas, 1996).

Nature of the Study: Qualitative

I used a qualitative methodology with a case study design for this study. Case study methods are useful when conducting in-depth investigations of a single person, group, event, or community (Yin, 2013). Tools most commonly used in a case study (unstructured interviews, combing through official documents) can generate suitable material for this particular study. I was able to identify the risks, staffing challenges, and employee buy-in when implementing the Eden Alternative model. Upper-level Eden Alternative management provided access to the population of nursing homes that had undergone Eden philosophy training. The non-clinical department heads were selected from nursing facilities in which the philosophy is implemented. The department heads that provided the best understanding of the risk management challenges were the maintenance director and administrator, while the director of housekeeping and dining services director shared thoughts on maintaining costs within established budgets. A

high-ranking Eden Alternative associate agreed to recruit liaisons to reach out to this population. This individual was the president and consultant for Elder Centered Solutions, LLC and is in contact with nursing homes across the United States that are undergoing Eden Alternative certification currently. The president provided access to the two Eden Alternative liaisons, who then reached out to specific facilities on the study's behalf, but ultimately the population agreed to be interviewed and share thoughts and feelings confidentially

As data was collected, the characteristics of team members were revealed through interviews including the motivation, information, power, and interaction between departments to determine what is possible and what is not possible with Eden Alternative implementation. Each NF was unique with regards to the environment and specific factors that influenced implementation challenges from one department to another. Going through the results collected one from facility had similarities and differences compared to other facilities used in this study.

A case study approach was the ideal approach for me to use in this scenario as the results could be interpreted to focus more on the participant's opinions as opposed to simply the experiences observed. A case study is an in-depth study of a particular situation rather than a sweeping statistical survey (Baxter & Jack, 2008). It is a method used to narrow down a very broad field of research into one easily researchable topic. In this scenario, it was beneficial because it focused on non-clinical departments through personal surveys that explore individual situations than simply looking at quantitative

data and drawing conclusions. This allowed for the collection of additional qualitative data.

Definitions

Baby Boomers: Baby boomers are individuals born post-World War II between the ages of 1946 and 1964 (Kleppinger & Robinson, 2012). This population makes up a substantial portion of the North American population and represents nearly 20% of the American public (Kleppinger & Robinson, 2012). This population has a significant impact on the economy and act as a primary focus for marketing campaigns and business plans.

CMS: Centers for Medicare and Medicaid Services. Federal agency within the United States Department of Health and Human Services (HHS) that facilitates the Medicare programs as well as assists individual state governments administer Medicaid.

Donabedian Model: conceptual model that provides a framework for examining health services and evaluating quality of health care. This model continues to be the dominant paradigm for assessing the quality of health care. The model is broken down into three sections: Structure, Process, and Outcomes (SPO) (Gardner, Gardner, & O'connell, 2014).

Minimum Data Set: (MDS) is a federally mandated assessment of the patients at a long-term health care facility (Allen, 2011).

Medicaid: Medicaid is a joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid also offers benefits

not normally covered by Medicare, like nursing home care and personal care services (Medicare, 2015).

Medicare: Medicare is the federal health insurance program for people who are 65 years or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure that requires dialysis or a transplant). Different parts of Medicare help cover specific services (Medicare, 2015).

Nursing Facility: A nursing facility is a place for individuals who require care, not as advanced to be in the hospital, but not able to be cared for at home. Most nursing facilities have nursing aides and skilled nurses on hand 24 hours a day. The facility is set up differently, but staff provide care for residents with both long-term and short-term care (Allen, 2007).

Person-centered care: Person-centered care focuses on people's individual health needs but also involves people in the process of planning and evaluating services and care given (Talerico & Swafford, 2003).

Quality Measure: Quality measures are tools that assist in measuring or quantifying healthcare processes, outcomes, patient perceptions, and organizational structure and systems that are associated with the ability to provide high-quality health care and that relate to one or more quality goals for health care. These goals include effective, safe, efficient, patient-centered, equitable, and timely care (Medicare, 2015).

Quality of Life: Quality of life is defined as the standard of health, comfort, and happiness that is experienced by an individual or group. It is a broad multidimensional

concept that typically includes subjective evaluations consisting of both positive and negative perspectives of life (Fayers & Machin, 2013)

State Surveys: All nursing home facilities are subject to inspection or survey by a certification to participate in Medicare and Medicaid, and licensure by the state in which the entity operates (Allen, 2014).

The Eden Alternative: The Eden Alternative is an international non-profit organization dedicated to creating a quality of life for Elders and care partners. Eden Alternative offers person-directed principles and practices that support the unique needs of different living environments through education, consultation, and outreach (Thomas, 2003).

Assumptions

I base this study on numerous assumptions that could affect the accuracy and validity of its findings. I assume that all respondents during each interview provided an honest response to the experience in implementing the Eden Alternative Philosophy within their given facility. Organizations draft employee handbooks that include a code of conduct which prohibit employees from discussing private or personal information that relates to the operation of the employer. Most managers were so used to adhering to this policy, there was a possibility the manager will retract or edit responses to protect the organization or the manager from any sort of ramifications. This issue was addressed immediately during the recruitment process. I was careful to assume that all answers are provided honestly to actual experiences implementing the Eden Alternative Philosophy.

I also assumed that all respondents understood the questions asked and answered the questions accurately and not just to complete the interview more quickly. I may not have been aware of how well the participant understood the interview questions, therefore, the answers provided may not have been as accurate as if the question had been fully comprehended. The participant may have responded in a manner that expedites the interview to completion.

The outcome of the Eden Alternative philosophy implementation is based on the successful translation and implementation set in motion by department leaders. The use of department leaders as participants is significant for the study. I remembered to ask participants to elaborate or clarify responses for the study. I did not assume the reader had the same understanding of the long-term living industry like that of the participants and myself.

Scope and Delimitations

In this study, I focused on the challenges of implementing a person-centered approach to care in non-clinical departments in nursing home facilities. To understand the intricacies of care delivery, one must understand the entire process of care delivery first before breaking down each element. The research problem is based on the fact that non-clinical departments in nursing home facilities complete tasks that involve assistance, collaboration, and support from other departments. Every department has an expected function that intertwines with another department's function. If a department is delayed or unable to complete its task on time, then it has an impact on another department's functions. I focused on interdepartmental interactions because an outcome of a nursing

home facility's quality depends on the final result of care provided. State and federal regulation audits determine scores and ratings as a final measure for overall satisfaction, and every individual department has an influence on a patient's overall experience.

I excluded members of the clinical staff from this study. Nursing home reimbursement and survey results are geared toward clinical outcomes; therefore, clinical departments are observed and evaluated for effectiveness. Setbacks in clinical performance are observed and corrected to ensure positive survey results with fewer complaints reported. The non-clinical delivery of healthcare was highlighted in the interview questions to identify issues that stem from philosophy implementation of a philosophical shift in care delivery that is considered successful based on clinical outcomes. The results of the study provided insight for readers to understand the experiences of non-clinical staff with the Eden Alternative implementation.

Potential transferability of this study relates to separating entities where one element (clinical outcomes) is weighted more heavily than another (non-clinical quality measurements). Most organizations are made up of a combination of important departments. Some departments may directly result in profit however without the other departments fulfilling its responsibilities, the organization as a whole will suffer setbacks. The same idea applies to NF because a great emphasis is focused on the clinical outcomes for care delivery, but other departments also contribute in conjunction with the clinical team. The focus of the study delved into the consequences of how ignoring supplemental parts of an organization might have lasting and direct influence on the entity as a whole during Eden Alternative implementation.

The transferability of this study refers to the degree in which the results of this qualitative research can be generalized or transferred to other contexts or settings (Krefting, 1991). The concern lies in demonstrating that the results of one's work can be applied to a broader population (Shenton, 2004). The participants selected were varied, which reflected a broad population and allowed for greater ability to transfer the results to similar populations. The participants were managers of non-clinical departments; however, the departments were not always the same. A manager from dietary, housekeeping, admissions, and maintenance to name a few, provided their experiences with Eden Alternative implementation since each of those departments have differing responsibilities in the nursing home. The managers were also from different areas of the country, so the participants did not simply originate from one state. Different states have different regulations for delivering health care, and the use of different states allowed information regarding challenges not to rely on one state's regulations alone (Cebul et. al, 2008).

Dependability in qualitative research is the stability of data over time and over conditions (Noble & Smith, 2015). Regardless of what departments the managers came from, the category remained non-clinical departments of the NF. Non-clinical department leaders are not subjected to clinical outcome measurements during surveys, therefore, responses and contributions to the study included a non-clinical department experience during policy implementation (Kapp, 1999). As long as other researchers continue to gather participants from non-clinical departments, the outcome of the study will account for a constant variable in ever changing conditions. Location and specific departments

may vary, but the over-arching category of "non-clinical" will remain the same (Karon & Zimmerman, 1996).

Limitations

There were issues that could have caused a bias on the part of the participants or myself, that could have presented potential limitations to the study. I did not take into consideration any events such as history of disciplinary action or history of dissatisfaction with ownership of the NF, which could have all contributed to the answers given, as those factors could have been a part of implementing the Eden Alternative model, or they could have been unrelated. Personal factors for each employee could have been a challenge to implementing any philosophy as opposed to the Eden Alternative philosophy specifically. I did not evaluate other initiatives and philosophies that could have influenced an employee to struggle with facility-wide philosophy change.

I am a licensed nursing home administrator, with experience working in severalNF . It was important not to allow my personal experiences, beliefs or biases regarding to how a situation should be addressed interfere with the interview. Each nursing home organization has a unique mission and vision and establishes policies and procedures accordingly. My past work experience may vary from what another organization emphasized. I managed my bias by following the interview protocol and asked the participant for clarification when the response to questions were unclear.

Significance

The outcome of this study addressed a gap in literature as it sought to review and identify the challenges in implementing the Eden Alternative model for non-clinical staff.

The departments that fell under the category of non-clinical included housekeeping, dietary, social services, administration, human resources, maintenance, and case management. Members of these departments contribute to the care of patients in the facilities; however, from a risk management standpoint many challenges come with implementing the Eden Alternative model, and a facility leader must acknowledge and identify these challenges in order for the Eden Alternative model to work successfully. Implementation of the Eden Alternative model without considering the challenges to non-clinical staff can result in serious violations of federal and state regulations. This finalized study can assist many organizations in understanding areas of concern and could increase the chances of the Eden Alternative model being successful.

The gap in research existed as studies focus on outcomes related to the clinical team and feedback from residents (Karon & Zimmerman, 1996). The study contributed to shifting the attention toward non-clinical systems and highlight barriers experienced for the departments that fall into this category. This research support professional practice and is qualified for practical application as it addressed the areas of implementation from an operational and risk management perspective. The idea of person-centered care may result in positive outcomes related to the psychotropic med use and physical restraints; however, the successful implementation does not include whether the philosophy addresses staffing and operating costs for all departments (Hearld, Alexander, Fraser & Jiang, 2008). Healthcare facilities, like all organizations, rely on multi-layered departments working together cohesively to achieve optimal results. If one department fails to produce as expected, it will deter other departments from achieving success and

will ultimately influence a resident's experience in a healthcare center (Hearld, et. al, 2008).

Positive inter-professional relationships improve the quality of patient care and staff job satisfaction (Chang et. al., 2009). Identification of challenges and barriers to achieving successful inter-professional relationships will greatly improve a resident's quality of care (Karon & Zimmerman, 1996). A facility's leadership that achieves this goal with employees consistently taking all departments into consideration when measuring outcomes of the Eden Alternative philosophy could lead to a positive social change in many other areas in the healthcare industry. If the greatest frustration for staff in high-pressure environments is interdepartmental communication, then creating a more united and open environment will allow a better-facilitated atmosphere to work (Hearld, et. al, 2008). If the concepts and core values of the Eden Alternative philosophy brings success and team growth to a nursing home facility, then the same approach can be applied to hospitals, home health, and hospice agencies. Removal of the monotony of an institutionalized setting in delivering care has the potential to renew purpose and meaning in not only patients but the staff as well (Kaldy, 2008).

Summary

Chapter 1 provided an introduction to the significance of the Eden Alternative model philosophy implementation and the challenges non-clinical staff faced once the staff adapted to the changes required by new policies that accompany a philosophical change in care delivery. Researchers suggested that there is a conflict between natural and culture demands among employees in cases of philosophy implementation in which

established and tested approaches to delivering care clash with one another (Hearld, et. al, 2008). There is a need to understand these factors in philosophy implementation as it results in challenges for non-clinical staff members that are not being addressed.

I used Chapter 2 to delve into Bressers' CIT , as well as a detailed review of current literature. The chapter begins with a summary of how Bressers observed governance and the motivation, cognitions, and resources of actors (employees) in the case of significant philosophy implementation and philosophical change in delivering care. This literature review includes topics addressing cooperation with differing knowledge perception, the convergence of stakeholders toward cohesion and compliance, and the conflict of natural verse cultural demands during philosophy enforcement. Chapter 2 concludes with a discussion of how non-clinical employees experienced challenges in implementing a philosophy when the results focus on the success of clinical employees.

Chapter 2: Literature Review

Introduction

In the last two decades, the Eden Alternative philosophy model has provided an effective alternative to the institutional approach of developing health care to the elderly in a nursing home setting (Yeung, et. al, 2016) . Once implemented, the objective is to focus on eliminating loneliness, helplessness, and boredom (Thomas, 1996). This philosophy requires the implementation of new policies and a retraining of common skills and practices in delivering health care services. A focus on patient-centered care and surrounding each resident with elements such as plants, animals, and children requires a solid enforcement of philosophy to ensure patient safety, as well as compliance with federal and state regulated standards (Barba et. al, 2002). Concerns remain, however, about how quickly and effectively those policies are translated into effective care programs and services within an organization as it adopts the Eden Alternative principles. In many organizational studies the transformation of any existing patient centered care philosophy into specific programs has long been recognized by scholars and practitioners as fraught with implementation difficulties that are not easily remedied (Waring & Bishop, 2010).

The complexity of the philosophy implementation process has challenged researchers to develop theories or models with a limited number of explanatory variables that predict how and under what conditions policies are implemented (O'Toole & Montjoy, 1984). In an effort to evaluate the differential influence of culture change models (CCMs) on long-term care staff empowerment and provision of individualized

care, Caspar, Rourke, and Gutman (2009) set out to determine if differences exist across CCMs in relation to formal caregivers' perceived access to empowerment structures and reported provision of individualized care.

To complete this study, I recruited staff working in facilities that implemented the Eden Alternative.. Caspar, O'Rourke, and Gutman revealed that the greatest benefits existed for staff working in facilities with an FSSMOC as opposed to an Eden Alternative facility (Caspar et. al, 2009). These researchers also indicated that if an organization adopted a Facility Specific Social Model of Care then it will achieve the same, if not better results, than forcing the implementation of an Eden Alternative philosophy model that may not address the unique nature of each individual facility (Caspar et al., 2009).

The participants of Caspar, O'Rourke, and Gutman's study elaborated on the motivations and influences (both internal and external) experienced during an implementation period. In my study, I sought out the possible challenges that came with new philosophy implementation. Caspar et al, (2009) looked into several nursing home philosophies (not just the Eden Alternative specifically). The study resulted in every facility facing challenges based on the unique characteristics from one entity to the next.

This section begins with a discussion of the theoretical framework of the CIT by Bressers (2007). The literature review includes a discussion on the philosophy implementation process, barriers, delays, and disincentives associated with implementing policies and why there are challenges when implementing the principles of the Eden Alternative model without focusing on the unique properties of each facility. Peer-

reviewed literature and other scholarly sources for the Eden Alternative model were limited.

Literature Search Strategy

I identified the articles used for this literature review through Google Scholar, and full articles were available through Walden University's online library system. The databases I searched for relevant articles for this research study were Health Sciences by SAGE, Management and Organization studies by SAGE, and ProQuest Central. Keywords used for searching the databases included: *Eden Alternative model philosophy, philosophy implementation, philosophy transition, challenges in learning new skills in the healthcare industry,* and *nursing home regulations on patient-centered care*. I used only articles available in English, from a peer-review journal, available in full-text, and published within the last 10 years, preferably the last 5 years. The following table outlines the number of available articles in each keyword search and each database.

Table 1

Chart of Research

Key terms searched	Books	Scholarly Journals	Secondary Sources	Reviewed	Used
Eden Alternative model Philosophy	8,020	65,400	5	120	30
Philosophy Implementation in Nursing Homes	16,500	148,000	0	65	26
Philosophy transition in Nursing Homes	12,400	95,500	0	88	15
Nursing home regulations on patient-centered care	67,900	28,500	3	121	14

Quality of Life, skilled nursing facility	48,700	161,000	2	95	18
Skilled nursing facility staff challenges	18,100	85,900	0	67	15
Aging in place	300,000	3,020,000	5	21	20
TOTAL SOURCES	471,620	3,604,300	15	577	138

Theoretical Foundation

Bressers (2007) conducted research regarding CIT, which included governance and the motivation, cognitions, and resources of actors. The framework surrounds integrative systems and the boundary problem (ISBP) as Bressers focused on relationships and interactions between users. Users in the case of a nursing home would include members of both the clinical and non-clinical staff in a facility. ISBP addresses questions such as:

- How to make people cooperate when knowledge perception differs.
- How to stimulate *convergence* of stakeholders toward cohesion and compliance.
- How to set *boundaries* of social *systems* and problems without negatively affecting social cohesion (Bressers, 2007).

Natural and cultural demands conflict in numerous cases of philosophy implementation when there is an established approach in care delivery; however, a new response is required as opposed to the learned and conditioned response (Hearld, et. al, 2008). A natural demand would be closely associated with a nurse or dietary manager responding a situation based on years of experience and managing based on education or training (Hearld, et. al, 2008). When a new philosophy such as the Eden Alternative

model is implemented, the same nurse or dietary manager must now substitute a response or action that yields expected results for a new cultural response that aligns closer to the Eden Alternative approach. For example, a 70-year-old resident with dementia displays signs of aggression to staff and the typical institutional response to this situation would be assess surrounding patient and staff safety and attempt to medicate and restrain the resident, so no further damage will incur to the resident or surrounding individuals. The Eden Alternative philosophy requires a nurse to stop and attempt to connect with the agitated resident through a series of questions and calming techniques without the use of any chemical or physical restraints. A dementia resident during an episode can suffer short-term memory loss, problems with speech and comprehension, disorientation, delusions, impaired executive function, depression, and behavioral disorders (Baker, 2014). A staff member with years of experience must be trained properly to quickly and effectively diagnose the resident's condition and manage it accordingly.

Another example of institutional versus the Eden Alternative model is the availability of meals to residents in a nursing home facility. A nursing home facility has a sub-acute unit that admits residents at almost all hours, depending on transportation and discharge from the hospital (Rahman & Applebaum, 2009). In an institutional setting, breakfast is typically scheduled for 7 a.m.; lunch is scheduled for 12 p.m. and dinner is ready at 5 p.m. Residents have the option of dining in a lunch area with other residents or having the meals delivered to the room. When there is a late admission that arrives at 8 p.m., the kitchen may be closed, and according to the institutional model, that individual may not receive a dinner that night because of the fixed scheduling of the dining room

and kitchen. An Eden Alternative approach proposes pantries and kitchen areas that resemble a centralized dining area where meals are available for preparation and consumption at any time. The benefits of having such a service may appear appealing to the new admission and residents, but the implementation, training, and staffing involved in implementing this feature to the non-clinical staff may reveal challenges and additional risks that are not assumed when implementing it. Nursing home leadership anticipates problems during a transition period as staff revert to training and experience to address situations as opposed to the required response that aligns with the Eden Alternative Philosophy.

Contextual Interaction Theory

CIT was used by Kruijif, Bressers, and Augustijn (2014) in a study related to an international collaborative water project. The issue of reducing water management problems across multiple platforms was addressed in order to reduce flood risks. There were different agencies at play and the risk of division existed as the established approach of the Dutch agencies went up against the practices of the Romanians. (Krujif, et. al, 2014). In order to complete the study, both philosophies had to be combined to unify under one set of principles to be adhered to. The Dutch organizations had various reasons to participate in the project (creation of business opportunities, help reduce water problems in the area, etc.). When the Dutch actors interacted with the Romanian actors, there was a negative effect on the Dutch actor's motivation. Romanian actors were hesitant to take the initiative, which made the Dutch actors doubt the Romanian actor's

motivations and had fewer insights into and influence on policy processes, so the Dutch actors felt misinformed (Krujif, et.al, 2014).

Through interactions, the actors on both sides learned about the policy network, the potential of the adopted approach, the problems in the area, and the potential solutions. This realization through interaction is what the skilled nursing facilities face when coming together from an institutional approach to delivering care to a new Eden Alternative philosophy approach. Through social collaboration, two very different teams were able to combine existing motivations and conceptions of an issue and collaborate effectively to achieve the desired outcome. There were barriers for the water project team such as language and experience; however, through effective collaboration they addressed the issues and overcame them (Krujif, et.al, 2014). The CIT by Bressers (2007) is a solid theory to use for this study because it steps away from simply the implementation aspect of the study and focuses on the actors involved. The actors in the study have motivations and established ideals on how work is to be completed and understanding these factors is important when establishing a new philosophy from an existing one.

Early Nursing Home Reform

The United States experienced significant growth in its elderly population during the 20th century. The number of Americans aged 65 and older climbed to 40.3 million in 2010, which is higher than the number in 2000 at 35-million and significantly greater when compared to 3.1 million in 1900 (Kumar & Lim, 2008). The baby-boom generation includes people born during the demographic Post-World War II era, between the years

of 1946 and 1964 (Kumar & Lim, 2008). As this population grows older, the aging population trend will continue to increase. Between 2010 and 2050, the elderly population is projected to grow to 88.5 million comprising approximately 20% of the total population (Vincent & Velkoff, 2010).

As the population ages, elders and the families of elders may turn to nursing home care for assistance. Common concerns for nursing home leaders relate to the quality of care elders receive. The measurement and identification of quality in nursing home care continues to be contested and scrutinized (Hughes & Mitchell, 2008). A significant development in nursing home reform legislation entered into the forefront upon the passing of the Omnibus Budget Reconciliation Act (OBRA) by Congress in 1987. OBRA enhanced the regulation of nursing homes and included various requirements on the quality of care, resident assessment, care planning and the utilization of neuroleptic drugs, as well as physical restraints (Hawes et. al., 1997).

In response to allegations of widespread neglect and abuse in nursing homes, Congress enacted the OBRA legislation in 1987 that requires nursing homes participating in Medicaid and Medicare to comply with certain quality of care rules (Snowden & Roy-Byrne, 1998). Nursing homes "must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident by a written plan of care" (CMS, 2011, pg. 146). Nursing homes at a minimum, must comply with these regulations if they receive Medicare or Medicaid payments. The exact regulations vary from state-to-state, but every facility is responsible for meeting these requirements. Minimal compliance means that elders are exposed to institutional,

structured nursing care, which affects the quality of one's end of life experience (Kapp, 1999).

CMS

CMS is a federal agency that administers the Medicare program and works in connection with state governments to establish standards for Medicaid including changes in rules and regulations (CMS, 2015). A Medicaid rule makes patient-centered care a requirement for home and community-based services and defines home- and community-based settings (HCBS). With these rules in place, there is a greater emphasis toward a person-centered approach to care for all aspects of regulations. Significant person-centered components lead to the creation of the new Life Safety Codes of 2012 (CMS, 2013). These new codes represent an industry that is moving toward creating environments that meet the needs of the residents rather than reflecting the institution's bottom line.

Every year CMS requires SNFs and NFs to comply with the requirements established by CMS to receive payment under the Medicare or Medicaid programs. Many facilities structure patient care using an institutional approach, which will soon result in deficiencies during annual surveys, ultimately leading to fines and removal of a star (Hawes et. al, 2012). Surveyors visit facilities with a manual constructed by CMS to conduct specific searches or gather information to determine whether the facility meets compliance according to CMS standards. According to CMS, facilities are designated a rating after an annual survey based on a 5-star grading scale regarding facility compliance in several areas (Elliot et. al, 2014). Federal regulations that govern long-

term care facilities are known as F-Tags. Each state's Department of Health and CMS use F-tags survey quality of care outcomes to gauge the care provided to residents in all participating facilities (Allen, 2014). For example, F-Tag 309- 483.25 under Quality of Care states: "each resident must receive, and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care" (CMS 2011, pg. 146)

CMS instructed surveyors to use federal regulations as a guideline for all residents. Under F-tag 240 483.15 Quality of Life, "a facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's qualify of life (CMS, 2011, pg. 67)". The surveyor determines whether the facility is successfully able to create and sustain an environment that humanizes and individualizes each resident. The compliance decision is based off of each resident's experience from both a clinical and non-clinical perspective (Castle & Ferguson, 2010).

Once the annual survey is complete, the NF or SNF receives a star based on the five-star quality rating system, which indicates the quality achieved at the facility and its importance to consumers, families, and caregivers when comparing facilities (Allen, 2011). Nursing homes with five stars are known as above average quality, and nursing homes with one star are considered to provide quality much below average. There is one overall 5-star rating for each nursing home, along with a separate rating for each of the following three sources of information: health inspections, staffing, and quality measures (QMs) (Allen, 2014). Health inspection ratings consist of information that contains the

last three years of onsite inspections, including both standard surveys and any complaint surveys. Staffing ratings provide information about the number of hours of care provided on average to each resident each day by nursing staff (Allen, 2014). Quality measure ratings include information on 11 different physical and clinical measures for nursing home residents (Allen, 2014).

Star ratings for each part and the overall rating range from 1 star to 5 stars, with more stars indicating better quality. The first step is to start with the health inspections rating. One star is added if the staffing rating is four or five stars and greater than the health inspections rating if the staffing rating is one star then one star is subtracted from the overall (Medicare, 2015). If the rating for the quality measures is five stars, then a star is added to the overall rating, while a star is subtracted if the rating for quality measures is one star (Williams et. al, 2010). If the rating for health inspections is one star, then the overall rating cannot be upgraded by more than one star based on the staffing and quality measure ratings (Medicare, 2015). A survey team's interpretation of federal regulations affects the results of the survey and if corrections are not made, or a plan of correction is not submitted there are financial and operational penalties enforced by CMS (Medicare, 2015).

Eden Alternative Philosophy

"The American Nursing Home is in the center of a 'perfect storm' as a result of financial, workforce and liability issues" (Thomas, 2003). William H. Thomas, MD is the President of the Eden Alternative. The philosophy to begin the Eden Alternative initiative stemmed from Thomas' belief that conventional approaches to improvement in quality

within the nursing home setting have been infective in fundamentally changing notions of care and treatment for Elders. The Eden Alternative began in 1992 as an effort to transform life in a single nursing home. A decade later the movement includes more than 5000 Eden Alternative Associates and 200 organizations as members (Thomas, 2003).

The main principles of Eden Alternative organizations are constructed as a "direct response to combat loneliness, boredom, and helplessness in the lives of the elderly" (Thomas, 2006, p. 53). Thomas (2003) believed that total institutions damage people and when nursing homes run like total institutions the nursing homes inevitably damage people. The American nursing home, as it is run today cannot sustain its current model because of the rising expectations of the incoming generation of elders: the baby boomers.

More babies were born in 1946 than ever before: 3.4 million, 20 percent more than in 1945. This rise in births began the era of the so-called *baby boom* (Kleppinger & Robinson, 2012). In 1947, another 3.8 million babies were born; 3.9 million were born in 1952; and more than 4 million were born every year from 1954 until 1964 when the boom tapered off (Kleppinger & Robinson, 2012). By then, there were 76.4 million *baby boomers* in the United States, almost 40 percent of the nation's population (Kleppinger & Robinson, 2012).

The founder of the Eden Alternative Philosophy sought to transform long-term care facilities into places where elders feel at home, family members enjoy visiting, and life is worth living (Barba et. al, 2002). In addition, staff are respected, listened to and appreciated, the care is good, and legal action is unnecessary (Nesbitt, 2014). The Eden

Alternative has grown in size, scope, and complexity since it began in 1992. It began as a concerted effort to improve the quality of life for residents in a single nursing home. The Eden Alternative Philosophy is founded on 10 principles that remain prevalent through all training and business operations.

The ten principles of Eden Alternative Philosophy are:

1. The three plagues of loneliness, helplessness, and boredom account for the bulk of suffering in a human community.
2. Life in a truly human community revolves around close and continuing contact with children, plants, and animals. These ancient relationships provide young and old alike with a pathway to a life worth living.
3. Loving companionship is the antidote to loneliness. In a human community, caregivers must provide easy access to human and animal companionship.
4. To give care to another makes society stronger. To receive care gracefully is a pleasure and art. A healthy human community promotes both of these virtues in its daily life, seeking always to balance one with the other.
5. Trust in each other allows society the pleasure of answering the needs of the moment. When individuals fill one's life with variety and spontaneity, that individual honors the world and one's place in it.
6. Meaning is the food and water that nourishes the human spirit. The counterfeits of meaning tempt individuals with hollow promises. In the end, they always leave individual's empty and alone.

7. Medical treatment should be the servant of genuine human caring, never its master.
8. In a human community, the wisdom of the elders grows in direct proportion to the honor and respect accorded to the elders.
9. Human growth must never be separated from human life.
10. Wise leadership is the lifeblood of any struggle against the three plagues. For it, there can be no substitute (Brownie, 2011, p. 65).

The Eden Alternative initiative began as a grant project including an evaluation component, funded by the New York State Department of Health. The Project was conducted in 1992 and 1993 at the Chase Memorial Nursing Home in New Berlin, New York, an 80-bed not-for-profit facility (Thomas, 1994). The findings revealed significant results in terms of powerful associations between the implementation of the Eden Alternative and improvements in staff turnover, resident infections, polypharmacy and resident longevity (Thomas, 1994). The statistically significant findings served as the groundwork to radically change the physical and social environment that is inhabited by the residents in a nursing home facility, which can ultimately have a substantial impact on the well-being of staff and elders alike (Thomas, 1994).

Early Adaptations of Eden

After the first iteration of the Eden Alternative facility, the next major effort was to replicate the same effect observed at Chase Memorial. In 1994, the Eden Alternative initiative entered into three progressive facilities in Upstate New York - Ideal Senior Living Center, Vestal Nursing Center and Tioga Nursing Center (Thomas, 1994). In these

centers, it was learned that implementing the ideology held by the Eden Alternative initiative came with its challenges. Facilities possess a hair-trigger sensitivity to the issue of "being told what to do". (Thomas, 1994) Defensiveness is a chief barrier encountered by any attempt to "change the culture of long-term care" (Thomas, 1994). The result of ignoring the barrier of participant defensiveness to change leads to wasted effort and resources (Thomas, 1984).

In 1996, Jude Thomas (wife of William Thomas) developed the Eden Alternative Associate Training program, a three-day course on the Eden Alternative philosophy, as well as all of its practices and principles (Thomas, 2003). This course provided in-depth training and activities, which sought to improve the replication process from facility to facility. The program would serve as a powerful mechanism to bring the Eden Alternative philosophy and implementation process to organizations outside of the New York area (Thomas, 1984).

In late 1998, the Eden Alternative associate training program increased in popularity and demand surpassed the company's capabilities to meet the demand. (Thomas, 2003).Thomas developed the Eden Alternative Regional Coordinator model in which regions in the United States and Canada were divided, and a highly skilled Eden Alternative educator was placed in each region (Thomas, 2003). This change resulted in improvement in the availability of Eden Alternative education. The Eden Alternative associate training program was able to reach approximately 100 to 200 people over the course of a year (Thomas, 2003). With the Eden Regional Coordinator model, that number increased to 1000 people a year (Thomas, 2003).

A year later, the American Association of Homes and Services for the Aged (AAHSA) and Eden Alternative created the Eden Across America Tour (Bowman, Edu-Catering, & Education, 2008). The tour lasted 31 days and reached 27 cities spanning over 10,000 miles (Thomas, 2003). The Eden Alternative group met with government officials and conducted public lectures, as well as created partnerships with local elder-centered charities. By 2002, the Eden Alternative organization reached 7,000 Eden associates and presented more than 200 organizations with the official seal (Thomas, 2003).

The Green House Project

The Eden Alternative model continued to educate and redevelop the approach to delivering services in the long-term care environment into the 21st century (Barba et. al, 2002). The Eden Alternative group sought to change the way care was regulated and delivered to people coping with difficult changes that often accompany old age (Thomas, 2003). According to the Eden Alternative group, the facility-based approach that the American long-term care industry adopted for the past three decades no longer kept pace with society's rising demands for quality of care and quality of life. This development allowed for the creation of the Green House project that was brought in and used as a model for nursing home care delivery reform (Thomas, 2003).

The Green House Project was an attempt to design, build, and test a profound new approach to residential long-term care for older people. The project was based on the idea that the physical and social environment in which caregivers and nursing institutions deliver long-term care can and should be warm, smart and green (Zimmerman et, al,

2013). The Green Houses were modeled to be small (six to eight people) community homes where those that required skilled nursing services could have lived and received care (Zimmerman et, al., 2013). The first Greenhouse began construction in Tupelo, Mississippi in 2002 and occupancy was planned for 2003 (Cutler & Kane, 2009).

The houses were furnished with warmth in mind throughout its furnishings, decor, and floor plan and staffing. The Green House provided 36 hours of staffing a day (six hours per elder per day) (Zimmerman et, al., 2013). Federal requirements list, on a state-to-state basis, plausible minimum staffing levels for providing nursing home quality care (Cutler & Kane, 2009). However, there were difficulties establishing evidence-based minimum staffing ratios so institutions staffed according to the minimum requirements because specific nurse-to-resident staffing ratios for registered nurses, licensed practical nurse, or nursing assistants are not established (Harrington et, al., 2012). The Green House model has an established practice of providing six hours of care per elder per day and it is expected to far surpass the minimum nurse-to-resident care ratio that the institutional model requires (Cutler & Kane, 2009).

The founders of the Eden Alternative model believed that people will find great pleasure in the company of animals, the laughter of children and the growth of green plants. Contact with the living world was a major factor in both quality of life and improved clinical outcomes (Thomas, 2003). Proponents of the Green House model believed that the model could become a high-quality, safe, cost-effective alternative to institutionalization for frail and disabled people who require skilled care (Zimmerman et, al., 2013). The difficulty in achieving this outcome had to deal with the parameters of

existing funding and regulation that CMS had established for nursing home facilities. The general regulatory scheme did not grant approval for Green House centers, which disqualified them from participating in Medicare and Medicaid programs (Thomas, 2003).

The Eden Alternative model used the foundation of the Green House model and adopted major fundamental components to combine with Eden Alternative 's understanding of existing long-term care institutions (Thomas, 2003). The Eden Alternative model identified institutions that were Eden certified and recognized them as forward thinking and progressive. These buildings served as training centers to test out new practices with fundamentally different philosophies. A study by Southwest Texas State University (Ransom, 2000) revealed that "Edenizing" homes resulted in significant improvements in specific areas associated with the quality of care provided:

- A 60% reduction in behavioral incidents (altercations between two or more residents)
- A 57% decrease in decubitus ulcer formation
- A 25% decrease in numbers of bedfast residents
- An 18% decrease in use of restraints
- An 11% increase in census sustained over two year period
- A 48% decrease in staff absenteeism
- A 59% increase in self-scheduling (Ransom, 2000).

Even though the data gathered from the Southwest Texas State University study showed promise in the Eden Alternative model, only 2% of nursing homes in the United States

adopted the Eden Alternative approach (Thomas, 2003). There were challenges that arose when implementing the Eden Alternative model and many of the challenges stemmed from introducing new policies and behaviors in an industry with established and accepted practices (Ransom, 2000). Aside from national armies, few people inhabit organizations that are as rigidly compartmentalized and uniformly hierarchical as the American nursing home. It's all about how exact the staff can execute the daily tasks as assigned by the patient's care plan (Thomas, 2003, pg. 150).

Medical care for the elderly

There are developments in the realms of medical innovation and geriatric clinical intervention that affect one's understanding of the nature of late life and the possibilities for health in advanced age, medical decision making, and family responsibility (Bookman, 2008). These possibilities may not have existed 15 years ago; therefore, the ethical field is updated, and thus the standard of medical care come together with societal expectations to reveal a shifting ethic in normalcy in delivering care as well as socio-cultural ramifications (Kaufman, Shim & Russ, 2004).

In 1989, Carroll L. Estes and Elizabeth A. Binney revealed the rapid pace of developments in the biomedical sciences and in geriatric medical care as both individuals continued to shape the knowledge and information in how society views the aged body and how the medical community holds expectations about a medical intervention that late in life (Estes & Binney, 1989). Estes and Binney (1989) viewed the biomedicalization of aging as having two components. The first view is that aging is a medical problem and

the second view is that behaviors and policies are created to address the first view (Estes & Binney, 1989).

With these two views on aging, the medical model becomes prominent in how to address individuals as they advance in age. Nursing homes, in most cases, adopted the medical model in its approach to delivering care just as hospitals did. This approach to aging has grown in popularity as diagnosis-related groups (DRGs) became prominent in the late 1980s (Greenfield & Nelson, 1992). Hospitals were forced to discharge patients "quicker and sicker, " and nursing homes were the alternative option for these patients who were not yet ready to go home. Over time, nursing homes became more and more like hospitals and less and less like a home (Thomas, 1996).

Elderly people who enter into a nursing home environment suffer multiple losses, and under a medical model, the nursing home environment does little to address those losses (Thomas, 1996). The setting in most nursing homes only perpetuates the existence of learned helplessness as care partners dictate the terms of care, as opposed to the residents and patients having an influence on the care provided. A lack of personalization conflicts with the residents' perception of control of the environment and current predicament (Thomas, 1996). When patients lose control over the care received, environments no longer feel like areas of care, but rather cold institutions similar to that of a prison.

Restraints: Traditional approach vs. Eden Alternative approach

A traditional medical model treats dementia patients with medications or physical restraints to counter the disruptive and sometimes aggressive behavior of the patients

(Brune, 2011). In a memo sent to State Survey Agency Directors from the Director of Survey and Certification Group on May 24, 2013, surveyors are reminded of National Partnership to Improve Dementia Care and Reduce Unnecessary Antipsychotic Drug Use in Nursing Home initiative launched by CMS (CMS, 2013). The nursing home industry utilizes various types of psychopharmacological medications to attempt to address behaviors without first determining whether there is a medical, physical, functional, psychological, emotional, psychiatric, social or environmental cause of the behaviors (Wallace & Herzog, 1995). Medications might be effective when used appropriately; however, medications are ineffective and harmful if given without a clinical indication (CMS, 2013). Strict requirements exist to monitor efficacy, risks, benefit and harm for these medications. This reality explains the increased necessity of choosing a philosophy such as the Eden Alternative model to structure care and policies, as it aligns with many of the new changes that CMS requires from all facilities. An Eden Alternative philosophy creates an environment to combat traditional interventions of a modern medical model and aims to reduce chemical and physical interventions (CMS, 2013). Facilities that are unable to reduce chemical and physical restraints successfully will be declared deficient and risk facing the consequences (CMS, 2013).

State surveys and federal agencies determine facility compliance based on clinical outcomes. Clinical outcomes are recorded and publicly available to serve as quality measures that indicate the level of care one would receive if admitted to that facility (Lilford, Mohammed, Spiegelhalter & Thomson, 2004). Organizations and state surveys track clinical outcomes and monitor ratings as a result of state surveys since the public

uses the same outcomes to decide what facility to select. No studies were identified concerning non-clinical departments and challenges that are not measured or explored in depth during the philosophy implementation process.

Challenges to Person-centered care implementation

Risk management threats are measured based on state regulations and the ability of a nursing home to address the concerns outlined by CMS' Medicare and Medicaid standards. When a new philosophy implementation goes into place, the nursing home must then audit how it complies with each regulation and whether or not it is in jeopardy of being out of compliance. Brownie (2011) agrees that the implementation of The Eden Alternative is not without challenges. The philosophy is based on challenging traditional models of care and management because it focuses on the entire facility management system. The priority is to eliminate the nursing organization hierarchy and promote a decentralized team approach to care delivery (Brownie, 2011) State surveyors focus on a facility's compliance with all regulations. Decentralized teams means less oversight by management teams and more ownership by lower level staff members to deliver care and meet compliance standards. If a resident is told that the facility staff offers residents the flexibility to dine at any time and that the resident can order from a menu that is always available, the dietary team must ensure that staff is available to provide the service. This service means that management must order food for the coming week without accurately knowing what items will be used or not because of the unpredictability of what a resident would want.

If the new philosophy implementation of person-centered care causes a dietary department to shift staff ratios, and food ordering and the nursing home is not prepared for such changes, then the resident will not receive adequate nutrition in a timely manner, thus compromising the facility staff's ability to meet clinical regulations pertaining to that resident's medical health. The gap in knowledge that needs to be addressed focuses on the challenges of long-term care employees that take on non-clinical positions that must still be accounted for as it may indirectly affect the quality of care received in a nursing home facility.

The quality measure may not reveal the cause of a dietary deficiency but rather measures what the nursing home facility failed to do. The purpose of the study was to identify quality measure outcomes, compare them to staff concerns and feedback, and finally interview non-clinical department members to bridge the gap in knowledge for the challenges non-clinical departments experience during a complete philosophy implementation. Institutional care is organized and often follows a direct algorithm of responses. If a patient with dementia becomes aggressive, then a nurse administers medication to suppress such behavior. With person-centered care, the staff no longer has a simple algorithm to follow, nor a script to recite, but rather assesses the situation and responds to the resident with a personalized approach to resolve each situation without the use of chemical or physical restraints.

The successful implementation of this model requires good leadership and effective, stable management; capable and established teamwork; excellent communication systems; an investment in staff training and education regarding the Eden

Alternative philosophy; the capacity to provide the necessary care for plants and pets; a strong commitment to a person-centered care model; and a shared belief that older people are entitled to pursue opportunities for the full development of one's potential (Steiner, Eppelheimer, & De Vries, 2004; Barba et. al, 2002). With person-centered care and new CMS regulations, the outcome is unpredictable for the circumstances a healthcare provider experiences when an elderly resident begins to act in a manner that is difficult to control. The staff and other employees are susceptible to increased levels of injury, damages, and other risk management issues. The responses for these risk management issues are part of the gap of knowledge. The outcome of this study addresses the gap in knowledge and provide administration a better understanding of how these issues emerge.

Quality of Life

Over the years, research focused on the distinction between two main concepts: quality of care and quality of life (Thomas, 1996; Brooks & Kosecoff, 1988; Wyszewianski, 1988). Quality of care focuses on the performance and behaviors of certain activities in a facility that increases or prevents the decline of an elder's health status that would have occurred naturally because of a condition or disease (Ory & Cox, 1994). Wyszewianski (1988) states that the quality of care is the measure of whether the care is good or bad, appropriate or inappropriate, and well implemented and enforced or poorly implemented and enforced.

Fayers and Machin (2013) argued that subjective indicators should be considered when determining one's quality of life. Fayers and Machin focused on the development,

analysis, and interpretation of data from quality of life instruments such as questionnaires. Quality of life (QoL) is an ill-defined term (Fayer & Machin, 2013). The World Health Organization (WHO) (WHO, 1993) declares health to be 'a state of complete physical, mental, and social well-being', and not merely the absence of disease' Many other definitions link 'health' and 'quality of life' together. Success of an Eden Alternative implementation depends on a patient's quality of life, however, to measure one's quality of life some questionnaires place greater emphasis upon psychological aspects, such as anxiety and depression, yet others try to allow for spiritual issues, ability to cope with illness, and satisfaction with life (Thomas, 1996).

Philosophies such as the Eden Alternative have fostered the growth of resident-directed care within organizations. The approach begins with the resident and places the individual at the center of the decision-making process. It allows the traditional top-down model of decision making to become inverted to allow staff (e.g., nurse aides) to work closely with the residents to make decisions (i.e., what to wear, when to eat) (Castle, Ferguson, & Hughes, 2009). This approach recognizes the importance of residents' QoL(Castle, et. al, 2009)). Quality indicators used in this case, that is QoL, related would include measures that focused on energy levels, sleep, self-esteem, and sense of mastery (Castle, et. al, 2009). The benefits of culture change have proven difficult to gauge. After a 1-year study comparing the first year of implementation of the Eden Alternative and a control nursing home run by the same organization, very few quantitative differences existed (Coleman et, al., 2002).

Quality of Care

The quality of care provided at nursing homes remains a consistent issue of concern for consumers, government, and researchers alike. The Institute of Medicine (IOM, 1996) provided an example of quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Lohr, 1990 p. 707). Professionals and leaders within the nursing home industry face the challenge of operationalizing that definition of quality of care to assure that the elderly resident receives it. Government agencies in turn, establish quality measures and quality indicators that will allow nursing homes to measure the efforts put forth in all facilities to provide quality services (Castle & Ferguson, 2010) Consumers use these measures as a way to gauge the quality of care that one can expect at a facility and compare the results with other facilities prior to making a decision (Castle & Ferguson, 2010). Unfortunately, definitions for quality are very general and subjective; therefore, quality measures fall short in covering the concept of quality (Kaldy, 2008).

The inability to measure "quality" effectively in a nursing home requires more emphasis to be placed on quality indicators throughout the industry (Kaldy, 2008). In measuring quality, government agencies that oversee nursing home care established many quality indicators. Researchers use a Donabedian (1985) approach when organizing quality indicators in order to conceptualize how to accept an indicator. Donabedian proposed that quality is measured in terms of structures (S), processes (P), and outcomes (O) (SPO) (Donabedian, 1985). Structural measures are the organizational characteristics

associated with the provision of care given (Hearld et. al, 2008). Process measures are characteristics of things done to and for the resident. Thus, the outcome measures are the desired states one would (or would not) like to achieve for the resident (Hearld, et. al, 2008). This SPO approach means that good structure should ultimately lead to good process and then the good process that is established should facilitate good outcomes.

Measuring Quality

A powerful proponent for nursing home quality is derived from federal and state oversight entities. Nursing home facility licensure and certification requirements, as well as payments from federal and state programs, all play a role in how a nursing home's quality affects its standing. State health departments use a thorough licensing process to establish standards for care received and delivered in a nursing home setting (Castle & Ferguson, 2010).

In 1961, the Public Health Service focused on nursing home state licenses after a number of states by the Commission reported numerous issues related to chronic illness (Chassin & Galvin, 1998). The Public Health Service issued the Nursing Home Standards Guide in 1961 that required standardized definitions to exist across all nursing homes, including vital terminology. This guide included "basic minimum standards applicable to all nursing homes" (Department of Health, Education, and Welfare, 1961). These recommendations consisted of 77 total health and safety standards, which included 55 structural quality indicators (Chassin & Galvin, 1998).

The nursing home industry continued to change throughout the years. The standards that the modern nursing homes are held to today were constructed by the late

1960s (Castle & Ferguson, 2010). This industry growth and development was a direct response to the newly created Medicare and Medicaid programs. In order to receive reimbursement for patient services, the nursing home must undergo a certification process for Medicare and/or Medicaid residents (Castle & Ferguson, 2010). The certification process is conducted annually and consists of an on-site inspection conducted by a team of surveyors. The surveyors selected to inspect the facility must monitor and determine whether the facility meets standards for certification (Castle & Ferguson, 2010).

By 1974, 90 health and safety standards existed, and nursing homes were considered Skilled Nursing Facilities. Of the 90 health and safety standards, 59 existed as structural quality indicators (Chassin & Galvin, 1998). In 1977, a new federal organization was launched specifically for the coordination of Medicare and Medicaid, known as the Health Care Financing Administration (HCFA) (Castle & Ferguson, 2010). HCFA assumed jurisdiction over nursing home certification processes and development of standards for that certification. The HCFA included a change in the 1980s known as deficiency citations, which represents an area in which a facility does not meet a Nursing Home Standard for certification Castle & Ferguson, 2010).

In order to improve the standards kept for the certification, the governing bodies introduced process quality indicators. Process quality indicators included triggers such as daily physical restraints, occasional bladder/bowel incontinence without a toileting plan, and indwelling catheters (Castle & Ferguson, 2010). By 1987, certification included 136

health and safety standards, 98 of the standards were structural quality indicators, and 38 were process quality indicators (Chassin & Galvin, 1998).

Despite lengthy and specific amendments to regulations regarding standards and the stringent certification process, policies could not keep pace with the rapidly changing nursing home industry, which included increased complexity of care needed for residents. The nursing home industry lobbied hard to weaken the certification process (Grassley, 1999). At this point, media outlets began reporting heavily on the existence of fraud, abuse, neglect and poor care that exist in nursing homes (Grassley, 1999). HCFA commissioned the Institute of Medicine (IOM) to examine and report on nursing home regulations. This committee concluded that care given was "shockingly deficient" (Lohr, 1990). Combined with the General Accounting Office (GAO), the IOM advocated for stricter government oversight in order to protect nursing home residents (Grassley, 1999).

The recommendations made by the IOM and GAO were placed into Subtitle C of the Omnibus Budget Reconciliation Act of 1987 (OBRA-87) (Castle & Ferguson, 2010). The provisions that specifically focus on nursing home reform are often referred to as the Nursing Home Reform Act. Ultimately, forty-seven recommendations were added along with a timetable for implementation (Castle & Ferguson, 2010). OBRA-87 was responsible for serious nursing home reform and for the quality environment in which nursing homes operate today. Among the changes evident, are a more stringent survey process, revised care standards, sanctions and remedies, training of nursing aides, and use of the Resident Assessment instrument (of which the MDS) is a major component) (Castle & Ferguson, 2010).

Quality Indicators focused on Clinical Outcomes

The interpreters of the IOM report (2010) suggested that regulations that guide nursing home systems should be refocused in order to move from an assessment of structure and processes in place to an assessment of outcomes achieved. The regulations that focus on outcomes were derived from MDS results. MDS is a summary assessment of each patient in the nursing home, which. includes measures of a resident's functional status, as well as health conditions (Castle & Ferguson, 2010). With the information derived from MDS, outcome indicators were developed such as falls, behavioral symptoms affecting others, the appearance of depression, bladder/bowel incontinence and urinary tract infections (Castle & Ferguson, 2010). In 1999, Nursing Home Standards for health and safety used during the certification process consisted of 153 standards (Castle & Ferguson, 2010). 81 of the standards were structural quality indicators, 48 were processed quality indicators, and 24 were outcome quality indicators (Castle & Ferguson, 2010).

Structural quality indicators are beneficial for several reasons. Structural quality indicators are easy to measure. Therefore data that is used can often be routinely available and is relatively inexpensive (Campbell, Roland, & Buetow, 2000). This can be a negative for consumers because many nursing homes can meet structural quality measure standards, but not provide quality care (Rosenthal, Fernandopulle, Song, & Landon, 2004). Structural quality indicators, in this case, are considered important for assuring quality but are best viewed as not sufficient enough to confirm overall quality although very necessary.

One example of a commonly used structural quality indicator is the use of staffing levels in a particular nursing home. Staffing levels, in a large sense, are utilized in many current quality improvement initiatives. It would appear intuitive that with higher levels of caregivers, one would achieve a higher quality of care. However, empirical studies suggest that there is no such relationship (Castle, 2008). It is better understood that although staffing levels are very important, how the staff is utilized (i.e., processes) may be just as important of a link to quality (Rosenthal, et. al, 2004).

Process quality indicators, like structural quality indicators, have advantages. Such indicators are often very easy to interpret. For example, a surveyor can easily see whether a resident received a vaccination or not. This also allows the observed process quality indicator to exist without adjustment. Process quality indicators can assist providers with how to improve the quality of care at a center (Karon & Zimmerman, 1996). The existence of occasional bladder and bowel incontinence would require a toileting plan for the resident; however, according to Nursing Home Compare there are statistics that reveal that there are a significant number of patients who do not have a toileting plan, despite the existence of occasional bladder and bowel incontinence (Schnelle et. al, 2003). Another example of a process quality indicator that is important to nursing home care delivery has to do with medications. Medications act as a process indicator in relation to whether it was given to the wrong resident, wrong dosage, incorrect time, incorrect prescription, or even given when the medication was not needed (Handler et al., 2008).

The criticism that surrounds process measures relates to documentation and reporting of these processes. Federal regulations mandate that physical restraints must be released, exercised, and repositioned every two hours; however, there are inaccuracies between actual care provided and documented care provided (Scott-Cawiezell & Vogelsmeier, 2006). The process quality indicator of physical restraints also deals with the application and professional expertise of those providing care. A physical restraint may be allowed in a particular case. However, the way the restraint is placed on a nursing home resident can lead to restricted circulation to limbs or even bruising (Scott-Cawiezell & Vogelsmeier, 2006).

Outcome quality indicators are considered the strictest quality indicator over structural and process indicators (Karon & Zimmerman, 1996). Outcomes state the end result of a resident's care throughout the stay at a nursing home facility (Mor et. al, 2003). If quality care was provided, then the resident in question should have experienced positive health outcomes as a result of the stay (Mor et. al, 2003). If a resident's health outcome did not achieve positive results as expected, then it reveals a deviation from that resident's plan of care. The issue with an occurrence of a positive result is that a facility must provide documentation to prove that a resident's undesirable health outcome did not come from a previous environment. Outcome indicators must reveal that the change in a resident's health status must have occurred while under the control of the care provider. Isolating the "facility effect" can be difficult to prove in some cases because of outcomes that are influenced by genetic, environmental, or other factors unrelated to care (Coglianese, Nash, & Olmstead, 2003). Care provided, in this case, stands as only one

component out of many other health determinants. In order to separate all other factors from the facility's contribution to delivering care, the nursing home must utilize statistical manipulation to account for differences (Zimmerman, 2003). This "risk adjustment" in outcome quality measures results in facilities over or under adjusting the value of an outcome indicator - which will bias the reported outcome rate (Zimmerman, 2003).

Inconsistencies in Measuring Quality

The "quality" within a nursing home is generally assessed using several different types of quality indicators. SPO indicators are popular, and a mixture of these indicators go into a standard nursing home assessment (Zimmerman, 2003). An important set of quality indicators are known as the deficiency citations, and this is used as part of the Medicare/Medicaid certification, the Facility Quality Indicator Profile Report, Nursing Home Compare, and the Advancing Excellence Campaign (Castle & Ferguson, 2010). These quality indicators are important because they are national in scale and this current set includes a comprehensive scope of quality indicators. These quality indicators allow providers to focus on issues because the indicators are what regulators will particularly examine during the survey (Castle & Ferguson, 2010).

Deficiency citations are influential quality indicators because it is a representation of an assessment of quality that comes from the main nursing home oversight body (Walshe, 2001). The results of the assessment are then reposted on several report cards (including Nursing Home Compare) and in government reports (such as those from the GAO). The Center for Health Systems Research and Analysis developed indicators that could be used to evaluate nursing home care (Zimmerman, 2003). The indicators that are

developed by the Center for Health Systems Research and Analysis are often times called Nursing Home Quality Indicators (or NHQIs). There is a total of 24 indicators that cover 12 areas of care that were found to be the most relevant to information collected from MDS (Meiller, 2001). These NHQIs are influential because through the National Automated Quality Indicator System, regulators can assess quality issues as a preliminary step to the certification process (Meiller, 2001). These deficiencies act as precursors as to what surveyors will look for and emphasize when a facility undergoes an annual inspection (Meiller, 2001).

Nursing Home Compare was developed by the CMS. Nursing Home Compare provides information on all Medicare/Medicaid-certified nursing homes in the United States (Castle & Ferguson, 2010). The information made available online includes the NHQIs discussed above. Nursing Home Compare is influential and useful because it presents standardized quality information that is publicly available in most nursing homes in the United States (Castle & Furgeson, 2010).

There are issues with the quality indicators used in nursing homes when using the SPO (Structure, Process, and Outcome) model. There is no established consensus as to what method should be used when dealing with specific quality indicators (Zimmerman et. al, 1995). One major issue is that no single quality indicator is able to represent the overall quality of a nursing home. The closest overall measure of a nursing home is the Five Star Quality Rating System recently introduced by CMS as an addition to the Nursing Home Compare Web site (CMS, 2010). The Five Star Quality Ratings provide a simplified summary of a nursing home's quality for a consumer to review (CMS, 2010).

The rating system provides a star representation of overall high and low performance in three areas: Health Inspections, Staffing, and Quality Measures (CMS, 2010). Use of multiple quality indicators leads to limitations. One disadvantage of using multiple quality indicators is the inconsistency in findings. Quality indicators include multiple dimensions that play a factor in how the quality indicator is measured. Required quality indicators continue to be a significant issue. A narrow focus on a single (or a few) quality indicators may lead to erroneous, incomplete, or simply incorrect conclusions. More quality indicators simply open the possibility of confusion and more errors (Mor, 2005).

Measurement issues are another factor that results in inconclusive data. Quality indicators have the limited ability to detect real differences in quality. The standard errors for rare events are large, and it gives rise to several issues (Castle & Enberg, 2005). The true quality level lies within the standard error, so the reliability of one measure can be questionable (Castle & Enberg, 2005). When comparing multiple facilities, it becomes evident that measurement of issues are not uniform and can result in far more errors (Castle & Enberg, 2005). It can be difficult to measure if one facility truly has better/worse quality level than of another. Detection bias can occur based on the feelings and opinions of the surveyors at the time of the survey (Castle, 2001). There are multiple state surveyors, and the same team may not always survey the same facility. With this bias in place, a survey team may be easier/harder on a center than another team would (Sangl et. al., 2005).

Detection bias is a measurement issue that is inherent to deficiency citations, and there are considerable differences between many states with the emphasis on the same

deficiency citations (Castle, 2001). Some states are more or less aggressive in the use of deficiency citations in general. The high degree of variation can limit the usefulness of deficiency citations not only for CMs but also for consumers and providers. The reliability and validity of the data have been subject to some criticism due to this variation (Rahman & Applebaum, 2009).

Another variable that affects nursing home quality comes down to the characteristics of the nursing home. Nursing homes across the United States consist of a diverse group of providers. Some of the diversity that exists relates to structural characteristics of a nursing home that can work against the use of many quality indicators (Castle & Ferguson, 2010). One obvious example is that the small number of beds limits statistical power (Mor et. al., 2003). Less frequently noted is the unit-based nature of many nursing homes. This structural arrangement can lead to distinct practices and outcomes that occur in different units (Mor et. al., 2003). Another changing variable that plays a role in quality measures are the residents. Nursing home residents vary tremendously from one another. Nursing home residents may have limited exposure to facility influences based on diagnosis and residency in a center (Intrator, Castle & Mor, 1999). Health statuses can be transitional, therefore, distinguishing between the individual health status and facility influence can be problematic. The specificity used on a case by case purpose defeats the purpose of having generalized quality indicators (Castle and Ferguson, 2010).

Residents are exposed to distinct needs and characteristics that can influence quality provided. The residents assess quality based on demographics, age, gender, and

race, but also requires the residents needs to be based on characteristics such as religion (Castle and Ferguson, 2010). It is difficult to label a nursing home a "typical" nursing home or a "typical" nursing home resident because of these factors. The quality indicators are often criticized as not having a person-centered focus, but rather a medical focus, and as such, some dimensions of quality that consumers' value does not get reflected (Munthe, Sandman, & Cutas, 2012). Use of resident and family satisfaction scores may be utilized as quality indicators to represent a "consumer voice" however, the practice is uncommon due to the expense involved in collecting satisfaction information (Castle & Ferguson, 2010).

Resident and family complaints are investigated, first as part of the Long-Term Care Ombudsman Program is the complaint was filed through the Ombudsman (Allen, Klein, & Gruman, 2003) and again as part of the state certification agency if the complaint was filed to this agency (Stevenson, 2006). The focus on families and the patient drives the industry to accommodate policies and philosophies that reach out to the consumer directly. Since the early 1990s, some nursing homes have adopted resident-directed philosophies (or resident-directed care known as culture change) (Brune, 2011).

Philosophy Implementation Barriers

Spratt (2009) analyzed philosophy implementation barriers in which national policies fail to achieve desired results or success based on specific barriers. Spratt proposed that a final stakeholder assessment process can best generate specific recommendations to respond to such lessons. There are many specific lessons and insights on philosophy development and implementation that are observed. One lesson

includes conflicting and intersecting policies. This conflict occurs when national policies include broad and general language and are not always supported by operational or local policies and guidelines (Spratt, 2009). Another issue is low motivation and commitment; personal, organizational or institutional motivation and commitment can facilitate the philosophy implementation process (Locke, 1996). Numerous factors play a role in low motivation or commitment such as different priorities, a lack of incentives, and limited resources (Locke, 1996). The next lesson observed focuses on the implementation at multiple levels. The introduction and implementation of any philosophy often meet some level of community resistance or low engagement that impedes effective implementation (Brodsky, Habib & Hirschfield, 2003). Early engagement of all stakeholders becomes essential to combating this type of barrier. Barrier analysis acts as an effective way to engage stakeholders while increasing the commitment and understand of rules during implementation (Spratt, 2009). There are issues that are often times not considered in philosophy development, and yet they contribute significantly to the success or failure of a philosophy implementation. These issues can be narrowed down to stigma, discrimination, and gender (Spratt, 2009). Finally, there should be a strong analysis between philosophy formulation and implementation. Key differences exist between philosophy implementation and formulation that must be addressed in order to maximize the impact of the new philosophy (Spratt, 2009).

Implementation is the process of turning philosophy into practice (Kitson et. al., 2008). Gaps exist between what was planned and what actually occurred as a result of the philosophy (McClellan et. al, 2010). There are three major theoretical models of

philosophy implementation: Top-down approach, Bottom-up approach, Principal-agent theory (Buse et al., 2005). Using one approach over another requires careful planning and forecasting, as well as a strong understanding of company policies and procedures. The top-down approach sees philosophy formation, as well as philosophy execution as distinct activities (Tangen, 2004). The policies are set at higher levels in a political process and then communicated to subordinate levels, which are then charged with the technical, managerial, and administrative tasks of putting such a philosophy into practice. Political scientists have theorized that the top-down approach requires that certain conditions must be in place prior in order for philosophy implementation to be effective (Matland, 1995). The first condition must be clear and logically consistent objectives. Policies fall apart when employees are expected to complete tasks that contradict one another or end up having no clear purpose to the completion of the philosophy (Cameron & Green, 2015).

Keys to Successful Implementation

An implementation process structured to enhance compliance by an organization must be in place in order to grant employees an investment in completing and embracing the philosophy change. The initiative to enhance compliance can include both incentives and sanctions (McLaughlin, 1987). Employees buy-in if convinced that it would benefit the staff experience, as well as create a better atmosphere to work (Collier & Esteban, 2007). This also plays a role with the implementation officials. A new philosophy implementation process requires dedicated and committed officials. The officials (leadership) responsible for rolling out new policies in phases must make sure all phases

go interrupted as it can cause a disruption to successful implementation (McLaughlin, 1987). Ensuring that all phases are accounted for benefits a smooth transition from learned behavior to new expected behaviors. The implementation team must ensure that there are adequate time and sufficient resources available to see the implementation see through. There are setbacks that arise at any moment. However, poor planning and forecasting may lead to discontinuation of an implementation process, which leads to significant damages in both times, reputation and costs for an organization (McLaughlin, 1987).

Good coordination and proper communication will take care of several of the barriers as it allows team members to be updated on processes at all phases. It is very unlikely that all pre-conditions would be present and available in an organization at the time of implementation (Foster-Fishman & Keys, 1997) and that entails the problem with the approach. This will require proper forecasting, as well as flexibility in adjusting to changes in environmental factors of an organization. Another disadvantage that will appear when implementing a top-down approach comes down to the organization only adopting a perspective from those higher up in the company (governing officials in administrative positions) (Foster-Fishman & Keys, 1997). It is important not to neglect the roles and feelings of direct actors and employees involved. If the direct workers discover items that need to be addressed, then the company runs the risk of policies changing frequently creating disorder throughout employment structure.

A bottom-up approach represents the type of philosophy implementation approach where the individuals at the subordinate levels are expected to play a very

active part in the implementation process, as well as have the discretion to reshape objectives of the philosophy as well as the way that philosophy is implemented (Foster-Fishman & Keys, 1997). The bottom-up approach is considered a much more interactive process as philosophy makers, actors, and administrative members come together and change policies as implementation continues. It requires strong bureaucratic accountability as policies shift too often with too many actors having a say to make changes without seeing the full process through (Eden & Ackermann, 2013).

During implementation, there can be instances of a principal-agent problem (also known as agency dilemma or theory of agency) (Laffont & Martimort, 2009). This occurs when one person or entity (the "agent") is able to make decisions on behalf of, or that impact, another person or entity: the "principal" (Laffont & Martimort, 2009). This occurs when there are many elements at play that affect the principal moving forward with a philosophy established by the agent. This goes into the nature of the problem that exists with the philosophy. It reveals issues the principal may have with the complexity of the problem, the clarity and difficulty of the problem, as well as the length of time before changes become apparent (Laffont & Martimort, 2009).

The philosophy implementation requires key activity to take place in this case. The first is interpretation, which is the translation of the philosophy into administrative directives (Laffont & Martimort, 2009). Next, the philosophy requires organization, which is the establishment of administrative units and methods necessary to put a program into effect (Laffont & Martimort, 2009). Finally, the application is the routine

that the principal uses to administer a service. According to Gunn (1978), there are ten common barriers that exist when attempting to implement effective health policies:

- The circumstances that are external to the implementing agency impose constraints that make philosophy implementation very difficult
- There is a lack of adequate time and sufficient resources.
- The required combination of resources is not available.
- The philosophy to be implemented is not based on a valid theory of cause and effect.
- The relationship between cause and effect is indirect, and there are multiple intervening links
- Dependency relationships are multiple
- There are poor understanding and disagreement of objectives.
- Tasks are not fully specified in the right sequence.
- There are imperfect communication and coordination among implementation staff.
- Those in authority are unable to demand or obtain perfect compliance from direct actors (Gunn, 1978, p. 173).

Summary and Conclusions

Chapter 2 provided a review of current literature, the Contextual Interaction Theory by Bressers, and an explanation as to how the quality of life is perceived, and the barriers that exist when implementing policies. The Contextual Interaction Theory includes governance and the motivation, cognitions, and resources of actors (Bressers,

2007). The beliefs and training of each actor involved (in this case nursing home employees) play a role in how a new philosophy is adopted in an organization. The focus of the Eden Alternative Philosophy has been on the elimination of loneliness, helplessness and boredom in the aging population (Thomas, 1996). The founder of the philosophy, William H. Thomas MD, introduced a philosophy that decentralized the institutionalized organizational structure and introduced plants, animals and children into a long term care environment. Early nursing home reform struggled with widespread allegations of neglect and abuse therefore federal agencies were established and introduced tough guidelines and regulations for nursing homes to adhere to in order to receive payments and remain functional.

The Eden Alternative philosophy is a relatively new care delivery approach and continues to evolve through training and implementation of health care centers (Brownie, 2011). The adoption of the Eden Alternative philosophy includes rejection of established practices and companies work to eliminate barriers to ensure the least amount of errors when undergoing an expensive and time consuming implementation (Brune, 2011). Ultimately, measurement of the quality of care and quality of life that residents receive determine if an implementation was successful or not. A focus on clinical outcomes and inaccurate measurements result of a gap in research related to non-clinical department challenges (Kaldy, 2008). Exchanging ideas and open-communication play a significant role to an implementation's success which is why I will conduct interviews that will gather information from a non-clinical team management's perspective.

New regulations by CMS share a common focus on the industry's shift to a person-centered care (Koren, 2010). The success of an Eden Alternative model is now measured by regulatory agencies within the industry, and nursing homes must address these changes for upcoming annual surveys (Karon & Zimmerman, 1996). Research exists on some negative outcomes that might be anticipated when transitioning to the Eden Alternative model (Caspar et. al, 2009). However, there is a gap that exists in the literature for how nursing home employees and administrators will prepare for a survey while both meeting regulatory standards and successfully following a true Eden Alternative approach.

The outcome of this study filled this gap as I conducted interviews and gauged actual employee's participation in nursing homes that have adopted the Eden Alternative model and how compliance with annual nursing home survey regulations are achieved. I used outcomes of the study to evaluate the answers and gathered themes from responses that determined whether a nursing home facility is in compliance with federal regulations while aligned with Eden Alternative principles. Nursing home departments are connected and reliant on one another. Therefore, a challenge that may not be addressed by one department could possibly affect another department.

Chapter 3 will provide the research methods used in this study, as well as an explanation for specifically choosing those methods. The qualitative study collected and identified themes through interviews of key department figures in the long-term care industry. I was able to identify some of the challenges of implementing the Eden

Alternative model while remaining compliant with the heavily regulated industry of long-term care.

Chapter 3: Research Method

Introduction

In this chapter, I focus on the research design and rationale of the study and on philosophy implementation barriers that apply to nursing home facilities when transitioning from an institutional approach to delivering health care to a person-centered one, specifically the Eden Alternative model. The purpose of this study is to measure the preparedness of several non-clinical departments throughout a long-term care center as they attempt to successfully implement key elements of the Eden Alternative philosophy, while the nursing home facility remains in compliance with state and federal regulations. I use elements of this study to identify challenges and barriers through interviews of non-clinical department leaders regarding their thoughts, experiences, and reactions to their Eden Alternative model implementation. This chapter explores the research design and rationale involved in gathering information from participants. I will review the structure of the study method based on the approach and in detail explore the variables in play throughout this study.

Research Design and Rationale

The central concept of the study was philosophy implementation and challenges related to adopting the new Eden Alternative philosophy within a nursing home facility. Several non-clinical departments may determine the success or failure of an Eden Alternative implementation. Non-clinical and clinical departments must adhere to the policies and regulations established by governing agencies when structuring the approach used in delivering care. The nursing home industry is heavily regulated, and the

institutionalized model of delivering health care is the standard for years (Williams, et. al., 2010). Implementation of a patient-centered approach to care, rather than an institutional model presents challenges that must be addressed if nursing home facilities want to achieve successful implementation, as well as remain compliant with strict federal regulations (Yeung et. al., 2016). Such implementation philosophy comes with several barriers to achieve success. This implementation philosophy requires the right motivation and personal commitment from the actors involved (Spratt, 2009). It is important to gauge employee buy-in as a strong indicator of philosophy's success or failure (Yeung, et. al., 2016).

Understanding the issues that surround employee motivation and buy-in can act as indicators for whether Eden Alternative implementation will be successful or not (Bressers, 2007). For this study, I used a qualitative method with a case study design. The primary reason for this approach is to engage the "actor" in order to understand whether the theoretical principles of the Eden Alternative model can be applied in the real world to an active and functioning health care facility (Yin, 2013). Case studies are valuable as they can isolate a specific event or population and provide further detail into a developing phenomenon that can create a framework for organizations to handle similar challenges that arise with other philosophy implementation processes (Yin, 2013). The findings from this study could assist with future philosophy implementation challenges as it engaged each participant to better understand and convey challenges experienced and addressed in order to achieve successful compliance with philosophy implementation.

Research Questions

The research design for this study was a case study research design. As a researcher, it is important to isolate a small study group and in this case, it was a particular population (Yin, 2013). Healthcare management is responsible for ensuring patient safety, regulation compliance, and organizational philosophy alignment (Nieva & Sorra, 2003). This population of non-clinical department heads provided valuable insight in responses to the research questions posed in this study. I use the following questions to guide this study:

1. What are the specific challenges that affect non-clinical staff from a staffing, operating, and risk management standpoint when implementing the Eden Alternative model?
2. Will identifying the challenges of adopting the Eden Alternative model from a non-clinical perspective be a determinant as to whether complete transition achieves Eden Certification?
3. What are the internal and external motivations that influence non-clinical departments to commit to new philosophy implementation?

The first research question refers to the specific challenges that affect non-clinical staff from a staffing, operating, and risk management standpoint when implementing the Eden Alternative model. A case study research design offered the opportunity to understand how the participants viewed these challenges as the individuals selected were interviewed and allowed to express thoughts and concerns that stem from the transition to the Eden Alternative model. Managers of a non-clinical department may not have the

same regulations apply to them as managers of clinical departments. Healthcare reimbursement and quality of care are measured directly to the wellness of a patient, and the clinical team is responsible for monitoring and caring for a patient/resident until a measured functional capacity is achieved (Castle & Ferguson, 2010). Non-clinical teams support the environment surrounding patients and staff with events and responsibilities that may not be considered direct care but can still affect the quality and experience of care provided at a nursing organization (Kapp, 1999). The case study approach collected evaluation tools that measured non-clinical department performance, and in addition, the participants had the chance to elaborate on whether or not tasks became difficult with challenges or barriers when implementing the new Eden Alternative philosophy to the facility.

In order to answer the second research question, I was able to ask the department heads to specify if the participants felt certain steps or elements to Eden Alternative implementation overlooked a non-clinical department's function or responsibilities and made tasks more difficult to complete, and whether or not this would prevent the nursing home facility from achieving Eden Alternative certification. Upon completion of that portion of the interview, I asked the participants to suggest changes in the implementation process that include addressing challenges and barriers to the non-clinical departments. The responses and adjustments to the implementation process answered whether or not the overall implementation was considered a success. Departments are interconnected in NFs as one directly, or indirectly affects another (Hearld et. al, 2008). I used this study to determine whether a challenge or barrier that affects a non-clinical department and is not

addressed accordingly will affect other departments or will it prevent a facility from achieving Eden certification.

The third question is in relation to internal and external motivations for participants of philosophy implementation. To answer this question, I asked department heads to explore risk management issues the facility is susceptible to upon completion of an Eden Alternative implementation. The founders of the Eden alternative model believe in making a nursing home facility as "home-like" as possible, which eliminates the presence of security cameras, metal detectors, security guards, and any other measure that may come off as threatening to a home-like experience in a long term care facility (Thomas, 1996). Through the designed interview questions, I explored participant's feelings toward risk management issues departments are exposed to once the Eden model is successfully implemented. Rules are structured and implemented to address risk management issues and protect organizations from liabilities (Reuvid, 2010).

A person-centered care approach may leave some departments susceptible to damages or consequences from policies that are considered person-centered (Horton, 2005). A true Eden Alternative certified director does not believe that patients should have name bands on their wrists and that staff should know the names and details of patients (Forman, 2010). If a large facility implements this element of care, what challenges stem from patients moving from unit to unit, eloping, or having new hires (in both clinical and non-clinical departments) interact with a patient without knowing the patient personally? I addressed these research questions through a case study design and gathered insights from the very specific population that was selected, which is discussed

later. These elements reflect the unique circumstances that apply to the NF itself and the administration must implement policies that address the concerns in order to comply with federal regulations. Each NF's approach to philosophy implementation is unique therefore a case study approach was the best approach since because of it, I was able to investigate the contemporary phenomenon of Eden philosophy implementation within a real-life context described by the participants in the study.

The outcomes of the case study allowed me to understand a very specific population of health care workers. Person-centered care philosophy shifts in the health care industry stem from the growing participation of baby boomers in health care programs, as well as an organization's need to adapt to the ever-changing landscape of the healthcare industry and user requirements of services (Kleppinger & Robison, 2012). Philosophy implementation requires careful planning and participation of all "actors" in an organization (Castle & Ferguson, 2010). A well-connected system like healthcare delivery does not solely rely on a few branches alone. Interconnected departmental approaches to healthcare delivery rely on factors to be considered that may be difficult depending on whether or not the end goal is achievable or not. Regulations and reimbursement are driven off of a patient's quality of care, however, what quality of care entails is not easily established within this discipline (Zimmerman, 2003).

Role of the Researcher

My role as the researcher in this study was to conduct the interviews to explore the experiences and beliefs of participants regarding the challenges of implementing the Eden Alternative philosophy from a non-clinical perspective. The interview questions

allowed me to focus on experience and behavior questions, as well as opinions and values. These questions allowed the participants to open up and freely express their thoughts and experiences, as opposed to structured elements such as outcomes and measured qualities. I was the interviewer who allowed the participant to open and voice concerns and opinions about the philosophy implementation process through the semi-structured interview.

There were no personal or professional relationships between the participants and myself. The President of Elder Care Solutions, LLC had a professional relationship with me in a previous site. The Elder Care Solutions President was a consultant for Eden Alternative and worked at a NF that underwent Eden certification. This individual contacted Eden liaisons who then accessed the Eden directory to locate three non-clinical participants from five separate facilities. These participants and I did not have any prior interaction, nor did I have any preference on what facilities were chosen to seek out participants.

I managed my biases throughout the study because I do have experience running a NF. My philosophy and approach to delivering care did not influence the responses from participants. I did not have expectations for responses. My experiences could have introduced bias into the interview if I anticipated a particular response over another. I did not have any expectations of responses for policies or philosophies that differed from the policies and philosophies I was accustomed to. If a response from a participant violated a nursing home regulation or revealed an illegal practice that is taking place in the NF, I did not point it out because it may have influenced the remaining responses from the

participant, or even caused the participant to withhold information in fear of punishment, consequences, or passing judgment. I used discretion when following up on a question. The follow-up questions in the interview process should have required further elaboration for a response as if the reader had no knowledge of healthcare policy and practice.

Had illegal practices or regulatory violations occurred during the interview process, I would not have stopped the interview or data collection to address those violations or practices. I would have allowed the participant to continue addressing the questions asked and had him or her clarify any comments made throughout the portion of the interview. The interview would not be interrupted for my input as it would have changed the course of the participant responses and have created fear or hesitation in the participant that there was something wrong committed by responses and the remainder of the responses would be edited or shortened for fear or repercussion. Any responses that implicated that a violation of federal regulations or local regulations took place would have been addressed privately after the interview with that participant. The only violations that needed to be considered urgent were violations that caused immediate jeopardy for the well-being of a resident. These violations are addressed during state surveys, and any deficiencies or citations are handed down based on the survey teams discretion. It was not up to me to determine whether a violation took place so, for the most part, these violations did not occur but would have remained confidential.

Methodology

Participant Selection Logic

The population for the study were 15 directors and managers employed in nursing home facilities who participated in Eden Alternative philosophy implementation in the corresponding facilities. The 15 participants were directors and managers of what is considered non-clinical departments: life enrichment, administration, social services, dietary, maintenance, human resources and housekeeping. The interviews allowed me to highlight the challenges and experiences managers identified fulfilling job responsibilities during Eden Alternative philosophy implementation.

The criteria for the participant selection was based on employment from start to finish of Eden Alternative philosophy implementation. The director or manager must have had a minimum of 10 years of experience in the long-term care industry. This experience requirement ensured that the participant had observed both the institutional model at work and the Eden alternative model in place. The challenges varied from director to director, however selecting participants with established long-term care experience provided a stable baseline. The Eden liaisons distribute a letter to various facilities in the Eden directory. The administrators of the selected Eden approved homes read the recruitment letter prior to making a decision to allow their directors to participate in this study. The non-clinical department directors had the option of joining this study and contacted the recruiter if interested.

Sampling strategies vary based on using a quantitative or qualitative research approach. Sampling refers to the selection of individuals, units, and/or settings to be

observed (Teddie & Yu, 2007). Quantitative research has a strong foundation in random sampling (Neuman & Robson, 2012). Researchers conducting quantitative research strive to study large populations with numerous variables in order to find connections and simplify the group as a whole into trends that may commonly appear (Jick, 1979). Qualitative research often uses the purposeful or criterion-based sample, which consists of a sample that has characteristics related to the research question(s) involved in the study (Ryan, Coughlan, & Cronin, 2007).

The differences in both sampling strategies between quantitative and qualitative studies are due to the different goals and purposes of each research approach (Neuman & Robson, 2012). In this study, it was beneficial to utilize a homogeneous sampling. Homogeneous sampling brought together people of similar backgrounds and experiences (Teddie & Yu, 2007). Homogeneous sampling was able to reduce variation, simplifies analysis, and, if necessary, facilitates group interviewing (Teddie & Yu, 2007), The participants in this study had a minimum of 10 years of experience in long-term care, as well as transitioned from an institutional model of delivering health care to a person-centered approach with the Eden Alternative philosophy.

Sample sizes for qualitative research studies are typically much smaller than those utilized in quantitative research studies (Jick, 1979). In qualitative research, as the study continues along, more data does not necessarily mean more information. The frequency of an event or an occurrence is not as important in qualitative research because one instance of the data appearing can be potentially as beneficial as many occurrences when it comes to understanding the process behind a topic (Neuman & Robson, 2012). Value

from smaller occurrences is made possible through qualitative research because the goal of qualitative research is to understand the meaning instead of making generalized hypothesis statements (Mason, 2010). Qualitative research is also very labor intensive, therefore analyzing a large sample can be time-consuming and often times very impractical (Mason, 2010).

In any research area, the participants utilized within a study will have differing opinions. The sample size for qualitative research must be large enough so that most, if not all, perceptions that might be important are represented (Mason, 2010). If the sample selection is too large, the data becomes repetitive and superfluous (Ritchie et. al, 2013). Sample size in this study followed the concept of data saturation - when the collection of new data does not shed any further insight on the issue that is under observation (Francis, et. al., 2010).

Fifteen non-clinical managers were enough to achieve saturation. There are other factors that could have influenced how fast or how slow saturation was achieved in this qualitative study. Expertise could have played a significant role in how saturation is achieved in this process based on the type of questions asked during the interviews (Mason, 2010). Inviting front-line employees into this study would have made it difficult as front-line employees only receive directive for philosophy change from a superior without understanding the effects of that philosophy change. Department heads had a greater responsibility and direct experience and training with an Eden Alternative training team. Managers who have at least 10 years experience in long term care had the expertise

of delivering care from an institutional model, as well as establishing policies and delivering care from a person-centered care approach.

Participants were required to provide informed consent prior to moving forward with the study. I ensured that all participants understood what it means to participate in a particular research study so that each individual could decide in a conscious, deliberate way whether the individual wanted to participate. In this study, I adopted the universally accepted basis for research ethics that follow three core principles: Respect for persons, beneficence, and justice (Brydon-miller, 2008). Respect for persons includes a commitment to ensuring the autonomy of research participants and in the unlikely case that the autonomy is diminished, whether the people involved are protected from exploitation of vulnerability (Baxter & Jack, 2008). The dignity of all participants used in research was respected. Adhering to this principle ensured that the subjects in this study were not simply used as a means to achieve research objectives.

Instrumentation

There were several data collection instruments that I utilized in this study. The first source was be the Minimum Data Set 3.0 Public Reports, the background and validity of which were reviewed previously. As explained earlier, I used these reports to gain an understanding of the care provided to nursing home residents while admitted into a facility and completed periodically, as required by regulation, to assess a resident's well-being and that the plan of care for that resident is being followed (Rantz & Connolly, 2004). The MDS 3.0 Public Reports are accessible to the public through the CMS website.

Another tool that was used was the employee Warmth Surveys that are required by the Eden Alternative model to measure the levels of optimism, trust, and generosity throughout an organization while adopting person-directed care practices (Yeung et. al, 2016). The Warmth Survey was developed specifically for the Eden Alternative and was accessed by the Eden Alternative liaisons who were able to access the organization's Warmth Survey results. The main data collection instrument was a research developed interview guide. This guide will be used to conduct semi-structured telephone interviews that was audio-taped phone and completely confidential.

Through the first research question, I focused on identifying the challenges that affect non-clinical staff from a staffing, operating, and risk management standpoint when implementing the Eden Alternative model. Interviewing the participants directly sufficiently collected data to address this research question directly. An interview with specific questions regarding the identification of challenges allowed each participant with adequate knowledge (specifically managers of non-clinical departments) to express opinions and make comments that provided details directed toward the first research question.

Through the second research question, I referred to the identification and correction of barriers that existed for non-clinical departments when implementing the Eden Alternative model. In this research question, I asked if identifying such barriers will be a determinant of success in a full Eden transition. The Warmth Survey measured employee optimism and trust for an organization. Questions included answering whether an employee found work boring or if management was interested in money over people,

etc. These questions could be used to explore frustrations that existed with overlooking non-clinical department needs during a full transition.

In the third research question, I questioned whether the Eden certified homes would experience issues down the line after successful implementation. Through the MDS 3.0 Public Reports I was able to indicate trends that have existed in nursing homes and determined whether a NF has experienced declines in certain areas after it was Eden certified. If a NF achieved Eden Certification years ago and a newly formed deficiency or hindrance to clinical performance appear, I identified whether there was a risk management or non-clinical department issue that was not addressed during implementation that led to the findings in the MDS 3.0 Public Reports. Selection of a research instrument for data collection requires the understanding that the instrument selected represents the strategy for discovering facts (DePoy & Gitlin, 2015). I must ensure that the instrument chosen is both valid and reliable and examined to test the extent in which the outcome provides the expected results (DePoy & Gitlin, 2015).

Semi-Structured Interview

The main data collection tool that was used for this research is a semi-structured interview (DiCicco-Bloom & Crabtree, 2006). The semi-structured interview approach was a less formal type in which although sets of questions may be used, I was able to flexibly modify the sequence of questions, change the wording and at times explain or add to questions during the interaction based on responses (Ratcliffe, 2002). This flexibility allowed for further inquiry and elaboration, as well as the ability to navigate through a complicated implementation process that structured the interview for more

effective feedback (Ratcliffe, 2002). The atmosphere for the interview was often casual which benefitted openness and honesty in the responses of the participants. Healthcare requires strong discretion so healthcare employees with extensive experience in the industry and practice would naturally refrain from opening up too much about information or details that could compromise patient information or organizational policies (Scott, 1982).

A unique dynamic existed when I considered myself as the instrument of the research. Human factors in evaluation research exist when the interviewer provides non-verbal human factor cues to the respondent during an interview (Hiller & DiLuzio, 2004). This could be a nod or a smile during an answer, which could lead the respondent to continue or adjust responses according to the nonverbal cues provided (Hiller & DiLuzio, 2004). When critiqued by an observer, subjects are likely to respond with linked perceptions for a philosophy or program implementation (Brown, 2006). In this study, subjects had already undergone extensive training with the Eden Alternative initiative. Therefore the subjects anticipated outcomes and expectations for what a successful implementation required because of early training sessions.

The unique role for this particular study was the involvement, or lack thereof, of myself with the participant. The interviews were conducted over the phone. Therefore, physical cues were removed from the semi-structured interview as an instrument. I remained silent with any verbal cues while the participant was giving responses so that the participant was able to finish thoughts without redirection halfway through a response (Cuddy et. al., 2015). I allowed pauses after responses to transition into the next question,

as opposed to adding on to questions immediately and directing the respondent toward one area and away from another.

Interviews over the phone allow for limited unspoken cues, however, voice inflection and verbal confirmation of answers can act as an instrument that influences credibility and accuracy (Burke & Miller, 2001) The respondents are to answer as truthfully as possible and will adjust responses if I appear to judge the respondents answers for confirmations that align with my own personal notions on the subject matter (Cuddy et. al., 2015). I reviewed the basic set of questions first and took notes of placeholders to ask unstructured follow-up questions in the interview.

Procedures

I was required to make a connection with the representative from the Eden Alternative organization. This representative provided the information to the Eden liaisons regarding the study to the facilities that meet the criteria, with information for them to reach out to me. For this study, I established criteria in which participants are managers of a non-clinical department (dietary, housekeeping, administration, social work, case management or human resources) that have close to ten years long-term care experience at a nursing home facility. With this criteria in place, it ensured me that the facility once utilized an institutional model and not a person- centered approach.

The first step in the recruitment process was for me to connect with the Eden representative. The Eden representative then reached out to the Eden liaisons who were available to assist for this study. I provided the Eden liaisons with the Letter of Cooperation (Appendix B) to sign prior to beginning the research study. The Eden

liaisons were given the letter with the details of the study and how the facility (Appendix A) can reach me to move forward with study participation. The Eden liaisons gave the letter to the head of the facility, and the administrator asked non-clinical department directors for interest in voluntarily participation in the study (fifteen participants in total). Once the head of the facility contacted the liaisons, the NF administrator was provided with the Letter to potential participants (Appendix B) with my contact information to signal the non-clinical department leader's potential participation in the research study. It was voluntary and introduced as a study to better assist non-clinical departments in identifying issues with philosophy implementation for an institutional model to a person-centered one. The individual's participation would be brief and will only require an hour of the participant's time. The interviews would be approximately sixty minutes, so it would have been possible to schedule more than one participant in a single day for an interview. Additional days were allowed for rescheduling and alternative days for participants that could not agree to an interview in the initial agreement of a set interview date and time. Transcribing the interviews after it was completed kept me actively aware of themes and elements while collecting data. This confirmed consistency and reduced accuracy concerns.

Minimum Data Set 3.0

The second instrument used for this research was a reading of documents. Typically, the limitation of this instrumental approach had to do with privacy issues. However, the Minimum Data Set 3.0 Public Reports are made available for access, located on the CMS website (Saliba & Buchanan, 2012). The MDS is part of the

federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified homes (Mor, 2004). MDS is a powerful tool for implementing standardized assessment, as well as facilitating care management in nursing homes (Rahman & Applebaum, 2009) . The content provided in this report has implications for residents, families, providers, researchers and policymakers, all of whom have expressed concerns about the reliability, validity, and relevance of earlier MDS models. MDS has been designed specifically to improve the reliability, accuracy, and usefulness of the MDS, to include the resident in the assessment process, and to use standard protocols used in other settings (Saliba & Buchanan, 2012).

The MDS 3.0 reporting system possesses information on very specific quality measures that are divided by short-stay and long-stay in a nursing home (Saliba & Buchanan, 2012). For short stay, some of the quality measures that are documented include moderate to severe pain for residents, new or worsened pressure ulcers and residents who newly receive antipsychotic medication. In a skilled nursing home facility, the quality measures include physical restraints, falls, falls with major injury, antianxiety/hypnotic medication use, behavior symptoms that affect others, depressive symptoms, excessive weight loss, urinary tract infection and depressive behaviors as well as the same measures for short-term stay residents (Hammar et. al, 2010).

Evaluating the measures for MDS 3.0 reporting can provide a snapshot of the challenges that apply to a nursing home and the increase or decrease of numbers in the measure can rely on if the care is getting better or worse (Mor, 2004). The numbers are intended to reveal the kind of care a patient is expected to receive based on trends in

clinical outcomes reported through MDS. It is important to note, the measures in this report are based on clinical outcomes, and the results of the reports are indicative of the quality of care delivered in that nursing home. This is one of the reasons why the study focused on the non-clinical department challenges because ownership and administration may focus on the outcomes and consider an Eden Alternative implementation a success without taking non-clinical department challenges into mind as it moves forward.

Eden Alternative Warmth Survey

The other document that was analyzed in this research study is the Eden Alternative Warmth Survey - Employee Questionnaire (Eden Alternative, n.d.). This document required special permission to access, which was addressed at the beginning of the study. Through the Warmth Survey, I was able measure are different from standard satisfaction surveys that exist in measuring quality and outcomes in long-term care, such as the MDS 3.0 Public Reports. The Eden Alternative Warmth Survey measures the level of optimism, trust and generosity across an organization (Yeung, et. al., 2016). The Eden website (Thomas, 1996) has a metaphor of a gardener planting a crop in frozen soil; the soil represents the culture that exists in an organization. Eden Alternative has created tools such as the Warmth Survey to measure and assess the optimism and buy-in of staff during an Eden transition. Cold organizations are characterized by pessimism, cynicism, and stinginess while warm organizations are characterized by optimism, trust, and generosity (Kaldy, 2008).

Cold to warm characteristics reveal employee buy-in and commitment to philosophy change (Thomas, 2003). Failure to develop a warm environment by an

organization can compromise the success of the entire implementation process. The Eden Alternative Warmth Survey- employee questionnaire was developed by the Eden alternative and requests employees to provide feedback. The answer key provides a scale for employees to use when responding to prompts. It ranges from strongly agree, agree, neutral, disagree, and strongly disagree. The questions in this questionnaire include whether work is boring if the employee sees the administrator, if the working conditions are safe, etc. (Thomas, 2003). These questions come together to reflect whether the employee is pessimistic, cynical or even stingy with the responses provided. The questionnaire does not ask for the employee to self-identify, however, it does ask what the employee's job title is and how long has that employee worked in the organization (Thomas, 2003). With that information alone, a manager can deduce who the employee was that took the survey. This can affect validity in the responses provided by the employee for feedback on the Eden implementation process.

The Warmth Survey supplemented the interview, and the MDS 3.0 Public Reports to provide a good synopsis of the conditions surrounding an Eden Alternative implementation, as well as the conditions of the organization before, during and after implementation. The semi structured interview allowed me the freedom and flexibility to ask participants to elaborate on facility-specific issues that existed before, during and after the Eden implementation. This allowed for more accurate data as a structured interview allowed me to ask the participant to specify an issue that did not apply to other participants. The semi structured interview questions allowed myself to add or retract questions based on relevance and flow of the responses provided (DiCicco-Bloom &

Crabtree, 2006). With the semi structured interview, I could ask for elaboration and better flow for the participants as well as create a more relaxing atmosphere through topic transitions.

Data Collection Process

After the letter was sent out to eligible nursing facilities, non-clinical directors volunteered for the study and my Walden email address was provided for the directors to confirm interest in participating in the study. At this point, the participants were screened for eligibility including the type of non-clinical department the director is in charge of as well as tenure in the facility (pre-Eden and post-Eden experience at the facility). I then emailed an informed consent form for the directors to review and the directors responded back via email that the terms of the study were accepted, and consent was given. Once informed consent was received, I began scheduling interviews and confirmed availability with the directors in this study. A phone interview allowed for convenience as interviews could take place later in the evening or weekends, so it was more convenient for participants. Once participant availability was known, I prepared the materials for recording and documented the information exchanged.

While the interview took place over the phone on speakerphone, I was able to record the audio through my laptop microphone recording application but in case the participant did not agree to have the conversation recorded, I was prepared to take detailed notes in real time, as well as listen to the interview and steer the conversation to obtain as much relevant information as possible (Brinkmann, 2014). This element of the interview would have been challenging; so, recording tools fortunately were in place for

transcription because failure to have done so would have led to disruption in the interview and decreased the participant's willingness to continue on with the interview and affect the quality of responses provided (McLellan, MacQueen & Neidig, 2003).

The interview only required one single data collection event per participant. The decision to go with a single data collection event allowed me to confirm a schedule and complete the data collection process once the interviews were complete. Arrangements for following up may have required additional time and disruption to the schedule, which would have caused inconsistent data collection techniques from one participant to another. This issue was mitigated by not compromising the interview schedule once it was established and confirmed. The interview took approximately an hour; however, once the introduction and follow-up time for questions or elaboration of questions were removed it , most of the time it was approximately forty-five minutes per data collection event. The phone interviews were conducted with the participant on speaker phone and a microphone application recording the exchange. This allowed my hands to remain free so I could type and record notes on the laptop. Once the participants were assigned a time slot for a phone call, I was able to honor that time slot. Changes to the interview schedule would have caused for disruptions as participants would have to stop and start often if the interview would have taken place at a time different than the scheduled assigned time (King & Horrocks, 2010).

No follow-up interview was required of the participants at the end of this process. If the study required a follow-up interview, I risked voiding the first interview if the second interview was not completed (Brinkmann, 2014). The insertion of a follow-up

interview for participants would have been a significant threat to content validity as some participants will have a follow-up interview and others would not have (Brinkmann, 2014). Participants would have every chance to contact me if clarification or details need to be explained; however, information cannot be added or redacted after the scheduled interview was concluded (Brinkmann, 2014). The participant received the transcript of the interview conducted and verified that the content was valid that had been presented from the time the interview was conducted. Once again, new material or already stated material was not added or redacted to the text; the participants simply verified and validated the content presented.

The phone interview was in place to collect data from participants. After the data was collected from this method, I determined if there are enough participants to move forward with the study. If it turned out that a participant was disqualified from participating in the study for any reason, then I would have taken appropriate measures moving forward. If there were not 15 participants for the study, new participants would have been recruited, credentials would have to be reviewed to see if the new participants met the study criteria to qualify, and new schedules would have been created. This entire process was anticipated to take anywhere from one to three months total time to collect the data through interviewing participants. It was essential to organize the interview as concise as possible, so it limited stress and maintained subject participation and buy-in to assisting with the study (Brinkmann, 2014). I practiced the interview questions and had enough space when recording information to schedule additional questions or ask for participants to elaborate. A clock was present to record the time of the interview so that

the scheduled interview period was respected and upheld between both the participant and myself (Sommers-Flanagan & Sommers-Flanagan, 2012). Having the time recorded allowed me to anticipate the flow of the interviews with other participants as well (Legard, Keegan, & Ward, 2003). Questions were in order and files were saved as soon as possible so that I did not lose the information recorded. Losing record information would have disrupted the data collection process as a participant would have to schedule another interview and answers would not be exactly the same as initially provided (Legard, et. al, 2003). If participant's refused to provide complete answers or elaborate on responses for the sake of saving time or ending the interview, I would have reviewed the data collected as a whole and decide whether the data provided in that interview will be sufficient enough to be used for the study. Fortunately, I did not an occurrence in which a participant appeared to rush through answering questions to save time.

Data Analysis

An important facet of data analysis to be considered was the coding of qualitative data collected. Qualitative coding, unlike quantifying data, proceeds on the idea of linking diverse observations, statements, and tools and connecting it by common themes and patterns in a manner that allows me to draw all the particular examples together (Wesley, 2009). For this particular data analysis, I decided to go with an open coding approach. I read through the data several times and created tentative labels for chunks of data that summarized what I observe is happening (Ruona, 2005). The open code broke down key elements related to the research questions and interview prompts that

determined properties and then further broke down the table into examples provided by the participants themselves (Saldaña, 2015).

Open qualitative data coding required breaking down all data obtained into units that are then grouped according to characteristics (Ruona, 2005). In this study, I focused on first identifying the issues that are already identified as low performing quality measures. Through these quality measures, I was able to determine whether that facility failed to achieve satisfactory results during auditing of resources and surveying of care provided. The quality measure for a nursing home depends on clinical outcomes, but the clinical outcomes may have been affected by non-clinical departments (Walker, Johnston, & Adler-Milstein, 2005).

One specific example stems from a deficiency for passing out medications late or missing medication pass altogether. The quality measure focuses on a clinical outcome of the medication not being administered. However, a root cause analysis might determine that the patient was late for physical therapy and insisted on attending and the patient was late for physical therapy because meal trays arrived late on to the unit. This type of assessment of responses was required throughout the interview for me to focus on identifying poor quality measure outcomes and trying to understand if it was due to a challenge of a non-clinical department adjusting to new philosophy implementation.

Semi-structured Interview Data Analysis

It is important, as a researcher to ask consistent and specific sets of questions to produce applicable data. The coding strategy is to organize what is happening here and what is important. It is essential to interrogate all data systematically. The first phase after

data is collected is to skim through the entire data to see if there are any glaring similarities or patterns that emerge throughout the entire data (Onwuegbuzie & Byers, 2014). Any thoughts or ideas from the responses will be written down as memos as the study continues. This initial sorting of data will develop the initial coding scheme, which roughly divides the material into units (Campbell et. al, 2013).

The open coding process is explained by first understanding that the ideas and concepts provided through interviewing subjects must be given names and properly identified (Campbell et. al, 2013). Once identified, I was then able to define, analyze, and share those ideas and concepts. The definition of these ideas and concepts will allow for comparative examination, as well as the systematic organization of elements that connect with others (Campbell et. al, 2013). The open code process is possible by researchers by opening up texts and exposing the meaning, idea, and thoughts behind it (Campbell et. al, 2013). Open coding includes labeling concepts, defining and developing categories based on properties and dimensions (Elo & Kyngäs, 2008).

Once the initial stage is completed, the second stage would be to repeat the process, refine, expand or reject the initial categories that have been established (Campbell et. al, 2013). Once significant elements are identified, the elements will need to be 'tagged' or coded (Ritchie, Spencer, & O'Connor, 2003). The code will be written in words that somewhat describe the content so it would be easier to relocate in the document if needed.

Open coding will allow for quick access to relevant data if needed. Certain responses may have multiple properties depending on the different categories the specific

responses might be categorized as. Reading over transcripts of interview responses will allow me to identify areas where information overlaps and where it is different. The dependability and credibility must be considered when grouping information for coding structure (Corbin & Strauss, 1990).

MDS 3.0 Data Analysis

The remaining data collection consisted of reports (MDS Public Data records and Eden Alternative Warmth Surveys) that have already been completed and could become available upon request or access them at the place it is stored. Data from the stored reports were analyzed and extracted to provide clarification for the type of environment each participant derives from the organization. The second data collection instrument, in this case, came from the Minimum Data Set (MDS) 3.0 Public Reports. Institutions that participate in Medicaid and Medicare programs are required to submit the MDS 3.0 reports as scheduled (Saliba & Buchanan, 2012). The information becomes public and can be accessed through websites such as the Nursing Home Compare tool, which can be found on the Medicare website. In order to utilize the data derived from the MDS 3.0 reports, one can access them (Saliba & Buchanan, 2012). Once on the website, I entered the zip code and name of the nursing home where the participant is employed. It is important to emphasize that the identity of this nursing home will remain completely confidential and the only information provided are the results of the MDS 3.0 Public Reports.

Once on the nursing home profile, the quality measure tab and the information from the MDS 3.0 Public Report was extracted and displayed in both graphs and tables.

The information is displayed with the nursing home's results presented by quality measure and the result for that measure in the first column. The first column down the list possesses the results for the nursing home studied. The second column has the cumulative results for all the nursing homes in the state the searched nursing home is located in. This allows consumers to view how that nursing home is doing compared to the state average for the quality measure. Finally, the third column has the national average results for each quality measure as well.

Table 2

Nursing Home Compare Quality Care Measures

	Merwick Care and Rehabilitation Center	New Jersey Average	National Average
Percentage of short-stay residents who made improvements in function (Higher percentages are better)	42.90%	64.20%	63.50%
Percentage of short-stay residents who were re-hospitalized after a nursing home admission (Lower percentages are better)	20.20%	21.90%	21.10%
Percentage of short-stay residents who have had an outpatient emergency department visit (Lower percentages are better)	9.10%	9.20%	11.50%
Percentage of short-stay residents who were successfully discharged to the community (Higher percentages are better)	52.70%	51.90%	50.00%
Percentage of short-stay residents who self-report moderate to severe pain (Lower percentages are better)	11.50%	10.50%	17.10%

(table continues)

	Merwick Care and Rehabilitation Center	New Jersey Average	National Average
Percentage of short-stay residents with pressure ulcers that are new or worsened (Lower percentages are better)	0.80%	1.30%	1.30%
Percentage of short-stay residents assessed and given, appropriately, the seasonal influenza vaccine. (Higher percentages are better)	87.20%	85.00%	80.30%
Percentage of short-stay residents assessed and given, appropriately, the pneuomococcal vaccine (Higher percentages are better)	83.70%	86.50%	81.10%

The MDS 3.0 Public Report data, as presented on Nursing Home Compare, displays the most recent submission of the report (Saliba & Buchanan, 2008). This only provides the most recently updated status of the quality measure results in the nursing home. Use of accurate MDS 3.0 Public Reporting data will come with some challenges as it is important to have the quality measure results by NF aligned with the participant interviews from the NF as well as completed Warmth Surveys. If the participant mentions particular challenges that a department faces, I am able to reference that issue with the quality measure for that area and see if the recorded measures aligned with the information from other qualitative data sources attained.

Eden Warmth Survey Data Analysis

The Warmth Surveys used by Eden professionals are owned by the Eden organization and were approved prior to use in the study. The Warmth Surveys are scheduled and conducted to record progress prior to implementation, during implementation, and after (Horton, 2005). The Warmth Surveys will be used from the participant's associated nursing home to indicate the process as a whole during the transition (Yeung et. al, 2016). The data collected from this instrument was documented and organized along with participant and facility MDS 3.0 report. A complete package was assigned to each participant, so an overall snapshot of the facility's conditions and the quality environment was displayed for observation.

Consistent with case study research design, I utilized a triangulation of data sources. The second source that was included after the interview process was the Warmth Survey required by the Eden alternative organization during implementation. The Warmth Survey is completed by the employees to assess the employee's feelings toward the implementation process (Thomas, 2003). This gauged whether the employees believe the implementation will be successful through each phase. With the Warmth Survey data, one could see an employee's attitude on whether the organization is addressing important elements of the Eden philosophy. The Warmth Survey was analyzed through open coding utilizing the same process as described in the interviews. Once the coding was completed for each facility, the results were collated with the interview results for each facility to look for themes within each facility between the themes of the Warmth Survey

and the themes of the interviews. Next, the cross-case analysis was conducted comparing themes for similarities and differences.

With the Warmth Survey data, I could justify credibility and dependability of the interview responses. If the interview responses contradicted the responses of the Warmth Survey, then I would have had a contradicting narrative of how the Eden implementation process was introduced to a facility. The alignment of responses from both interview and Warmth Survey provided justification for the coding strategy and provide credibility for the participant's feedback.

Issues of Trustworthiness

Credibility

Establishment of credibility was essential for success in this study. In order to confirm credibility in this study, it required me to demonstrate that the results of this qualitative research were credible (believable) from the participant's perspective in the research. The purpose of qualitative research was to describe or understand the phenomena from the participant's view; therefore, the participants are the only ones who can legitimately judge the credibility of the results (Devers, 1999). At the same time, one of the key criteria addressed is internal validity, in which researchers seek to ensure that the study measures or tests what is actually intended (Thomas & Magilvy, 2011).

A strategy to establish credibility in this study was triangulation (Shenton, 2004). This strategy involved the use of different methods that forms the major data collection strategies for this qualitative research (Jick, 1979). The data for the study came from semi structured interview responses, a form used for CMS quality measure tracking (MDS 3.0)

and a form used by the Eden Alternative organization (Warmth Survey) to track progress of employee morale and implementation success these sources allowed me to determine the challenges that were introduced to non-clinical staff when implementing the Eden Alternative model through triangulation.

Transferability

The transferability of this study referred to the degree in which the results of this qualitative research can be generalized or transferred to other contexts or settings (Krefting, 1991). The concern often lies in demonstrating that the results of one's work can be applied to a broader population (Shenton, 2004). The participants were varied when selected, which reflected a broad population and thus allowed for a greater ability to potentially generalize the results. The participants were managers of non-clinical departments; however, the departments were not always be the same. A manager from dietary, housekeeping, human resources, and maintenance to name a few provided a variety of challenges since each of those departments had differing responsibilities to the nursing home. The managers were also from different areas of the country, so the participants did not simply originate from one state. Different states have different regulations for delivering health care, and the use of different states allowed information regarding challenges not rely on one state's regulations alone (Cebul et. al, 2008).

Dependability

The idea of dependability emphasizes the need for researchers to account for the ever-changing context within which research occurs (Bashir, Afzal, & Azeem,2008). If the work were to be repeated, in the same context, with the same methods, and with the

same participants, similar results would be obtained (Kreftin, 1991). In order to address the dependability issue, the process within the study should be reported in detail such that future researchers may be able to repeat the work. Triangulation in this study, as mentioned previously, allowed for data to be collected from several sources (Shenton, 2004).

I was clear in describing the research design and its implementation. This specification included describing exactly what was planned and how it was executed on a strategic level (Thomas & Magilvy, 2011). I then specified the operational detail of data gathering, which entailed the very specifics of what was done in the field to conduct the study. Finally, the reflective appraisal of the project included evaluating the effectiveness of the process of the inquiries undertaken. If done correctly, these steps confirmed dependability within this qualitative study (Thomas & Magilvy, 2011).

Confirmability

Finally, confirmability is accomplished through other researchers that are able to confirm the results and corroborate it by others (Krefting, 1991). It is difficult to ensure real objectivity in any study as interview questions are designed by humans, therefore will inevitably have the intrusion of my biases. The concept of confirmability is the same as identifying any instances and concerns of objectivity (Krefting, 1991). The role of triangulation in promoting such confirmability must again be emphasized at this point. Triangulation in this study allowed me to admit any predispositions held (Mertens & Hesse-Biber, 2012).

Ethical Procedures

The core principle of beneficence requires a commitment to minimizing the risks that are associated with research that includes both psychological and social risks while maximizing the benefits that result from research participation from subjects (Brydon-miller, 2008). I articulated the benefits of study participation to all subjects that allowed for more honest and open responses. The core principle of justice required a commitment to ensure a fair distribution of the risks and benefits that will result from the research (Emanuel, 2000). The research participants must be included and share in the benefits that may arise from research results. Ultimately, the individuals who were expected to benefit most from the knowledge should be the ones asked to participate in the study (Brydon-miller, 2008).

In order to conduct the study, candidates and researchers agreed to participate and must understand all ethical considerations involved in the process. Agreements must be documented, and any concerns individuals have for participating in the study should be addressed prior to moving forward in research. Gaining access to participants required assistance from the Eden Alternative organization. Liaisons for the Eden Alternative organization were the individuals that connected me with participants. The Eden liaisons used their network to reach out to facilities with information regarding the research study. The head of the facility presented the study to non-clinical department heads, and the department heads chose to reach out to me if interested in participating in the study. At this point, the non-clinical director was screened and vetted to determine eligibility in the study.

Participant Rights

It is important to have informed consent (Appendix E) by the candidates in order to advance the study. The details in the document will contain what the study was attempting to do in addition to a brief statement on the importance of conducting the study. The outcome of the study remained vague, so the participants would not feel obligated to provide specific answers that aligned with a predetermined outcome. The purpose of the study was to identify any challenges that departments face during Eden alternative implementation. The participants came from facilities that have completed Eden certification, and the participants were individuals that have transitioned from an institutional model to the Eden person-centered care model.

The informed consent provided enough information for the participants to understand how much time and availability is required. The less required of candidates, the more likely it was to obtain participation. The participants engaged in a semi structured interview that was conducted by me over the phone for approximately one hour. The interview was scheduled at the convenience of the participant, as promptly as possible after the initial contact explaining the study, once the participant was given their informed consent. Opportunity to cancel or reschedule was made available.

The participants all remained anonymous therefore there was no consequences tied to participation or survey outcomes. The participants were assigned a pseudonym, as well as the NFs the participants were associated with. The NFs were listed as Nursing Home A, Nursing Home B and so forth while participants will be given numbers such as participant 1 and 2. This allows readers to recap results and know what participant is

associated with which nursing home facility. The institutional review board (IRB) reviewed all participant involvement in the study and determined whether there were any ethical or moral conflicts involved with the organization associated with the participant for the study and approved the research prior to its commencement.

The treatment of human participants was respectful as the study did not necessarily involve participant interaction in the same room with me. The identity and the manner of which recruitment was done will remain confidential and not in any way like solicitation. I did not cold-call a nursing home facility and ask around until someone was available to assist without being given prior knowledge of the proposed study. If candidates did not pass the prescreening assessment, then I thanked each one for consideration and provided a $15 Starbucks gift card regardless of the candidate's eligibility. For this study, I needed participation and approval from the Eden Alternative organization to gain access to contacts, resources, and the Warmth Survey results required for data triangulation. Specific approvals were needed by facilities to use managers as participants and assurances that confidentiality will be upheld and respected.

No emails or contact information were stored for later use, so participants will not have to worry about personal information being used for any other study or function aside from the study participants agreed upon. The MDS 3.0 documents are public records and accessible for use, therefore no specific permissions or requests was required to access public information regarding the quality measures of a facility. Specific information regarding the nursing home that may not be available online would have been requested by the nursing home for further use. The interview questions were reviewed and

constructed in a respectful manner to avoid any compromise of identity or details that violated study agreements with participants.

Keeping results and responses confidential regarding specific places, people and details assured that participants did not face any discipline from the organizations that were represented in the study. No participant should risk compromising their employment status with an organization or future promotion considerations because of the study. The Eden Alternative organization must also understand that the challenges of implementing the philosophy should, in no way, reflect a failure or criticism of system implementation measures. I did not aim to discredit the Eden Alternative or its effectiveness in bringing forth person-centered care. This research was intended to highlight challenges to make the implementation process more efficient by gathering feedback from departments that actually underwent transition and highlighting specific areas that compromise operational, risk management, and payroll functions.

The participants were only required to complete the interview, and any additional participation would be done via email or text communications. A participant had the right to withdraw at any point during the study. I anticipated these setbacks and was prepared to replace recruits in order to reach the participant amount for successful completion of the study. Enough candidates were gathered in case participants became difficult to confirm or if there were cancellations prior to completion of the study to assure that the sample size is met (Jacob & Fergerson, 2012).

Only I had access to the data, as well as keeping all private information stored on an external hard drive, which requires password encryption before opening any file. The

information remained private until time to gather the data and placed into a single results area. The data remained accessible until the dissertation was approved. If the committee or other entities required additional analysis or elaboration, it is important to have the original data as is. Recreation of the data would have resulted in compromised results (Jacob & Fergerson, 2012). It was important to leave the data as is when originally collected. Editing the data after the fact would have compromised the integrity as the study and may void the results as I could have made any edits to allow the study results to align closer to my desired outcome (Jacob & Fergerson, 2012).

I could have faced ethical concerns because of the relationship I developed with the liaisons for the Eden Alternative organization. I limited any arrangements or informal communication with the liaisons to ensure that I am not benefiting in any other manner to produce results favoring the Eden alternative organization on purpose. The results revealed are honest and presented as is with no editing for purity and reliable of results. The results were not discussed with any member of the Eden Alternative organization until completed and no arrangement was put in place as a stipulation in exchange for assistance with coordination or participation.

I did not receive any form of compensation from the organizations involved nor have ties to the organizations involved in the study (Collier & Mahoney, 1996). I was not associated with nursing homes or participants used for the study as it would have created bias or personal attitudes toward the unstructured questions asked for the study. The semistructured questions were based on information gathered through the research questions and will coincide with the documents collected in order to confirm

triangulation. The questions did not stem from any personal interaction or bias I have toward a company or a participant's background.

Summary

In summation, the participant selection logic referred to the 15 directors and managers that are employed in long-term care facilities that participated in the Eden Alternative philosophy implementation in the given facilities The non-clinical directors and managers were required to have enough tenure at the center so that pre-Eden implementation experience and post-Eden implementation experiences were accounted for during the interview process.

Using a homogenous sampling reduced variation and simplified analysis throughout the process. The instrumentation used were an unstructured interview approach for gathering data. Unstructured interviews allowed participants to engage with me and vice versa so that topics that need to be elaborated on had the flexibility throughout the interview to be done so. The other two sources of data was a MDS Set 3.0 Public Report and an Eden Alternative Warmth Survey. These sources allowed me to gauge the environment of a long-term care facility and triangulate that information with the specific interview responses provided by the participants in this study. I then reached a conclusion based on the specific non-clinical staff challenges, the quality of care standards perceived to exist in a facility, and the buy-in and employee willingness to adapt a person-centered care philosophy different than an institutional model that exists in nursing homes currently.

The participants recruited were given schedules to interview with me and ample time to elaborate on answers. Parameters were put into place in the case of participant's failing to meet the assigned time frame for conducting the interview. Once the data was gathered, I organized each participant's file in order. The participant's file included the data gathered via an unstructured phone interview, the facility the participant came from, the MDS 3.0 Public Reports and finally the Warmth Surveys from the Eden Alternative organization. This information, once organized, will provided common themes and connections from the participants in the study that revealed the challenges the staff faced when transitioning into a person-centered philosophy for delivering health care services in a long-term care setting.

The credibility, transferability, dependability, and confirmability were confirmed and validated in this study through specific measures. Triangulation and clear descriptions of step by step processes will give readers a clear understanding of the research process that leads to the study's conclusion. Avoiding any bias and limiting error was essential in concluding a valid study. If appropriate steps are taken, the study can be replicated and confirmed by other researchers and the results will also remain the same.

As the dissertation shifts into chapter four, the setting and demographics will be explored further. The actual study is described through the data collection and analyzed soon after. The process used for sorting through the data is specified, and any actual issues were revealed. Everything documented so far was theoretical, and once the study was approved and prepared for, chapter four will reveal the results and any issues of trustworthiness or threats to validity.

Chapter 4: Results

Introduction

I used this qualitative study to explore the challenges of several non-clinical departments to determine whether key elements of the Eden Alternative philosophy could be implemented successfully. I used a case study approach to collect data and conceptualize the study as a whole. The case study approach allowed me to collect data and interpret and explain the various challenges non-clinical departments faced when implementing the Eden Alternative philosophy. In this chapter I discuss the background of the study demographics, data analysis, evidence of trustworthiness and the results of this study.

The three main research questions of this study were:

1. What are the specific challenges that affect non-clinical staff from a staffing, operating, and risk management standpoint when implementing the Eden Alternative model?
2. Will identify the challenges of adopting the Eden Alternative model from a non-clinical perspective determine whether complete transition achieves Eden Certification?
3. What are the internal and external motivations that influence non-clinical departments to commit to new philosophy implementation?

Setting

I conducted this study with the help of two Eden liaisons, who were able to access the Eden Alternative registry. The Eden Alternative organization agreed to assist with the

identification and recruitment of facilities that were Eden certified. Two liaisons assisted in emailing contacts in order for recruitment flyers to be shared with various Eden certified homes to locate directors of non-clinical departments who were there before, during and after Eden alternative model implementation. Once the directors reached out to me via email, they were asked prescreening questions (Appendix F) to determine if they were eligible for the study. Based on their responses, if they qualified for the study they were sent the consent form to review and return via e-mail. I interviewed the directors of non-clinical departments via telephone using the semi-structured interview technique. The participant and I worked out a date and time that was best to hold the interview.

The interviews were recorded through a laptop's microphone application as the audio could be heard through my cell phone's speakerphone. The responses were transcribed into a word document as a form of secondary note taking in case the audio recording was compromised. After each interview I placed the participants on a brief hold to verify that the audio was recorded and saved correctly.

Demographics

I recruited the participants for this study through the Eden Alternative registry that contains names and locations of the Eden Alternative qualified NFs across the United States. The nursing facilities that they worked in and their genders have been kept hidden to protect their identities; however, Table 1 below includes the participants, their title within the organization, and how many years of experience they have within their particular field.

Table 3

Information of the Participants

Participant	Title	Years of Experience
1	Director of Dietary	30
2	Director of Life Enrichment	24
3	Assistant Administrator	34
4	Administrator	20
5	Director of Life Enrichment	18
6	Director of Human Resources	16
7	Administrator	20
8	Assistant Administrator	19
9	Director of Life Enrichment	13
10	Executive Director	22
11	MDS	20
12	Director of Life Enrichment	18
13	Executive Director	25
14	Director	12
15	Director of Maintenance	20

Data Collection

Once I received the Walden Institutional Review Board (IRB) approval (Approval number: 03-16-18-0372788) on March 16th, 2018, I began the process of data collection. I reached out to liaisons who worked for the Eden Alternative and I informed them of what the study entailed and the steps the study required. The liaisons provided the letter of cooperation from the Eden Alternative organization (including access to their Warmth Survey results) and began emailing the nursing homes from the Eden alternative registry to inform Administrators that I was conducting a study and was seeking homes to allow my recruitment flyer to be placed (Appendix A). The flyer (Appendix G) described the

criteria participants needed to meet for the study, a brief overview of my study, and informed all participants that they would receive a $15 Starbucks gift card for their participation (whether selected or not).

I waited for participants to send me emails expressing their interest to participate. After the participants expressed interest, I sent them the prescreening questions (Appendix F) and based on the responses, I determined if the participants would be qualified to answer all the interview questions in the study. The prescreening questions ensured that the participant was a director of a non-clinical department in a NF in the United States and that they ran the department before, during, and after Eden implementation. I made sure to ask if any participants knew me to ensure that there was no bias and eliminate any participant who might answer differently based on any possible personal relationship with the interviewer.

The first participant contacted me on May 9th and the interview process took approximately 4 months to complete. After the prescreening process, the participant and I scheduled an interview on an agreed date and time that worked best for both parties. Each interview began with small ice breakers back and forth and then I informed the participant that there would be a slight pause and the next time the participant heard my voice the interview would begin. The interviews were semi-structured so that I could ask the participant to elaborate on certain elements that may not have appeared in other interviews or contained material not well understood to non-Eden certified observers.

The participant spoke via cell phone and was placed on speaker phone so that a microphone on a laptop could clearly pick up the audio. I also typed along as fast as I

could to keep pace with general concepts or ideas, just in case the audio did not save. After the interview was done, I explained to the participant that they could add anything or ask any questions they were not certain of. After I saved the audio file, I put the participant on mute and selected the file to make sure it saved properly. I thanked the participant and let them know that they will be receiving a written transcript of the interview within 3 days. The interview transcript was converted from a Microsoft Word document to a password protected portable document format (pdf) file. Each password is kept confidential and only revealed to the participant in the body of the email the file was attached in. No other individual has access to the password besides myself, and the participant. This ensured confidentiality remained throughout and the participant was aware that they would not be specifically identified in the study which made them more comfortable and confident in accurately revealing descriptions of events.

The shortest interview lasted approximately 18 minutes while the longest was 56 minutes. The participants answered each question as thoroughly as they could and did not have to stop or recuse themselves from the study during the interview process. Only three participants requested changes after receiving their transcript for spelling and sentence structure issues. There were no changes to content and the remaining participants expressed their satisfaction to accept the transcript as transcribed. I kept a running spreadsheet of all participants who reached out to me to keep track of who was selected, pending, not chosen, or completed as well as what phase in the process they were in. The participants names were removed but I kept track of what number they were identified as, each participant's title, their years of experience as well as what processes were

completed during the data collection phase (this helped with collecting Warmth Survey data as well as CMS Nursing home Compare data).

The 15 participants selected came from six NFs; therefore, the Eden Liaisons e-mailed me six Warmth Survey data sets for review and comparative analysis. As I went through the coding and developed categories and themes, I was able to compare themes with data from the MDS 3.0 Nursing Home Compare, as well as elements from the Warmth Surveys that were completed and collected.

Data analysis

I conducted the data analysis for this study in several phases. The first step was the transcription of the recorded interview data into the interview text. As I conducted the interviews over the phone, I attempted to transcribe the conversation so that was my first means of understanding and visualizing what I was hearing. The next step was to play the audio back from my computer. I used Windows Movie maker to save the audio along with a blank default image. Once the movie was saved, I could slow down the audio speed for any participant that spoke too fast for me to transcribe efficiently. I ended up with transcripts that were replicated with the exact responses verbatim of each participant in the study. All audio files were transferred over to a password encrypted one terabyte external hard drive. I purchased a premium package of Soda pdf online which allowed me to password encrypt each of the participant's interview transcript with a unique password. The participants were emailed their password protected pdf with their individual passwords. They were given 72 hours to review and confirm that the transcript

was accurate and everything they wanted to convey was represented accurately, as noted previously.

According to Punch (p. 173, 2013), "Coding is the starting activity in qualitative analysis, and the foundation for what comes later. For analysis directed at discovering regularities in the data, coding is central." I uploaded my files into the NVivo 12 Plus software to organize all my data in one central location. The next phase was to read, reread, and understand the participant's responses to see what was repeated and what stood out from one participant to another. I learned that the NVivo software created more confusion with coding with a lot of auto functions. I went through and wrote notes and highlighted codes manually through each individual document. I analyzed the contents of each of the transcripts and synthesized the data from each participant's written transcript to codes and then began identifying patterns that aligned with the research questions.

Codes appeared but I made sure to move aside any codes that may have repeated yet did not align with the research questions being asked. I was able to place the codes into categories then ultimately themes. The principal themes that were generated from the study include key elements related to job satisfaction, care management, "warming the soil," and several implementation challenges across disciplines.

The MDS national data base data is accessed for each participant's respective nursing facility. The MDS database contains information on every nursing facility including information regarding quality of care measures for each resident. This MDS assessment is done by the nursing home at regular intervals on every resident within a Medicare or Medicaid certified nursing home. The data that is gathered during the

assessment provides details about the residents' health, physical functioning, mental status, and general well-being. The Nursing Home Compare site compares each participant's NF standards to both state and national averages.

The Warmth Survey data allowed me to grasp a better understanding of how the nursing facility staff felt throughout stages of the Eden Alternative model implementation process. The staff buy-in and feelings toward acceptance of the philosophy shift in the organization were quantified for each home for the participant that participated in this study. The Warmth Survey data asked specific questions such as "Is management is leading us in the right direction?" The respondents answered from the choices of *strongly disagree, disagree, neutral, agree* or *strongly agree*. The data from the Warmth Survey maps out trends and a general consensus of staff feelings about the Eden Alternative model implementation at different stages of the implementation process.

Evidence of Trustworthiness

The goal of this research study was to identify the challenges of implementing the Eden Alternative for non-clinical staff. It was essential to determine whether those non-clinical departments overcame those challenges to successfully achieve Eden Alternative philosophy implementation. In order to achieve rigor in qualitative research I demonstrated that the study has credibility, dependability, confirmability and transferability (Houghton , et. al, 2013). There is persistent concern with achieving rigor in qualitative research because reliability and validity can be difficult in naturalistic inquiries as opposed to quantitative investigations (Cypress, 2017). I chose to use a semi-structured interview guide to ensure consistency across participant contribution. This

approach allowed me to probe deeper into the challenges mentioned as it applied to individual non-clinical department from one facility to another. Having consistent and standard methods of approach for each individual nursing facility makes it easier to conduct analysis.

Credibility

Credibility is present when the results of the research reflects the views of the people within the study. In qualitative research, credibility refers to the confidence of the data (Thomas & Magilvy, 2011). Credibility in qualitative data can be enhanced through four types of triangulation (Denzin, 1973). These types include: a) data triangulation that focuses on numerous sources of data; b) investigator triangulation that allows for numerous researchers to collect and then analyze similar data from different perspectives, c) theory triangulation that uses several theories to interpret study findings and d) methodological triangulation that involves using various methods to collect data (Denzin, 1973). I was able to use data triangulation and theoretical triangulation for this study. Data triangulation using interviews with 15 participants, Warmth Survey data from the Eden Alternative, and MDS 3.0 data results from CMS' Nursing Home Compare tool. I applied theoretical triangulation by using Bresser's CIT that evaluates what happens when an entity combines two separate sets of policies and philosophies into one environment (Bressers, 2007). Another form of data triangulation included NVivo software for data analysis, a voice recording application on a laptop and note taking as I transcribed audio through a video maker application in order to slow down audio.

In this study, participants had to recall events and decisions that took place in the past. These participants had to explain why certain actions were taken during early Eden Alternative philosophy implementation. I made sure to ask the participants about their pre-conceived notions of the Eden philosophy to identify any personal bias. I asked the directors about promises and expectations they were given before the implementation begin. This was done so they could recall their thinking and emotions during the time of policy shift and culture change (Yin, 2013). In this study, I used two additional data sources to corroborate the information from the interviews. There are also numerous occasions in the interview where I asked participants to clarify terminology that I was aware of because of my professional training. I am a licensed nursing home administrator, but I asked participants to clarify what they meant by common terms within the industry such as Assisted Living, quality of care, or Eden Learning circles. There was also instance where participant 15 asked me about home care regulations and what area of the country I lived in, and when participant 14 asked me if I knew an Eden executive personally. In both cases, I reminded them that I was not allowed to answer the question, so my knowledge or understanding did not influence their responses and they elaborated on any and all thoughts to explain things thoroughly. I wanted to ensure I did not insert any bias into the study, so I assumed the role of an outsider and none of the participants knew I was a licensed nursing home administrator.

Dependability

Dependability in case study methods can be achieved when a study is able to be replicated in the future to achieve comparable results (Yin, 2013). The step by step

recruitment process is highlighted and the main catalyst rests on the Eden liaisons. The Eden liaison scouted the database for Eden certified homes and flyers were posted for recruitment. Regardless of the numbers and how long it takes to achieve 15 participants, if other researchers follow the prescreening questions (Appendix F), they can move forward with the study as outlined.

I utilized a semi structured interview protocol and once the data was coded, the Eden Warmth Surveys and the MDS 3.0 data were used to triangulate the data. Keeping the basic interview questions regarding pre-implementation, implementation, and post-implementation increases dependability from one study to another. If the participants in another study are non-clinical department directors, then the responses will be provided with the department in mind as opposed to front-line staff that might only provide personal feedback. If the NFs are in the Eden database it means that Eden philosophy implementation has been reached. This requirement will give future researchers the confidence to ask all interview questions to completion without worrying if the implementation was completed or not.

Transferability

Transferability in this study refers to the degree in which the results of this qualitative research can be generalized or transferred to other contexts or settings (Krefting, 1991). To increase the level of transferability, I made sure not to limit the participant search to specific non-clinical departments. Any non-clinical director who met requirements could have joined the study once the pre-screening questions were met. If a future study focuses on another philosophy implementation process for non-clinical staff,

this study's approach can be used since it did not restrict the number of participants from one particular department who were represented. The study can be transferred to directors of different non-clinical departments of Eden Alternative model certified NF; as well as, in different states, as long as they are in the United States and the directors managed their non-clinical departments before, during and after Eden implementation.

Confirmability

Confirmability in qualitative research refers to the degree to which the outcome could be confirmed or corroborated by other people (Cypress, 2017). A strategy followed in this approach is to focus on taking on a *devil's advocate* role when focusing on the outcome. I was aware of my background and professional knowledge going into the study, so I took steps to avoid prompts or comments in between responses to sway or influence participant's future responses. In order to allow for the most accurate translation of text, I did little to no editing on grammar or sentence structure when transcribing participant quotes. I did not reveal to the participant's that I was a nursing home administrator so participant responses had to be elaborated even though I was familiar with the terminology or situation being discussed. This allows for any researcher to ask similar questions without having a nursing home administrator's training to learn about a participant's experience.

I was able to enhance confirmability by transcribing all audio recordings into a password secured PDF document and organizing it into a folder based on participant. This was then emailed to each participant within 72 hours, so the responses were fresh in the participant's mind. The participant was then given time to review their responses and

make corrections or clarifications in case they felt that anything they said needed adjustment. Several participants made minor adjustments to sentence structure and elaborated on a few statements. Most participants were fine with the transcript. I inserted details any time the participant laughed or said "um" just to get as accurate a transcript as possible.

Darawsheh (2014) suggested that reflexivity in research can be employed to establish the criteria of rigor, which increases the confidence, congruency and credibility of findings. I am aware of my training, background, and experiences of a nursing home administrator but I made sure if I heard a term or was described a process that was common in a nursing facility that I asked the participant to elaborate further as if I was not aware. Abbreviations or acronyms had to be elaborated by participants the same way another researcher without nursing home experience would require the participant to elaborate. In this manner, I increased the confirmability of the study and took every possible measure to acquire the most credible responses from participants.

Results

For the three research questions posed, I was able to gather four themes from the data analysis. The participant's responses were separated into codes and then categories so quotations will be used in each section to confirm the themes that were identified. For the purpose of confidentiality, each participant in this study was identified as P and assigned a number from one to fifteen. The three research questions posed in this study were:

1. What are the specific challenges that affect non-clinical staff from a staffing, operating, and risk management standpoint when implementing the Eden Alternative model?

2. Will identify the challenges of adopting the Eden Alternative model from a non-clinical perspective determine whether complete transition achieves Eden Certification?

3. What are the internal and external motivations that influence non-clinical departments to commit to new philosophy implementation?

Theme One: Job Satisfaction

The theme of job satisfaction included categories that highlighted intrinsic and extrinsic factors for employees as well as successful synergy between each and every department. These intrinsic and extrinsic elements includes factors such as happiness, less disciplinary actions, and increased staffing for departments. RQ3 poses the question "What are the internal and external motivations that influence non-clinical departments to commit to new philosophy implementation?"

Data analysis showed that non-clinical upon successful implementation of the Eden Alternative model directors noticed an increase in job satisfaction within their care team. This addressed RQ3 that regarding the internal and external motivations that influence non-clinical departments to commit to new changes. Directors who manage front line staff referenced the difficult obstacles faced during implementation initially but ultimately with the new philosophy in place. Following are quotes from the participants that support the theme of Job Satisfaction:

> Well the elders are happy, the staff is happier, the families are happier. I feel it's less stressful sometimes it always works out better in the end I feel when the elders are happy it really makes your job easier. (P.2)

P6 noticed the increase in job satisfaction based on observing interactions with staff and residents . P6 said , "Absolutely - your elders just live a better quality of life and your employees are happier, elders are happier, family members are happier I mean overall it's the better way to have a nursing home community."

> You're going to find that since everyone is going to lift it up to doing more to meet the elder's needs they're happier and then because you know you're part of a thing that's benefiting it- an 80 year old who's at the end of their life you feel good about it. The blessing comes both ways- you're giving the blessing but you're also getting one (P.1).

P1,5,6 and 9 also specifically referenced elder satisfaction leading to job satisfaction for staff members within the community. The internal motivation of experiencing increased job and elder satisfaction played a large role in allowing the staff to remain committed to changes, which answers RQ3.

Aligned with RQ3, experiencing positive outcomes such as getting funding for additional staff to achieve implementation goals played a role in the external motivations to keep continuing with Eden philosophy implementation. Data analysis showed that all participants believed that their team was committed to the changes. P6 in particular referenced that there was a decrease in disciplinary actions and abuse allegations because of the increase of education as well as the organization's commitment and monitoring of

satisfaction. P3 referenced education because as healthcare employees, staff is constantly being taught on how to comply with changing rules and regulations. P3 said the resources were made available so staff had guidelines on how to address conflict, so it helped them feel more comfortable with all the changes taking place.

External motivation for RQ3 focuses primarily on the money and funding for staff that is made available to carry out an Eden alternative implementation. P2 mentioned that in order to complete Eden implementation corporate had to provide the staff and money to apply the Eden Alternative philosophies the right way. For dietary, a bistro chef was provided to the team which allowed for a better quality and reputation for the dietary department in that organization.

> I would never have gotten more staff now I have a bistro chef I didn't have that position. I have more to work with now that I did not have that before. We're slowly getting corporate to realize if you're going to do all things for all people at any time of the day or night you're going to need more money for patient day. Per patient day you get money so you have to get how much you're going to spend on this program because if you're saying yes to every food request then you have to have the money to back you. So we've been - as we were going along we've been getting increases in budgets to be able to jump through these hoops and say yes when they ask for extra food - specialty foods. So those are resources I get to have, the staff and the money have gone up a bit since we started Eden and I'm thrilled because we can show off if we've got the tools we can show off and do everything they wanted us to (P1)

The theme of job satisfaction really resonated with RQ3 because it touched on areas such as employee buy-in, happiness, decrease in disciplinary action and increase in communication and it reflected the internal and external motivations for staff to remain committed to a process they saw working.

Theme Two: Care Management

I was able to identify the theme of care management through data analysis. The theme of care management stemmed from the importance of leadership support, role players (such as front-line staff, mid-level management), and continuity of care in assuring that the Eden alternative model was successfully implemented. The care management theme addresses RQ1 and RQ3 questions for the study. The specific challenges that affect non-clinical staff were identified by directors and the response and involvement by the directors had a direct influence on successful philosophy implementation. This requires directors to assess and evaluate what is working and what is not and make the necessary changes to keep implementation going. If there are staffing, operating and risk management challenges the leadership support and role players (front life staff, mid-level management) must communicate with one another and get the funding or the staffing needed to address those challenges.

RQ3 focuses on the external and internal motivations that influence non-clinical departments to commit to new philosophy implementation. If there was staff resistance, it means that the internal or external motivations for the staff to buy-in must not have been met. There must be a reason why the staff refuses to move forward with the implementation and the leadership team has to figure out why and resolve it.

The participants in this study all recognized corporate involvement in pushing the Eden implementation forward. The specific challenges that affect non-clinical staff from a staffing, operating and risk management standpoint are impacted with the tools and enthusiasm corporate provides in the early phases. The level of corporate buy-in tied together with RQ2 because it was a challenge that influenced complete transition. The care management theme for the types of challenges and training required was placed on the shoulders of the leadership team and it showed in the responses:

> Then we jumped through hurdles and sometimes you need more staff you have to get approval and you have to hire the staff and train the staff there's a lot of things so about 6 months we were like ok we're on our feet but we're still now - I can say within a year or two we were looking pretty cute we were looking like we're doing it but still 3 years later we're still working the kinks out of some of these Eden things. (P1)
>
> I think again I'm a Rec therapist you have people who are stuck in their ways. I don't want to do extra work. They're looking at it is extra work. You have to kind of remind them that we're changing we're doing a shift in a whole mindset and that's what you'll do change it and shake things and it'll be what you do you'll know it as what you know. It's not extra work it's just working. What you're learning to do will become what you do. We're not the boss of the elders -they're grown. You're not good at your job. Making the changes - this is a better way of doing things and this is what we want for our loved ones. If elders are happy - that what you're there for. (P5)

> I would say that was one of our biggest challenges from a staffing - huge adjustment and a lot of people didn't understand why we were doing that. Even some elders because their used to - they've been institutionalized basically it's kind of hard to break them out of that as well. So that was definitely a challenge - we have lots of unforeseen issues pop up with that. As far as a financial - like I said it does cost to get care partners certified that was a piece of it. And the extra time and effort during implementation phase can cost more and the changes you're wanting to make. Whether its aesthetics seem to making their rooms more home like. Getting more sporadic activities like that - all of that cost additional money. (P6)

Data analysis revealed that all participants referenced the Eden alternative training seminars and the three day director training seminars as a significant part of their Eden journey. The commitment to training is the type of support that not only includes emotional support, but the money and resources invested by upper management directly effects the care provided to elders. The commitment and investment from management relates to RQ1 from an operating challenge and RQ3 for an external motivation for non-clinical departments to move forward with the Eden implementation. If the leadership is committed and on board then it shows the lower level staff that management is leading by example.

> It's a marriage between yes we're going to do this program but yes you're going to give me the tools and then you're staff if they're encouraged enough- and let them pick what they're going to do next that's a big part of it (P1).
>
> I mean yes - even I struggled in the beginning. Yeah I think that we all struggled to see how we'd make it work and who's going to have time for this we just can't fit one more thing on our plate I think we all individually struggled from management all the way to how are we going to work without a shower team and just a different way of doing things change is just hard. Honestly once you have that Eden training it takes - its different for everyone but it's an aha moment and when it's your AHA moment and once you have it you get it it's the right thing to do it might be a pain it might not be easy we might struggle but this is the right thing to do. (P7)

Data analysis revealed that all participants referenced the initial training received as part of the Eden implementation as a crucial part of their care management competency. The internal and external motivations that influenced non-clinical departments to commit to the Eden alternative implementation was driven by the leadership engagement. Participants 3, 12, and 15 mentioned the attitude of leadership and seasoned staff who had gone through a failed Eden Alternative philosophy implementation at another location and how it influenced their perception of whether the implementation process would work or not for the current home. If there had been members of leadership that did not buy in to the Eden Alternative, they presented serious implementation challenges because a mixed message on commitment led to staff resistance.

> Well, when we first started the training I had an employee who was on our core team that had been through the Eden training at another facility and it was a negative experience for her so she already had she kind of felt like the other company that did it did it for marketing purposes only and um so she was negative from the beginning of any kind of let the team know what issues they had before so that was a struggle. She's no longer here but she left on her own (P3).

The motivations of the staff to move forward with an implementation were hindered because some members of leadership were on different parts of the Eden journey than the other directors. According to P4:

> We would try to meet every week for about an hour and a half. You know, that doesn't sound like a lot but that's difficult to get all the leaders together for that hour and a half and to just set aside their time and really think Eden.
>
> We are all at a different point in the training you can't get them all caught up like someone who's been through the entire process it's going to take a lot of time so I had a struggle with new employees especially department heads who want to know what we all went through from the very beginning (P3).

P11 and P14 addressed the challenge with training as well as remembering core person-centered care values. Both participants listed these challenges in order to have consistency with continuity of care as the participating nursing facilities shift from the institutional model to the person-centered care model. This works in RQ2 as to whether identifying challenges (pertaining to RQ1) would determine complete transition to

achieve Eden Certification. RQ1 was designed to help the researcher identify the specific challenges whereas RQ2 is designed to allow the researcher to find out if identifying those challenges helped achieve Eden certification. Leadership was responsible for identifying the challenges and once they did the leadership team responded with continuing education and recommitment to basic principles to ensure the process did not fall through.

> I think I would probably have tried to do the initial teaching the entire philosophy I think I would've tried to do it on a more regular basis so it wouldn't have taken such a long period of time. We got to where we were looking to see who all were trained in the Eden principles and we got to looking and probably 75-80% of people we trained prior have gone somewhere else- they weren't here anymore. It was kind of almost like almost starting all over again. I feel like if we had more people that was thought this whole principle and the way they were doing I we still have a long way to go. There's a lot of things that could be done. (P11).
>
> Again I think the Ongoing training- we provided biannual 3 day training for staff members. We had what the Eden alt uses a lot learning circles - getting people together with any new information or new processes with new challenges. Getting everyone involved in the decision in how to solve this- including the elders obviously. (P14)

According to data analysis, if upper management is properly engaged with funding and commitment to Eden training it really helped having key role players in place to address implementation challenges:

> Oh yeah everyone does - it's not a departmental thing. It's people are either in or not either they support it or not. It's more of an Individual problem than not. We know managers influence department right? if they're not in support of an initiative it's going to be harder initiative for folks that they supervise it'll be harder to get around. (P13)

P15 also provided a very important explanation of why consistent leadership training plays a key role in successful Eden alternative implementation and it also addressed RQ1 and RQ2 of identifying staffing challenges and addressing them:

> Consistent training with new team members we get team members team leaders we use a mentoring program when you have a new employee come on board mentor in their discipline - and this mentor normally will always here be Eden trainee and supporting so the mentor can kind of help a new employee or even help older team members who have been here a while just remember if they pick things up that they bring them to their attention - vocabulary whether it be telling someone well it's time for your shower today as opposed we have your shower scheduled today is it still convenient for you it's giving them a choice. (P15)

The researcher uses RQ2 to ask if identifying challenges of adopting the Eden Alternative model from a non-clinical perspective would determine whether complete

transition is achieved. Elements of a clinical model are very strongly observed in the traditional "institutionalized model" for healthcare delivery. Quantitative metrics are used and converted into policies and the staff treat elders according to those metrics and provide strict and rigid care. For example, according to the nursing home state regulations for the state of Arkansas, regulation 452.5 states that the minimum supply of linen based on patient capacity shall be approximately two (2) bath towels per patient per week and four (4) washcloths per patient per week (Rules and Regulations for Nursing Homes Office of Long Term Care, 2006). This quantitative calculation placed in the regulation has a qualitative effect on care delivery. If no clean towels or wash cloths are available, nurses really struggle washing and caring for a patient because based on the patient's condition one might need more than the minimum standard enforced by regulation. Nursing assignments and care are then assigned to the aides based on the towels and wash cloths made available to the staff. If laundry is backed up or towels are accidentally thrown out it limits the number of towels and wash cloths available for staff to use to care for each patient. P14 explained how proper management engagement and training can achieve greater success with a person centered care approach as opposed to the institutionalized clinical model that is widely accepted.

> I guess you can say more institutional model are safer because they're very stay in the box. I don't know how good they are for people's well being. Part of well-being is taking some risks exploring things you're not used to. Being an Eden culture does opens up things - opportunities for residents and other team members but it without the education and explaining the why and how and what to people it

> can go south. If there's no structure to it people can veer off to different directions and we move the whole purpose of direction and care and choices and all that. (P14)

Theme Three: Warming the Soil

According to data analysis, the theme of *Warming the Soil* is crucial in the Eden alternative training because all 15 participants referenced it throughout their responses. Elements of *warming the soil* in the Eden alternative gauges how prepared a facility is for Eden implementation based on responses collected by an Eden tool known as the *Warmth Survey*. One example of the Warmth Survey being used was with Participant 3's comment. This participant was asked about how to keep staff motivated and encouraged and if the team felt like they were appreciated and accepted when making philosophy changes.

> I think it's just taking things one thing at a time - um you know we kind of do a learning circle to say what would our elders benefit from this I mean we kind of - I asked those questions so we- we figure out as a team whether we want to do something or not. we don't just do it to do it. We want to just see that benefit from the beginning, so I try to make sure they understand that benefit. (P3)

I reviewed the associated Warmth Survey to see if the responses were similar to those given by P3. One question that was asked in the Warmth Survey was, "my immediate manager/supervisor is interested in me and my development as a person". Twenty-four participants handed in Warmth Surveys in that home and 70.83% (41.67% and 29.17% respectively) listed either Strongly agree or Agree as their response. Another home

submitted their Warmth Survey and in the same question ninety-six participants handed in Warmth Surveys and 65.63% (23.96% and 41.67% respectively) listed either Strongly Agree or Agree as their response for the same question "my immediate manager/supervisor is interested in me and my development as a person". This survey allowed me to validate responses through triangulation.

The theme of *warming the soil* touches all three research questions. Data analysis revealed the specific challenges from staffing, operation and risk management perspectives that accompany the Eden Alternative model implementation. It identified the challenges during philosophy implementation and indicated whether staff concerns were addressed after implementation. Finally, it gave a strong indication into the internal and external motivations that influenced non-clinical departments to commit to new philosophy implementation. *Warming the soil* from an Eden perspective implies that change cannot occur if the foundations are not in place to accept and embrace changes. Perception and culture play a large role in the staff engaging in change. Commitment to culture is important as directors hire and onboard new employees:

> Well as all new approaches there's a lot of resistance something we had to encounter and work thru first year or two of Eden implementation at xxx part and that's exhausting its tiring with constant pushback's from folks. Most of the time its either folks who Choose never to follow new direction and in that case there are other - plenty of other opportunities in the field if you want to explore that but also knowledge and education really diffuses fear that comes with change so we had to do a lot with that (P14)

> From a staffing perspective it's hard to find good people that can really fit into the Eden alternative mindset. It just doesn't seem like it should be, but it is - it gets more difficult. (P15)

Data analysis showed employee buy-in and culture change as key factors in achieving successful Eden alternative implementation. Proper education and on-going training are the strongest determinants as to whether the facilities met their Eden phase goals.

> Most times a lot of organizations and organizations from where we' come from we say we're going to do stuff and we say we're actually doing it but when things get hard they cut it off. With this - even though things got very hard - again it's a startup with no direction we used Eden alternative as our guide. (P9)

When the soil is warm and ready for culture change it can help complete successful transition and that covers both internal and external motivations for a team to commit to changes. A driving force behind RQ3 and internal motivation is the idea to pitch the idea of culture change to any organization interested in the Eden alternative. The Eden training and continuous education focuses on changing a culture from an institutional model to a person centered model . The staff's internal motivations was an important part of the staff remaining committed to changes.

> I think the biggest advantage is that having a culture change allows care partners to be more independent with their decisions and feel that they have a say in the way things are done and not have all the different layers of people to go through to make decisions. I think that they get a good idea from the beginning that if

you're making a decision in the best interest of the elder that we're going to back you every time I think that's the biggest benefit. (P3).

Theme Four: Implementation Challenges

Through Data analysis, I uncovered that there were consistent implementation challenges throughout all phases of the Eden implementation process for all non-clinical directors. Implementation challenges appeared pre-implementation, post-implementation and during implementation for NF. RQ1 and RQ2 of identifying challenges and determining whether they influenced implementation could be seen from this data analysis. Each facility is unique yet data analysis revealed that consistent changes in staffing, financial and risk management issues played a role with how directors handled the Eden implementation process.

P3 attempted to prepare for the implementation while minimizing risk management issues for P3's nursing facility annual survey, P3 decided to compare any and all upcoming changes to the states regulations in order to ensure challenges will be anticipated as early as possible. According to P3, "sometimes I would get the -print off the regulations and we'll take a compromise of what we're doing and we'll try to implement it and also keep the regulations in tact as well so it's kind of a compromise". (P3) This preparation ensured that P3's facility remained compliant with state and federal regulations while also meeting the Eden alternative standards for philosophy implementation compliance.

According to data analysis, all participants referenced their training prior to implementing the Eden Alternative philosophy. During the training the risk management,

staffing and financial challenges of continuing with Eden implementation became apparent. Data analysis revealed the unique challenges facing non-clinical departments and compared it to the differences a clinical department experienced.

> You know I think I would say nursing especially the nurses and clinical leadership had some different challenges just because their mind set the way they were taught at school task oriented clinical mindset I think for that type of mindset it's more of a difficult concept to grasp - they want to think of the elder as a patient and what are their ailments what can we do to help with those (P10)

The clinical mindset of assessing quality is challenged when implementing the Eden alternative model. For the most part, non-clinical directors have to continue running their department and following regulations but ultimately ensuring that clinical outcomes and the health and wellness of residents are taken into consideration as well. This led to conflicting approaches to care delivery and management.

> The Clinical department has certain things that absolutely have to be done. As far as their much more regulated than we are- from the state standpoint. These residents have to get meds at a certain time they have to have 3 meals a day get to their meals they're a little more time constrained than we are if I don't change a light bulb for 5-6 hours alright nothing's going to happen if someone doesn't get their medication dose - we can get fined person can suffer physical harm if they don't get their medication they are much more hamstrung by the amount of documentation they have to provided. Takes that much more time based on documentation. Part of the whole process is to streamline methods of

> documentation to give our cnas and nursing team to give more time just to do their job and to have the ability to interact with residents more often and for longer periods of time (P15).
>
> I think with the Clinical department -I think with them they were very worried about tasks. They are measured on tasks if I had this amount of people and make sure this amount are clean and bathed and dry why should I take people outside or do a manicure because I can but if someone needs to get dressed bathed or toileting but you can't come do that for me. They were looking at it in that way - we had to explain. Even that was a challenge because we had to explain to them that one hand washes the other if a person is - when you're doing that we can have another group doing something else with them or doing that with them that'll lessen your time less wandering less acting out. We can see if someone needs something before it becomes something that you have to clean up. If someone's up and needs a restroom vs. if someone wandered off and used it in the hallway. We kind of helped each other in that way and yes I can't do your job but I can sure do other things that'll lessen your load (P5).

Integrating clinical care with a person centered care approach did not have specific instructions or guidelines to assist but it did require consistent management involvement and training to discuss and agree on what had to be done while meeting both Eden principles and healthcare regulations standards.

Staffing challenges for the Eden Alternative implementation appeared as a strong hurdle for the way non-clinical departments provided care. The Eden Alternative

principles took residents away from an institutionalized approach and introduced more of a concierge approach to healthcare delivery. In order to fully establish a concierge/on-call service, directors emphasized that corporate had to be prepared to financially support implementation ventures and provide directors with the staff and resources they needed.

> When we initially changed we probably had 30-40% turnover in front line staff. But now it's much lower 8% right now. Like I said, it's harder on new employees to work somewhere else. It seems to be harder because their set in their routine (P10)

There were two participants that also shared the same sentiments in regard to financial investment to undertake a change in quality of service provided. Participant 6 and Participant 8 both shared their thoughts on having enough money. According to P6, "Some things you can do to implement change that isn't too costly but when you're working on making it a more home like environment - changing things - a lot of that costs money." (P6) P8 followed up along the same lines by saying, "along with the financial aspect of you try to do more but you need more money to try to help improve things as well".

Staffing, and training the staff regularly, as well as getting the staff to buy in is an important challenge to address when implementing the Eden Alternative model. Participant 15 shared their thoughts on this matter by stating "from a staffing perspective it's hard to find good people that can really fit into the Eden alternative mindset." (P15) Staffing adds to culture and the culture for an Eden Alternative philosophy implementation goes past regular tasks. According to data analysis, directors had to ask

their staff to go above and beyond their normal scope of care delivery sometimes but used elders as motivation for their actions. The importance of empathy played a key role in Eden alternative philosophy implementation.

> It's an evolutionary process - starts with a simple thing here like vocabulary. F word here is a facility it's not a facility it's a community. It's where they live. It's really emphasizing to your team members and the residents that this is - that it's a paradigm shift you have to change the way you think about your life think about the people that are involved in your life it's done by training - where we do have consistent training where we do have consistent training. (P15)

MDS 3.0 Data - Nursing Home Compare

The final form of triangulation with sources of data was the MDS 3.0 data that was collected and displayed on the Nursing Home Compare tool. I logged onto https://www.medicare.gov/nursinghomecompare/search.html? in order to access a data base tool known as Nursing Home Compare. Each participant in this research study was associated with a specific a nursing home and that nursing home followed both state and federal regulations. The MDS is part of a federally mandated process for clinical assessment of all residents in the Medicare and Medicaid certified nursing homes.

The MDS 3.0 data is collected and any kind of false documentation is considered fraud and very dangerous to commit. The Minimum Data Set (MDS) is part of a federally mandated process for clinical assessment of all residents in the Medicare and Medicaid certified nursing homes. All assessments are completed within specific guidelines and time frames and it is transmitted electronically by nursing homes directly into the

national MDS database at CMS (Rahman & Applebaum, 2009). MDS is considered a legal and binding document because it has real consequences for residents and the care the residents receive. The integrity of this report is crucial and inaccuracies in the data can trigger deficiencies, fines, and sanctions, including civil or criminal prosecution with charges of insurance fraud (Medicare, Medicaid and private pay).

The inaccuracies of MDS is analyzed by state survey agencies every nine to fifteen months and if there are inaccuracies found, providers are cited for being non-compliant with the relevant federal "tag" (F-tag) (Dodson, 2016). This process is federally mandated and required for all homes therefore the data collected is a reliable tool to use to get an understanding of the quality readings for the nursing homes in the study.

The 15 participants were selected from 7 facilities; therefore, the MDS 3.0 data from those 7 facilities were used for triangulation in this study. Nursing Home Compare is a tool available to the public that provides general information, health inspection findings, fire safety inspections results, staffing levels, quality of resident care outcomes, and penalties enforced by CMS for deficient annual survey findings about each and every nursing facility that participates in the Medicare and Medicaid program. This data can be used to make a decision about whether the individual would like to admit their loved one to that nursing home. Under the quality of resident care tab, the nursing home profile utilizes data submitted to them from MDS 3.0 data and calculates that nursing home's percentage (elders who fall under the category observed divided by

total elders available) under each category. The first tab is the organizational information, the middle tab is the state data, and the third tab on the right is the national average.

The data for the seven homes represented in the study are presented below:

Table 4

Nursing Home A

Number of Hospitalizations per 1000 long stay resident days (Lower numbers are better)	1.95	1.81	1.7
Percentage of low-stay low-risk residents who lose control of their bowels or bladder (lower numbers are better)	80.90%	47.20%	48.20%
Percentage of long-stay residents who lose too much weight (Lower percentages are better)	6.30%	7.70%	7.00%
Percentage of long-stay residents who have symptoms of depression. (Lower percentages are better)	15.40%	4.70%	4.60%
Percentage of Long-stay residents who got an anti anxiety or hypnotic medication (Lower percentages are better)	22.30%	24.40%	21.60%

Table 5

Nursing Home B

Number of Hospitalizations per 1000 long stay resident days (Lower numbers are better)	Not available	1.48	1.7
Percentage of low-stay low-risk residents who lose control of their bowels or bladder (lower numbers are better)	76.10%	43.00%	48.20%
Percentage of long-stay residents who lose too much weight (Lower percentages are better)	6%	7.40%	7.00%
Percentage of long-stay residents who have symptoms of depression. (Lower percentages are better)	6.00%	12.80%	4.60%
Percentage of Long-stay residents who got an anti anxiety or hypnotic medication (Lower percentages are better)	16.80%	23.10%	21.60%

Table 6

Nursing Home C

Number of Hospitalizations per 1000 long stay resident days (Lower numbers are better)	1.47	2.22	1.7
Percentage of low-stay low-risk residents who lose control of their bowels or bladder (lower numbers are better)	63.90%	49.30%	48.20%
Percentage of long-stay residents who lose too much weight (Lower percentages are better)	15.60%	7.80%	7.00%
Percentage of long-stay residents who have symptoms of depression. (Lower percentages are better)	6.30%	1.20%	4.60%
Percentage of Long-stay residents who got an anti anxiety or hypnotic medication (Lower percentages are better)	28.90%	25.20%	21.60%

Table 7

Nursing Home D

Number of Hospitalizations per 1000 long stay resident days (Lower numbers are better)	0.81	1.67	1.7
Percentage of low-stay low-risk residents who lose control of their bowels or bladder (lower numbers are better)	62.10%	55.10%	48.20%
Percentage of long-stay residents who lose too much weight (Lower percentages are better)	7.80%	7.80%	7.00%
Percentage of long-stay residents who have symptoms of depression. (Lower percentages are better)	0.00%	1.20%	4.60%
Percentage of Long-stay residents who got an anti anxiety or hypnotic medication (Lower percentages are better)	18.10%	25.20%	21.60%

Table 8

Nursing Home E

Number of Hospitalizations per 1000 long stay resident days (Lower numbers are better)	1.06	1.74	1.7
Percentage of low-stay low-risk residents who lose control of their bowels or bladder (lower numbers are better)	59.20%	40.20%	48.20%
Percentage of long-stay residents who lose too much weight (Lower percentages are better)	4.90%	7.00%	7.00%
Percentage of long-stay residents who have symptoms of depression. (Lower percentages are better)	0.00%	1.60%	4.60%
Percentage of Long-stay residents who got an anti anxiety or hypnotic medication (Lower percentages are better)	21.00%	19.30%	21.60%

Table 9

Nursing Home F

Number of Hospitalizations per 1000 long stay resident days (Lower numbers are better)	2.48	1.95	1.7
Percentage of low-stay low-risk residents who lose control of their bowels or bladder (lower numbers are better)	46.50%	49.30%	48.20%
Percentage of long-stay residents who lose too much weight (Lower percentages are better)	6.80%	7.60%	7.00%
Percentage of long-stay residents who have symptoms of depression. (Lower percentages are better)	7.70%	2.50%	4.60%
Percentage of Long-stay residents who got an anti anxiety or hypnotic medication (Lower percentages are better)	33.80%	29.90%	21.60%

Table 10

Nursing Home G

Number of Hospitalizations per 1000 long stay resident days (Lower numbers are better)	Not available	1.26	1.7
Percentage of low-stay low-risk residents who lose control of their bowels or bladder (lower numbers are better)	83.10%	48.30%	48.20%
Percentage of long-stay residents who lose too much weight (Lower percentages are better)	6.90%	7.00%	7.00%
Percentage of long-stay residents who have symptoms of depression. (Lower percentages are better)	0.70%	3.40%	4.60%
Percentage of Long-stay residents who got an anti anxiety or hypnotic medication (Lower percentages are better)	11.90%	14.30%	21.60%

I focused on these quality measures because they used metrics much as "long-stay residents who have symptoms of depression" and "long stay residents who lose too much weight." These metrics are compared to both state and federal statistics. When assessing the statistics further, one can observe that although Nursing Home D had 7.8% of long-stay residents who lose too much weight, the state average is identical at 7.8%. The national average was 7.0% indicating that even though Nursing Home D had a higher percentage of long-term stay residents who lose too much weight compared to national figures, the rate aligned with the averages of other nursing homes in the same state. The participant's responses elaborated further on how the Nursing Home Compare results might be directly impacted from the actions of a non-clinical department such as dietary resulting in elders losing too much weight when staying long term.

> I can say within a year or two we were looking pretty cute we were looking like we're doing it but still 3 years later we're still working the kinks out of some of these Eden things. Yanno, they don't they're not perfected yet so we're still working on some of that stuff. And people go back to old habits so fast. So - before you know it people will be like oh no its 10 o clock you don't get anything until noon they're thinking the way it used to be where at we don't think like that anymore. If you want a hot meal at 10 you eat a hot meal at 10. It's constant but it took a good six months to get our feet under us to get moving. (P1)

Nursing Home D had 0.0% (none) of its elders in long term stay documented as having symptoms of depression. When looking at state averages, the nursing home is in an area where the local average for weight loss was 7.8% and 2.3% for signs of depression respectively. This means that after successful Eden implementation, the non-clinical departments achieved success in maintaining Eden status while also remaining compliant and providing high levels of quality care compared to local and national averages. I identified a director of dietary for nursing home D and reviewed responses for specific questions about post Eden philosophy implementation. These questions ranged from whether the director felt that the Eden philosophy implementation was worth doing to what the director would have done differently and even if the director preferred the old way of healthcare delivery.

> Oh yeah I think it's great, the elders benefit so much and as we buy into it, we're happier because they're happier if that makes any sense. You're going to find that since everyone is going to lift it up to doing more to meet the elder's needs they're

> happier and then because you know you're part of a thing that's benefiting it- an 80 year old who's at the end of their life you feel good about it. The blessing comes both ways- you're giving the blessing but you're also getting one. (P1)

When reading the participant's responses on happiness and overall attitude of both staff and elders, I was then able to corroborate that with the MDS 3.0 data that there were no long term stay elders that were documented as experiencing symptoms of depression in Nursing Home D. The next part of the triangulation process is checking the Eden Warmth Survey results that were handed out to elders (nursing facility patients) to complete. Under the elder's response section, for the statement "I am happy here"., 31 elders selected Strongly Agree, 12 wrote Agree, 4 wrote neutral, and none wrote disagree. The Warmth Survey data coupled with the MDS 3.0 data confirmed the validity of the participant's responses indicating that the elders and staff in the nursing home experienced positive changes in overall happiness when implementing the Eden Alternative model while achieving federal regulatory compliance for the quality of care provided at the nursing home. A quote that stood out from one of the participants relating to dietary emphasized the struggle and balance the dietary department went through in order to fulfill Eden expectations as well as the non-clinical responsibilities of the dietary department.

> We got to get everybody out of the wheelchairs and put them in real chairs for the dining room that takes people. I have to do all sorts of alternative foods and specialty foods that takes people to cook and serve. I have to get people that are in the kitchen to be able to pull out a full meal at 2 o clock in the afternoon when

> usually we're just doing breakfast lunch and dinner well I got elders who want to eat in the middle of the day so that makes a difference. And then money follows, because all this extra food is going to make a difference. Not only for the money for the staffing but the money for extra food - we need to buy all this extra specialty food. And the risk are what we mentioned with the if I got a puree diet and this persons in a wheelchair rolling down the hall if I haven't run around to make sure that they're safe to eat a brownie, that food is sitting there potentially to get lodged in their throat and choke them. I mean chase around to make sure everyone knows who's safe and who isn't and to make sure there's an alternative for that person to eat something safe. If there's nothing - kept saying that brownie is not pureed I have to make sure or if they're diabetic I have to make sure there's a diabetic appropriate snack on the hall which we do that as well. The risk of it is to make sure they're safe. (P1)

Nursing Home D averaged 7.8% of its total elder population in long term care as losing too much weight in the facility. If the family were to place their elderly loved one in any NF in the area, they too would experience somewhere around that 7.8% rate of losing too much weight. According to the Eden Warmth Survey results, under the Elder's response section, for the statement "I can choose what I want to eat", 9 elders selected Strongly Agree, 30 selected Agree, 2 selected neutral, 13 selected disagree and none wrote strongly disagree. The data analysis indicated that some participants found dietary functions challenging and the warmth survey data revealed that 13 elders interviewed disagreed when asked if they are able to choose what they wanted to eat.

The family who uses the Nursing Home Compare tool may look at the 0.0% depression statistic as the selling point to admit their loved one into that NF. I compare the participant's responses for Nursing Home D to understand why 7.8% of the elderly population are losing weight. Data analysis revealed that the participants from Nursing Home D eluded to the Eden alternative philosophy of saying yes more to requests whereas other nursing facilities would say no. The dietary staff would be required to cater more towards the dietary needs of the elders even though it may require the employee's full attention. One participant referenced the risk of being overworked as it pertains to having better oversight for staffing responsibilities.

> The disadvantages is that it is a lot of work- it is a LOT to come in and make sure - they start at 5 am and we don't leave until 9 o clock at night so it is a long day. Of checking to make sure that everything is getting done because if someone's not always pushing this boat forward it stalls or it goes backwards (P1).

The other piece of data used for data triangulation is referring to the Warmth Survey responses from the staff. The Warmth Survey questions that state *my work has meaning and purpose* the responses remain overwhelmingly high with 57 responses selecting strongly agree, 22 agreeing, 6 remaining neutral, and 0 responses disagreeing. The question *management actively encourages cooperation and teamwork* has 29 responses for strongly agree, 37 responses for agree, 15 responses for neutral and only 3 responses for disagree. The Warmth Survey data combined with the participant's account of Eden implementation outcomes can provide a strong background to the MDS 3.0 data outcomes on the Nursing Home Compare website

Discrepant cases

There is a participant that underwent the Eden alternative process twice, once in a previous facility and the second time in their current facility. I tried to focus the director's responses on one of the implementation processes but there might have been instances in which the director merged the summary of both experiences into their responses. References for responses may have gone back and forth between two different implementation experiences and there was no way of knowing if the participant's responses were influenced by one implementation experience or the other.

Summary

The purpose of my study was to identify the challenges of implementing the Eden Alternative model for non-clinical staff. Successful implementation depends on several variables and in a nursing home model care delivery must pass criteria to be deemed Eden certified as well as be in compliance to both state and federal regulations. In Chapter 4, I discussed the study setting, the Eden community partners that assisted me with the research and how I recruited and screened participants. The study followed a case study approach and I ensured that all participants provided informed consent prior to the interviews.

Through the data analysis, I was able to identify four themes related to my research questions. The three research questions are: First, what are the specific challenges that affect non-clinical staff from a staffing, operating, and risk management standpoint when implementing the Eden Alternative model? Next, will identify the challenges of adopting the Eden Alternative model from a non-clinical perspective

determine whether complete transition achieves Eden Certification? Finally, what are the internal and external motivations that influence non-clinical departments to commit to new philosophy implementation? The four themes are job satisfaction, care management, *warming the soil*, and implementation challenges.

The first research question focused on the specific challenges non-clinical staff faced from a staffing, operating and risk management standpoint when implementing the Eden Alternative model. The theme of warming the soil and implementation challenges were evident throughout this section. The job satisfaction theme included examples of assessing staff happiness in non-clinical departments. The decrease in discipline played a huge role with challenges because it encouraged the staff to make mistakes without the fear of losing their job. It encouraged connection with the patients over completing predetermined job responsibilities. The increase of staff seen throughout the data analysis effected job satisfaction because it informed the participants that if and when challenges arose, the participants will have the tools and resources to undertake a challenge such as facility wide culture change.

Research question number two identified if the challenges of adopting the Eden Alternative model from a non-clinical perspective would determine whether the NF achieved full Eden certification. The theme of care management was evident throughout the data as it focused on the support from leadership, the usage of key role players, and the continuity of care that remained throughout the implementation process. It was important to collect feedback and have participants that stayed on top of challenges in order to continue the momentum of policy implementation changes.

Another theme that was evident throughout data analysis was the theme of warming the soil. Warming the soil required active feedback and not only identifying implementation challenges but addressing them as they appeared. A useful tool for collecting feedback was the Warmth Survey questionnaires the Eden Alternative to provide feedback and gauge just how receptive the leadership team was for personal and professional concerns. The Warmth Survey is available for staff, elders (patients) and even family members of elders to use to provide feedback. This allowed me to read into whether implementation challenges were being brought up and whether or not those implementation challenges were addressed.

The non-clinical departments recognized that there were no specific step by step instructions that could be copied to succeed for all non-clinical departments because the Eden Alternative organization encourages every nursing facility to assess their strengths and weaknesses accordingly. The Eden Alternative model emphasizes that each nursing facility is unique, and it requires unique assessments by staff and leadership for their own unique challenges. A departmental policy for health care delivery that worked for one nursing facility may not be able to work for another nursing facility. Directors had to continuously address Eden Alternative implementation challenges and make adjustments accordingly in order to meet state and federal regulation standards as well as fulfill Eden certification requirements. It took on-going training from leadership and continuous feedback from staff to make sure the Eden Alternative implementation process did not stop.

Research question number three was a crucial in understanding RQ1 and RQ2. The complete data analysis for this study revealed that all participants had to address the internal and external motivations throughout the entire implementation process in order to commit to changes and change the culture of a nursing facility. The two themes that illustrated internal and external motivations were job satisfaction and warming the soil. The Eden alternative model required buy-in from staff and upper management. There has to be training from the very beginning to the very end. The participants had to address their staff's motivation and emotions in order to maintain the commitment toward adopting Eden principles into the long term care continuum.

The MDS 3.0 data that appears in the Nursing Home Compare tool reveals the quality of care metrics that the nursing home achieved. The clinical outcomes provide an idea of how the nursing home treated the health of residents and how that nursing facility compared to both state and national results. The participants acknowledged that the clinical department had different challenges than the non-clinical department in that the clinical departments were more rigid and had to follow more specific standards. The non-clinical directors focused on a more holistic approach that most elders were not accustomed to.

The Eden Warmth Survey data showed how willing the staff was to adapt to these changes as well as the skepticism they might have had when moving away from an institutional model. Warming the soil included the on-going training as well as the apprehension and length of time required to complete certification. Some participants provided a specific length of time while other participants have indicated that the Eden

implementation process is an ongoing venture and required constant warming of the soil to cultivate that kind of care.

The tools used for acquiring feedback revealed a better idea to the commitment nursing facilities involved in the study had towards the Eden alternative philosophy. The perception of how well the implementation process was going was captured by the warmth survey feedback from staff and elders. It is an important indicator of moving forward with a lot of changes at a nursing facility because it reveals buy-in from staff and directors.

In Chapter 5, I will elaborate further on the results and limitations of the study. I will examine the themes and categories that stemmed from the director's responses, the implications for social change and include my experiences as a researcher throughout this study.

Chapter 5: Discussion, Conclusion and Recommendations

Introduction

The nursing home industry is experiencing a surge of new admissions from the baby boomer population (Knickman & Snell, 2002). With new clients come new expectations and standards for the care that is being provided. CMS regulations understood the coming need for change with healthcare delivery and introduced new regulations that focuses on person centered care (CMS, 2013). The Eden organization is one of the organizations that nursing homes reach out to when trying to implement a more person-centric approach to health care delivery. During this study, I focused on the challenges that non-clinical departments face when implementing the Eden Alternative model. Metrics that measure non-clinical departments are not as easy to interpret than clinical metrics when determining quality of care at a facility and compliance with state and federal regulations.

When analyzing the data collected from 15 non-clinical directors from Eden certified homes, I found that the additional steps implemented helped the NF to reach Eden Alternative certification status as well as remain compliant with state and federal regulations. The theme of implementation challenges included the corporate buy-in that was necessary in providing enough funding and staffing to achieve the non-clinical aspects of the Eden Alternative model. Understanding the themes of implementation challenges and care management reveal the challenges faced by non-clinical directors to get staff to remain on board for new changes. For example, the introduction of centralized dining required adequate amount of staff to prepare, transport, and monitor elders which

increased elements of risk that the dietary director was now responsible for with Eden that was not present during an institutionalized approach.

Warming the soil themes addressed the pre-implementation, implementation and post-implementation challenges of engaging the staff and educating individuals on remaining Eden Alternative compliant. Warming the soil meant that directors needed to understand the perception the staff held towards the Eden philosophy changes. Collecting feedback and having open communication helped directors understand the level of commitment and buy-in the staff and other employees in a NF had towards new changes.

Constant training and education were required as staff struggled not to revert back to the institutionalized approaches to care delivery, they had been conditioned in. Staff turnover and director buy-in also played a role with how the Eden concepts and Eden language remained in place with the staff in the nursing home. The buy-in of the staff and elders were monitored by the nursing home leadership through the Warmth Survey evaluation tool. Understanding the theme of job satisfaction in the study revealed some of the internal and external motivations for non-clinical team members as it played a significant role in reaching and maintaining successful implementation of the Eden alternative model.

Interpretation of the Findings

The literature review in this field references the challenges of implementing any philosophy to a long-term care organization because of the differential influence of culture change models (CCM) on long-term care staff empowerment and provision of individualized care (Caspar et. al, 2009). The results of this research allow me to

elaborate on the motivations and influences (both internal and external) experienced during an implementation period for the Eden Alternative model in long term care nursing facilities.

After I completed the literature review for healthcare philosophy implementation, I was able to review the data analysis I completed for my study. Through the data analysis I was able to identify key barriers that often time limit or restrict introducing health policies. During this study, I gathered responses from 15 participants and problems occurring at various phases of implementation resembled the common barriers discussed by Gunn in previous research. According to Gunn (1978), there are 10 common barriers that exist when attempting to implement effective health policies:

- The circumstances that are external to the implementing agency impose constraints that make philosophy implementation very difficult
- There is a lack of adequate time and sufficient resources.
- The required combination of resources is not available.
- The philosophy to be implemented is not based on a valid theory of cause and effect.
- The relationship between cause and effect is indirect, and there are multiple intervening links
- Dependency relationships are multiple
- There are poor understanding and disagreement of objectives.
- Tasks are not fully specified in the right sequence.

- There are imperfect communication and coordination among implementation staff.
- Those in authority are unable to demand nor obtain perfect compliance from direct actors (Gunn, 1978, p. 173).

In existing literature for philosophy implementation, Laffont and Martimort (2009) pointed out the potential challenges of principal-agent problems. This occurs when an entity (known as the 'agent') is able to make decisions that impact another entity (the 'principal'). An organization exists because of decisions made by an agent and the principal is expected to comply with the rules and policies set in place and retain employment based on that compliance. In this study, I note what happened when an agent (NF leadership/ownership) decided to make numerous changes to a group of people. In this study the non-clinical departments of NF were considered the ‘principal’. Laffont and Martimort (2009) stated that the first phase of a philosophy implementation starts with interpretation. This requires a translation of the incoming philosophy into administrative directives (Laffont & Martimort, 2009). The next phase comes down to organization, which is the establishment of administrative directives and methods that are necessary to put that program into effect (Laffont & Martimort, 2009). Finally, the application is considered the phase where the principal (non-clinical department members) administers a service through routine compliance.

The nursing home industry is a highly regulated industry when it comes to surveys and regulation compliance (Medicare, 2015). The data analysis for this study revealed challenges from different non-clinical departments regarding pushing person

centered care policies but showed little to no negative impact on annual state survey results. Most participants responded that the department had great annual survey results after achieving Eden Alternative certification. According to CMS guidelines, survey results means adequate compliance to state and federal regulations. Successful Eden Alternative certification means person-centered care policies were implemented that promoted Eden Alternative principles and if a facility is achieving successful annual survey results while being Eden Alternative certified it means that the facility is reaching high quality of life and quality of care standards. According to Collier and Estaban (2007), employee buy-in would increase if the philosophy would prove to create a better atmosphere to work and improve NF experience for both staff and patients. For non-clinical departments (principal), the staff is following a philosophy that successfully achieves compliance under two separate entities guidelines: the CMS regulations for Medicare and Medicaid recipients and the Eden Alternative organization

Participants explained how the health policy implementation challenges appear and what steps were adjusted or included to have ensured continuation of the Eden philosophy implementation. Despite success with other versions of person-centered care models in the mid-90s (The Green House Project), NFs, in most cases, became more like hospitals and less like a home (Thomas, 1996). Hospitals discharged patients *sicker and quicker* and the nursing homes became the intermediate solution for patients between the hospital and going home (Thomas, 1996). Once I completed the data analysis, I understood the struggle for early Eden implementation as staff and patients clung to the

traditional model of healthcare delivery as the facility transitioned to a person centered model.

The Bressers (2007) CIT included governance and the motivation, cognitions and resources of actors as part of the driving factors behind philosophy implementation shifts. The goal of reducing water management problems across multiple platforms was addressed in order to reduce flood risks by Augustijn, Bressers, and Kruijif (2014). Similarly, the goal of successfully implementing a person-centered care model like the Eden alternative and complying with both state and federal regulations required NF leadership to take into consideration all layers of the organization. Examples of how the CIT further explains the study's findings can be seen further along in this chapter.

The findings of the study are broken down to key themes of job satisfaction, care management, warming the soil, and implementation challenges. These themes allowed me to address the three research questions presented in this study. Through the first research question, I was able to focus on the specific challenges that affect non-clinical staff from a staffing, operating and risk management standpoint when implementing the Eden Alternative model. The elements of funding, leadership buy-in, ongoing training and overall commitment align with Bresser's theory of understanding the actors on all sides and what it took for each party to buy-in to new policies and agree on potential solutions. Despite the training and background of non-clinical staff, the leadership of selected nursing facilities were able to adapt and adjust to bring non-clinical departments into full Eden compliance.

When interpreting the findings based on the CIT, I focused on themes that affect staffing, operating and risk management. Staff buy-in was assessed by the participant's willingness to identify what was not working and recommend solutions moving forward. The element of adequate funding and staffing appeared in the participant's responses as the participants felt comfortable having a line of communication with leadership. Participants were encouraged to request staffing or funding if it meant achieving succesful Eden Alternative transition. The participants had to interact with other disciplines to decide if more staffing or funding was available. In order to achieve full Eden Alternative compliance, some participant's lent staff to assist other departments. Expanding the responsibilities for a department such as dietary to help another department such as nursing reflected the CIT model of achieving success across platforms for the purpose of a singular goal.

The CIT was important to this study because identifying the challenges that are unique to non-clinical staff (actors) are critical to ensuring that motivations are addressed and drive the culture change shift to ensure success. Throughout this study, I confirmed that this theoretical framework applies to a person-centered care philosophy implementation. The second research questions asked if the challenges of adopting the Eden Alternative model were adopted from a non-clinical perspective determined whether complete transition achieves Eden certification. Non-clinical departments experienced additional challenges during the transition and meeting those challenges played a large role in overall facility buy-in towards the new philosophy.

When identifying challenges for non-clinical departments undergoing Eden philosophy implementation, the findings of the study provided instances where participants had to establish lines of clear and active communication and feedback between staff and directors. This was referenced by Gunn (1978) as he explained the most common barriers to implementing effective health policies. The staff for most participant's departments had to be encouraged to communicate issues to superiors and in most cases have the authority to act on issues without their superior's involvement if the outcome benefited the elders. The process of identifying challenges is encouraged as participant's reported a decrease in disciplinary actions. Non-clinical directors wanted there to be trust between the front-line staff and themselves. Front-line staff was encouraged to be honest and open with the mistakes made during implementation transition. The identification of challenges and barriers to successful Eden implementation became important, so participants encouraged staff to make suggestions and give feedback whenever possible.

According to Spratt (2009) when barriers to philosophy implementation were analyzed, most policies across the nation failed to achieve desired results based on specific barriers. Spratt proposed that a powerful determinant of whether a philosophy implementation will succeed is the final stakeholder's assessment of the process being implemented and whether specific recommendations were allowed to be heard and accepted. This means that in my study, the governing actors (NF leadership) adjusted throughout the implementation process according to the stakeholder’s assessments (non-clinical staff).

With the third research question, I focused on the internal and external motivations that influenced non-clinical departments to commit to new philosophy implementation policies. This research question is important based on existing research conducted by Edwin Locke that focused on motivation through conscious goal setting. Locke (1996) believed that another major issue to philosophy implementation is low motivation and commitment; personal, organizational or institutional motivation and commitment can facilitate the entire philosophy implementation process. Using the Warmth Survey as a litmus test was critical in revealing how the staff responded to ongoing changes and restructuring of policies and expectations.

When interpreting the findings and comparing it to CIT, the internal and external motivations aligned with what Bresser's stated during philosophy implementation in relation to CIT (Bressers, 2007). Those in authority should not demand or anticipate perfect compliance from front line staff (direct actors) when implementing new health policies. Numerous factors play a role in low motivation or commitment such as different priorities, a lack of incentives, and limited resources (Locke, 1996). My study correlates with Edwin Locke's findings that if internal and external motivations are met by the direct actors, front line staff in non-clinical departments would achieve higher levels of compliance with the tasks asked of them. The directors may understand what needs to be done but if the front line staff (actors) do not buy-in to completing tasks as instructed, then Eden certification cannot be achieved. If there is a poor understanding and disagreement of objectives for the front line staff (actors) to comply then the

directors need to identify it, correct it, or replace the front line staff with other employees who will adhere to person-centered care policies.

According to studies that presently exist on philosophy implementation, there are several barriers that organization's leadership positions face during policy transition (Spratt, 2009; Locke, 1996; Brodksy & Hirschfield, 2003). For most health policies, communication, engagement of stakeholder, and sufficient resources were listed as the most common barriers. With non-clinical departments, the transition to Eden alternative certification required clear communication between directors and front line staff. The CIT provided the framework to understand how various philosophies and training merged together to achieve success toward one common goal (Bressers, 2007). Overcoming several barriers were necessary for the selected participants to achieve success in both state and federal regulation as well as Eden Alternative certification.

Limitations of the Study

A limitation of this study may have stemmed from the surrounding environment of participants during the interview. Some participants were interrupted during the time designated for their interview and it could have resulted in a change of the participant's train of thought or rushed the participant in answering questions. The interruptions were documented in the transcript and often written out so the I knew where the breaks took place in the participant's responses.

Another limitation for accurate responses from participants may have been influenced by the length of time that has passed since the participant's NF officially starting Eden Alternative implementation. Questions were asked specifically on the

introduction of the process and early phases of the Eden implementation and participants admitted to having a hard time remembering specific details from so long ago. The general idea of the responses was provided but specific details might not have been remembered well.

One last possible limitation that occurred occasionally is when select participants underwent two separate Eden Alternative implementations with two separate organizations. When discussing thoughts and feelings toward practices, it was hard to decipher whether the thoughts and opinions toward the Eden process was from the current organization or from a prior organization's implementation process. I reiterated that the participant should discuss elements from the participant's current organization, but it would be very difficult to tell where the participant's responses came from regarding pre-Eden implementation concerns.

Recommendations

The development of new models for aging in place offers an opportunity to theorize about social capital in relationship to age (Bookman, 2008). The development of new models for aging in place in the United States are able to shift the public discourse about what it means to be old (Bookman, 2008). According to a study by Gail Wagnild RN, PhD (2001), 776 adults who were 55 years or older were asked to identify barriers to achieving their preferred futures as well as plans they were making to ensure that they could grow old where they prefer. Respondents were asked to identify the most important benefit of remaining in their homes as they age. The top four reasons were:

1) feelings of independence and control (61.1%)

2) feelings of safety and security (44.5%)

3) being near family (43.7%); and

4) familiarity with their surroundings (39.4%). (Wagnild, 2001).

There is an overwhelming need for healthcare entities to adopt person centered care and aging in place models (Kaldy, 2008; Kapp, 1999). The non-clinical challenges for nursing facilities were just one area that was not fully understood when it came to the Eden Alternative philosophy. There are other types of NF: assisted living centers, retirement communities, adult day cares, and hospitals that may have areas that quality surveys may not easily identify as a problem area (Hearld et. al, 2008). Identifying blind spots in quality assessments could lead to significant improvement in available nursing care options elder population will have access to.

With incoming changes to regulations and compliance for CMS guidelines, it is crucial that future studies understand the importance of person centered care models and the development of more efficient training models and limitations in barriers can significantly improve healthcare delivery to seniors in the future (Koren, 2010). The development of more comprehensive training programs can offer cost effective person centered care models and more nursing facilities will consider undertaking a philosophy implementation shift.

Implications

There is significant potential for positive social change with this study. The person centered care approach to healthcare delivery provides a humanized solution to

the systematic and institutionalized model of healthcare today (Thomas, 1996). The shift to a person centered care approach comes with challenges in financial requirements or policy development as well as risk assessment and regulation compliance. As Eden Alternative model continues to be implemented in more locations, some organizations may struggle to overcome unexpected challenges and it stunts growth or fails all together when taking on a philosophy implementation (Steiner et. al, 2006).

The participants of this study mentioned that they wished someone had told them about some of the challenges non-clinical departments faced prior to implementation, or they would have liked to follow a reference for what a functioning Eden home would look like. Ultimately, each home is unique, and it was difficult for Eden Alternative certified trainers to explain every possible scenario for participants. Having non-clinical directors share their experiences and challenges of reaching Eden Alternative certification could be passed along to future non-clinical directors as they prepare to undertake a person centered care journey on their own. If the organization is able to achieve Eden Alternative implementation success faster, they are able to save money as well as avoid high turnover and ultimately less disgruntled staff as the non-clinical directors navigate through numerous changes at once. Owners or governing bodies of nursing facilities, who are responsible for implementing philosophy changes would also able to prepare in advance since they would have the tools necessary to succeed early on as opposed to feeling blind-sided by unexpected costs or staffing requirements to achieve success.

The Eden Alternative organization understands that when individuals enter nursing homes, they must deal with the loss of family, friends, identity, autonomy,

physical functions, items accrued over a lifetime and even personal fulfillment (Eden Alternative, 2016). The Eden Alternative incorporates its own principles that focus on reducing suffering; promoting relationships with children and animals; companionship; opportunity to give as well as receive care; variety and spontaneity; meaningful activity such as caring for plants; making medical treatment the servant, not the master, of caring; placing decision-making into hands of older people; embracing continual human growth; and wise leadership that flows from relationships (Eden Alternative, 2016). These principles, if successfully implemented in a wider scope, can create very positive social changes in communities. The Eden Alternative philosophy places elders and front-life staff at the very center of the decision making process when it comes to care delivery and quality outcomes.

The individual, or the elder, who is late into the aging process can feel comfortable knowing they regain autonomy over decisions and are not placed in a metaphoric jail cell or institutionalized setting for the rest of their life. Front line staff for non-clinical departments are given expanded roles and responsibilities when providing care to elders in this system. The non-clinical front line staff is no longer asked to simply do institutional tasks solely designated to the department. Dining room staff used to simply deliver food and return back to the kitchen but the findings in this study show that the dining room staff can now engage with elders and sit and have conversations with them. This also has a positive impact on the staff, the elder, and even the elder's family who has the peace of mind of knowing their loved one is in a safe and nurturing environment.

During this study, I explored the challenges of implementing the Eden Alternative philosophy model, which is very easily considered a bottom-up approach to philosophy implementation. According to Foster-Fisherman and Keys (1997), the bottom-up approach is considered a much more interactive process as philosophy makers, actors and administrative members come together and change policies as implementation continues. A bottom-up approach represents the type of philosophy implementation approach where the individuals at the subordinate levels are expected to play a very active part in the implementation process, as well as have the discretion to reshape objectives of the philosophy as well as the way that philosophy is implemented (Foster-Fisherman & Keys, 1997). The themes of job satisfaction, warming the soil, care management, and even implementation challenges focus on the Eden Alternative implementation from the perspective of non-clinical departments with close proximity to the elders in a NF. Participants of this study referenced the hesitations and adjustments that took place during implementation. The participants recalled the constant training and reminders needed for front-line staff to remain focused during transition.

Care management themes were referenced as participants had provide leadership support to key role players in order to maintain the continuity of care delivery in NFs. Feedback was required from non-clinical front line staff and the employees who did not agree to Eden alternative philosophy changes were phased out and replaced with new staff. Qualified staff also referred to staffing levels and nursing facilities involved in the study had to field enough employees for non-clinical departments to achieve the results expected to be considered Eden certified. Policy adjustments, as mentioned by Foster-

Fisherman and Keys (1997) were heavily influenced by the non-clinical staff informing the directors on which "Eden leaf" they wanted to work on next. This differs from the institutional model of health care delivery and allows for positive social change for employees in the work place.

Warming the soil themes from participants highlighted exactly what it was like getting staff to buy-in to implementation changes and how the departments embraced change. The happiness and satisfaction in the elder's lives motivated many non-clinical staff members to continue moving forward with the Eden alternative model. I list examples of participant's listing specific interactions with Elders that may not have existed before in the institutional model of health care delivery. The staff was encouraged to say "yes" more often to elders and find creative ways to allow elders to make the most out of life. Resources, funding, risk management assessment and safety concerns were all addressed in this study as participants listed examples on what future facilities should look for in order to achieve similar success. This promotes positive social change because it lends a hand to future directors of non-clinical departments that may have overlooked the same challenges.

In order to understand this study's impact on positive social change, one has to accept that the Eden alternative model is valuable to future societies with how it shapes the health care model. My focus is to identify the challenges implementing this model for non-clinical staff. Thus, the value of identifying challenges and pointing out how the participants (directors of non-clinical departments) overcame difficult barriers is crucial in how the Eden model would successfully be presented to future nursing facilities. If

non-clinical departments failed to adapt to changing policies, nursing facilities would have to abandon its commitment to philosophy implementation and that can have lingering consequences to any organization. Time, training, and financial resources are wasted if the Eden alternative implementation is abandoned. Throughout this study, I sought to identify key factors and themes that appeared to address challenges as it appeared for non-clinical departments.

Conclusion

There are developments in the field of medical innovation and geriatric clinical intervention that impact the understanding of the nature of late life and the possibilities for health in advanced age, medical decision and family responsibility (Kaufman, et. al, 2004). The possibilities available for the elderly population may not have existed 15 years ago therefore medical standards, ethics, and risk management issues are updated and must be observed. The Eden Alternative philosophy is a person centered care approach to health care delivery that introduces plants, animals and pets into the long term care continuum (Thomas, 1996). It focuses on granting autonomy and freedom to the elder population and shifts away from a rigid institutional model of healthcare delivery. The institutional model has been so popular because of its ability to limit risk and increase efficiency in care delivery for health care model. As an entire industry shifts away from this approach and into a person centered care approach, the success and quality of service are affected by how the new model stands after implementation.

> "Much of the aging literature focuses on elders as individuals and their roles as *patients* of health care providers, *clients* of elder care service agencies, and

> *tenants* of housing. The development of new models for aging in place provides the opportunity to see elders as actors with agency, who can shape their physical environment and their social relationships, and have a positive impact on the future of the communities in which they live and the lives of younger generations". (Bookman, 2008 p. 434)

Person-centered care is a key concept in the culture change movement. Increasingly, health care providers, consumers, researchers and advocates are working to develop and implement new models of care that fundamentally change the way long-term care services are viewed and how it is delivered (Crandall, White, Schuldheis, & Talerico, 2007).

In this study, I focused on an important aspect of the NF that may have caused cancellations of a person-centered care implementation in the past for some organizations. For this study, I gathered together experienced directors of non-clinical departments for NFs that fully achieved successful accreditation by the Eden Alternative as well as remained in compliance with both state and federal regulations that are critical in maintaining funding and high ratings in public quality reports. The non-clinical department leaders attested to the benefit and value of having the Eden Alternative philosophy in place as well as highlighted some of the most critical challenges that threatened completion of this ongoing process. The participants in this study referenced some reasons why the Eden Alternative model failed implementation in other instances. Having those mistakes referenced in this study is significant moving forward as it

highlights areas of importance future parties may be interested in when undertaking an Eden Alternative implementation.

The study was not only selected to highlight challenges for non-clinical employees when implementing the Eden Alternative model but also point out how person centered care changes the way both staff and elders respond to aging in nursing facilities. The institutionalized delivery of health care models can be convenient and cost effective but there are non-quantitative metrics in place that are often times overlooked. A NF metric that is difficult to measure is dignity (Kaldy, 2008). Defining and measuring a resident's ability to maintain dignity requires an individual assessment from one person to the next. The Eden Alternative philosophy puts these non-quantitative metrics in perspective because it forces nursing facilities to consider the individual's personality and preferences as part of the care plan. Non-clinical and clinical departments work together to make elders feel as if they are more at home. The Eden Alternative model provides tools to NF leadership and staff to positively impact both an elder's quality of care received and quality of life experienced.

References

Allen, J. E. (2014). *Nursing home federal requirements: Guidelines to surveyors and survey protocols*. Springer Publishing Company.

Allen, J.E. (2011) *Nursing home administration* (6th edition). New York, NY: Springer Publishing Company, LLC.

Allen, P. D., Klein, W. C., & Gruman, C. (2003). Correlates of Complaints Made to the Connecticut Long-Term Care Ombudsman Program The Role of Organizational and Structural Factors. *Research on Aging*, *25*(6), 631-654.

Allen, J. E., & NHA, I. (2007). *Nursing home administration*. Springer Publishing Company.

Baker, C. (2014). Developing excellent care for people living with dementia in care homes. Jessica Kingsley Publishers: Philadelphia, PA.

Barba, B. E., Tesh, A. S., & Courts, N. F. (2002). Promoting thriving in nursing homes: The Eden Alternative. *Journal of Gerontological Nursing*, *28*(3), 7-9.

Bashir, M., Afzal, M. T., & Azeem, M. (2008). Reliability and validity of qualitative and operational research paradigm. *Pakistan journal of statistics and operation research*, *4*(1).

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The qualitative report*, *13*(4), 544-559.

Boer, C. L. (2012). *Contextual water management: A study of governance and implementation processes in local stream restoration projects*. Universiteit Twente.

Bookman, A. (2008). Innovative models of aging in place: Transforming our communities for an aging population. *Community, Work & Family*, *11*(4), 419-438.

Bowman, C. S., Edu-Catering, A. C. C., & Education, C. (2008, March). The environmental side of the culture change movement: Identifying barriers and potential solutions to furthering innovation in nursing homes. In *Creating Home in the Nursing Home: A National Symposium on Culture Change and the Environment Requirements* (p. 14).

Bressers, H. (2007). Contextual Interaction Theory and the issue of boundary definition: Governance and the motivation, cognitions, and resources of actors. *External report ISBP EU-project, ISSN 1381, 6357*.

Bressers, H., & de Boer, C. (2013). Contextual interaction theory for assessing water governance, policy and knowledge transfer. In *Water governance, policy and knowledge transfer* (pp. 56-74). Routledge.

Brodsky, J., Habib, J., & Hirschfeld, M. (2003). *Key philosophy issues in long-term care*. World Health Organization.

Brown, J. H. (2006). Interviewer as Instrument Accounting for Human Factors in Evaluation Research. *Evaluation review*, *30*(2), 188-208.

Brownie, S. (2011). A culture change in aged care: The Eden Alternative. *Australian Journal of Advanced Nursing, The*, *29*(1), 63.

Brune, K. (2011). Culture change in long-term care services: Eden-greenhouse-Aging in the community. *Educational Gerontology*, *37*(6), 506-525.

Buse, K., Mays, N., & Walt, G. (2005). Making health philosophy (understanding public health). *Berkshire, England: McGraw-Hill Education*

Campbell, J. L., Quincy, C., Osserman, J., & Pedersen, O. K. (2013). Coding in-depth semistructured interviews: Problems of unitization and intercoder reliability and agreement. *Sociological Methods & Research*, *42*(3), 294-320.

Cameron, E., & Green, M. (2015). *Making sense of change management: a complete guide to the models, tools, and techniques of organizational change*. Kogan Page Publishers.

Campbell, S. M., Roland, M. O., & Buetow, S. A. (2000). Defining quality of care. *Social science & medicine*, *51*(11), 1611-1625.

Carman, J. M., Shortell, S. M., Foster, R. W., Hughes, E. F., Boerstler, H., O'Brien, J. L., & O'Connor, E. J. (1996). Keys for successful implementation of total quality management in hospitals. *Health care management review*, *21*(1), 48-60.

Caspar, S., O'Rourke, N., & Gutman, G. M. (2009). The differential influence of culture change models on long-term care staff empowerment and provision of individualized care. *Canadian Journal on Aging/La Revue Canadienne du vieillissement*, *28*(02), 165-175.

Castle, N. G. (2001). Innovation in Nursing Homes Which Facilities Are the Early Adopters?. *The Gerontologist*, *41*(2), 161-172.

Castle, N. G. (2008). Nursing home caregiver staffing levels and quality of care a literature review. *Journal of Applied Gerontology*, *27*(4), 375-405.

Castle, N. G., & Engberg, J. (2005). Staff turnover and quality of care in nursing homes. *Medical care*, *43*(6), 616-626.

Castle, N. G., & Ferguson, J. C. (2010). What is nursing home quality and how is it measured?. *The Gerontologist*, gnq052.

Castle, N. G., Ferguson, J. C., & Hughes, K. (2009). Humanism in nursing homes: The impact of top management. *Journal of health and human services administration*, 483-516.

Cebul, R. D., Rebitzer, J. B., Taylor, L. J., & Votruba, M. E. (2008). Organizational fragmentation and care quality in the US healthcare system. *The Journal of Economic Perspectives*, *22*(4), 93-113.

Centers for Medicare & Medicaid Services (2010) Design for nursing home compare *Five-Star Quality Rating System: Technical users' guide.* Retrieved from: http://www.cms.hhs.gov/CertificationandComplianc/Downloads/usersguide.pdf.

Centers for Medicare & Medicaid Services (CMS). (2011). State operations manual appendix PP – Guidance to surveyors for long term care facilities. Rev. 11-07-2016. Retrieved from http://www.cms.gov/ Regulations-and-Guidance/Guidance/ Manuals/downloads/som107ap_pp_ guidelines_ltcf.pdf Centers for Medicare &

Centers for Medicare & Medicaid Services (2015). Home. Retrieved from: http://www.cms.gov/

Centers for Medicare & Medicaid Services, personal communication, May 24th, 2013.

Chang, W. Y., Ma, J. C., Chiu, H. T., Lin, K. C., & Lee, P. H. (2009). Job satisfaction and perceptions of quality of patient care, collaboration and teamwork in acute care hospitals. *Journal of advanced nursing*, *65*(9), 1946-1955.

Chassin, M. R., & Galvin, R. W. (1998). The urgent need to improve health care quality: Institute of Medicine National Roundtable on Health Care Quality. *Jama*, *280*(11), 1000-1005.

Collier, D., & Mahoney, J. (1996). Insights and pitfalls: Selection bias in qualitative research. *World Politics*, *49*(01), 56-91.

Coglianese, C., Nash, J., & Olmstead, T. (2003). Performance-based regulation: Prospects and limitations in health, safety, and environmental protection. *Administrative Law Review*, 705-729.

Coleman, M. T., Looney, S., O'Brien, J., Ziegler, C., Pastorino, C. A., & Turner, C. (2002). The Eden Alternative: Findings after 1 year of implementation. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, *57*(7), M422-M427.

Corbin, J. M., & Strauss, A. (1990). Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative sociology*, *13*(1), 3-21.

Crandall, L. G., White, D. L., Schuldheis, S., & Talerico, K. A. (2007). Initiating person-centered care practices in long-term care facilities. *Journal of Gerontological Nursing*, *33*(11), 47-56.

Cuddy, A. J., Wilmuth, C. A., Yap, A. J., & Carney, D. R. (2015). Preparatory power posing affects the nonverbal presence and job interview performance.*Journal of Applied Psychology*, *100*(4), 1286.

Cutler, L. J., & Kane, R. A. (2009). Post-occupancy evaluation of a transformed nursing home: the first four Green House® settings. *Journal of Housing for the Elderly*, *23*(4), 304-334

Cypress, B. S. (2017). Rigor or reliability and validity in qualitative research: Perspectives, strategies, reconceptualization, and recommendations. *Dimensions of Critical Care Nursing*, *36*(4), 253-263.

Darawsheh, W. (2014). Reflexivity in research: Promoting rigour, reliability and validity in qualitative research. *International Journal of Therapy and Rehabilitation*, *21*(12), 560-568.

de Boer, C., Bressers, H., Özerol, G., & Vinke-De Kruijf, J. (2013, September). Collaborative water resources management: What makes up a supportive governance context?. In *7th ECPR General Conference, Sciences Po, Bordeaux* (pp. 4-7).

Denzin, Norman K. (1973). *The research act: A theoretical introduction to sociological methods.* New Jersey: Transaction Publishers.

Department of Health, Education, and Welfare. (1961) Nursing Home Standards Guide.Washington, DC: Department of Health, Education, and Welfare; Public Health Service.

DePoy, E., & Gitlin, L. N. (2015). *Introduction to research: Understanding and applying multiple strategies*. Elsevier Health Sciences.

Devers, K. J. (1999). How will we know" good" qualitative research when we see it? Beginning the dialogue in health services research. *Health services research*, *34*(5 Pt 2), 1153.

DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical education*, *40*(4), 314-321.

Edelenbos, J., & Teisman, G. (2013). Water governance capacity: The art of dealing with a multiplicity of levels, sectors and domains. *International Journal of Water Governance*, *1*(1-2), 89-108.

Eden Alternative (2019, February 9th). *Mission, vision, values, principles*. Retrieved from . http://www.edenalt.org/about-the-eden-alternative/mission-vision-values/

Eden, C., & Ackermann, F. (2013). *Making strategy: The journey of strategic management*. Thousand Oaks, CA: Sage

Emanuel, E. J. (2000). Justice and managed care: four principles for the just allocation of health care resources. *Hastings Center Report*, *30*(3), 8-16.

Elliot, A., Cohen, L. W., Reed, D., Nolet, K., & Zimmerman, S. (2014). A “recipe” for culture change? *The Gerontologist*, *54*(1), S17-S24.

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process.*Journal of advanced nursing*, *62*(1), 107-115.

Estes, C. L., & Binney, E. A. (1989). The biomedicalization of aging: Dangers and dilemmas. *The gerontologist*, *29*(5), 587-596.

Forman, H. (2010). *Nursing leadership for patient-centered care: Authenticity presence intuition expertise*. Springer Publishing Company.

Foster-Fishman, P. G., & Keys, C. B. (1997). The person/environment dynamics of employee empowerment: An organizational culture analysis. *American Journal of Community Psychology*, *25*(3), 345-369.

Fayers, P., & Machin, D. (2013). *The quality of life: the assessment, analysis, and interpretation of patient-reported outcomes*. John Wiley & Sons.

Francis, J. J., Johnston, M., Robertson, C., Glidewell, L., Entwistle, V., Eccles, M. P., & Grimshaw, J. M. (2010). What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychology and Health*, *25*(10), 1229-1245.

Gardner, G., Gardner, A., & O'connell, J. (2014). Using the Donabedian framework to examine the quality and safety of nursing service innovation. *Journal of clinical nursing*, *23*(1-2), 145-155.

Gunn, L. A. (1978). Why is implementation so difficult. *Management Services in Government*, *33*(4), 169-176.

Grassley, C. (1999). The resurrection of Nursing Home Reform: A Historical Account of the Recent Revival of the Quality of Care Standards for Long-Term Care Facilities Established in the Omnibus Reconciliation Act of 1987, The. *Elder LJ*, *7*, 267.

Greenfield, S., & Nelson, E. C. (1992). Recent developments and future issues in the use of health status assessment measures in clinical settings.

Hammar, T., Finne-Soveri, H., Mikkola, H. M., Noro, A., & Hujanen, T. (2010). Quality assurance and quality management in long-term care. Helsinki, Finland: National Report

Handler, S. M., Hanlon, J. T., Perera, S., Roumani, Y. F., Nace, D. A., Fridsma, D. B., ... & Studenski, S. A. (2008). Consensus list of signals to detect potential adverse drug reactions in nursing homes. *Journal of the American Geriatrics Society*, *56*(5), 808-815.

Harrington, C., Choiniere, J., Goldmann, M., Jacobsen, F. F., Lloyd, L., McGregor, M., ... & Szebehely, M. (2012). Nursing home staffing standards and staffing levels in six countries. *Journal of Nursing Scholarship*, *44*(1), 88-98.

Hawes, C., Mor, V., Phillips, C. D., Fries, B. E., Morris, J. N., Steele-Friedlob, E., ... & Nennstiel, M. (1997). The OBRA-87 nursing home regulations and implementation of the Resident Assessment Instrument: effects on process quality. *Journal of the American Geriatrics Society*, *45*(8), 977-985.

Hawes, C., Moudouni, D. M., Edwards, R. B., & Phillips, C. D. (2012). Nursing homes and the affordable care act: A cease fire in the ongoing struggle over quality reform. *Journal of aging & social philosophy*, *24*(2), 206-220.

Hearld, L. R., Alexander, J. A., Fraser, I., & Jiang, H. J. (2008). Review: how do hospital organizational structure and processes affect the quality of care? A critical review of research methods. *Medical Care Research and Review*, *65*(3), 259-299.

Horton, J. A. (2005). A model leadership curriculum for managers of an Eden Alternative nursing home (Doctoral dissertation, University of New Hampshire).

Houghton, C., Casey, D., Shaw, D., & Murphy, K. (2013). Rigour in qualitative case-study research. *Nurse researcher*, *20*(4).

Hughes, R. G., & Mitchell, P. H. (2008). Defining Patient Safety and Quality Care. Retrieved from: http://www.ncbi.nlm.nih.gov/books/NBK2681/

Jacob, S. A., & Furgerson, S. P. (2012). Writing interview protocols and conducting interviews: Tips for students new to the field of qualitative research. *The Qualitative Report*, *17*(42), 1-10.

Jick, T. D. (1979). Mixing qualitative and quantitative methods: Triangulation in action. Administrative science quarterly, 24(4), 602-611.

Kaldy, J. (2008). Sadly, It's Hard to Measure Resident Happiness. *Caring for the Ages*, *9*(9), 10-11.

Kapp, M. B. (1999). The quality of care and quality of life in nursing facilities: What's regulation got to do with it. *McGeorge L. Rev.*, *31*, 707.

Karon, S. L., & Zimmerman, D. R. (1996). Using indicators to structure quality improvement initiatives in long-term care. *Quality Management in Healthcare*, *4*(3), 54-76.

Kaufman, S. R., Shim, J. K., & Russ, A. J. (2004). Revisiting the biomedicalization of aging: Clinical trends and ethical challenges. *The Gerontologist*, *44*(6), 731-738.

Koren, M. J. (2010). Person-centered care for nursing home residents: The culture-change movement. *Health Affairs*, *29*(2), 312-317.

King, N., & Horrocks, C. (2010). *Interviews in qualitative research*. Sage.

Kleppinger, A., & Robison, J. T. (2012). Are Baby Boomers Who Care for their Older Parents Planning for their Own Future Long-Term Care Needs?.

Knickman, J. R., & Snell, E. K. (2002). The 2030 problem: caring for aging baby boomers. *Health services research*, *37*(4), 849-884.

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. American journal of occupational therapy, 45(3), 214-222.

Kumar, A., & Lim, H. (2008). Age differences in mobile service perceptions: comparison of Generation Y and baby boomers. *Journal of Services Marketing*,*22*(7), 568-577.

Laffont, J. J., & Martimort, D. (2009). *The theory of incentives: the principal-agent model*. Princeton university press.

Lilford, R., Mohammed, M. A., Spiegelhalter, D., & Thomson, R. (2004). Use and misuse of process and outcome data in managing the performance of acute medical care: avoiding institutional stigma. *The Lancet*, *363*(9415), 1147-1154.

Locke, E. A. (1996). Motivation through conscious goal setting. *Applied and preventive psychology*, *5*(2), 117-124.

Lohr, K. N. (Ed.). (1990). *Medicare:: A Strategy for Quality Assurance* (Vol. 1). National Academies Press.

Mason, M. (2010). Sample size and saturation in Ph.D. studies using qualitative interviews. In *Forum qualitative Sozialforschung/Forum: qualitative social research* (Vol. 11, No. 3).

Matland, R. E. (1995). Synthesizing the implementation literature: The ambiguity-conflict model of philosophy implementation. *Journal of public administration research and theory*, *5*(2), 145-174.

McLellan, E., MacQueen, K. M., & Neidig, J. L. (2003). Beyond the qualitative interview: Data preparation and transcription. *Field methods*, *15*(1), 63-84.

McClellan, M., McKethan, A. N., Lewis, J. L., Roski, J., & Fisher, E. S. (2010). A national strategy to put accountable care into practice. *Health Affairs*, *29*(5), 982-990.

McLaughlin, M. W. (1987). Learning from experience: Lessons from philosophy implementation. *Educational evaluation and philosophy analysis*, *9*(2), 171-178.

Medicare (2015) www.medicare.gov. Retrieved from: https://www.medicare.gov/NursingHomeCompare/About/HowWeCalculate.html

Miller, R. (2001). Quality indicators keep nursing care on track. *Madison: University of Wisconsin-Madison*.

Mertens, D. M., & Hesse-Biber, S. (2012). Triangulation and mixed methods research: Provocative positions.

Mor, V. (2005). Improving the quality of long-term care with better information. *Milbank Quarterly*, *83*(3), 333-364.

Mor, V., Berg, K., Angelelli, J., Gifford, D., Morris, J., & Moore, T. (2003). The quality of quality measurement in US nursing homes. *The Gerontologist*,*43*(Suppl 2), 37-46.

Ory, M. G., & Cox, D. M. (1994). Forging ahead: Linking health and behavior to improve the quality of life in older people. In *Improving the Quality of Life* (pp. 89-120). Springer Netherlands.

Neuman, W. L., & Robson, K. (2012). Basics of social research: Qualitative and quantitative approaches.

Nesbitt, E. (2014). The Culture Change Movement among Nursing Homes: Social Workers/Health Care Professionals Perspective.

Noble, H & Smith, J. (2015). Issues of Validity and reliability in qualitative research. *Evidence-Based Nursing*, *18*(2), 34-35.

Rules and Regulations for Nursing Homes Office of Long Term Care 2 C.F.R. § 452 (2006)

Onwuegbuzie, A. J., & Byers, V. T. (2014). An exemplar for combining the collection, analysis, and interpretations of verbal and nonverbal data in qualitative research. International Journal of Education, 6(1), 183.

O'Toole Jr, L. J., & Montjoy, R. S. (1984). Interorganizational philosophy implementation: A theoretical perspective. *Public Administration Review*, 491-503.

Owens, K. A., & Bressers, H. (2013). A comparative analysis of how actors implement: Testing the contextual interaction theory in 48 cases of wetland restoration. *Journal of Comparative Policy Analysis: Research and Practice*, *15*(3), 203-219.

Punch, K. F. (2013). *Introduction to social research: Quantitative and qualitative approaches*. Sage.

Rahman, A. N., & Applebaum, R. A. (2009). The nursing home Minimum Data Set assessment instrument: manifest functions and unintended consequences—past, present, and future. *The Gerontologist*, gnp066.

Ransom, S. (2000). *Eden Alternative: The Texas Project.* IQILTHC Monograph Series 2000-4. San Marcos, Texas: Texas Long-Term Care Institute, Southwest Texas State University.

Reuvid, J. (2010). *Managing business risk: a practical guide to protecting your business*. Kogan Page Publishers.

Ritchie, J., Lewis, J., Nicholls, C. M., & Ormiston, R. (Eds.). (2013).*Qualitative research practice: A guide for social science students and researchers*. Sage.

Ritchie, J., Spencer, L., & O'Connor, W. (2003). Carrying out qualitative analysis. Qualitative research practice: A guide for social science students and researchers, 219-262.

Robinson, G. E., & Gallagher, A. (2008). Culture change impacts the quality of life for nursing home residents. *Topics in Clinical Nutrition*, *23*(2), 120-130.

Rosenthal, M. B., Fernandopulle, R., Song, H. R., & Landon, B. (2004). Paying for quality: providers' incentives for quality improvement. *Health Affairs*, *23*(2), 127-141.

Ross, A. (2012). Easy to say, hard to do: integrated surface water and groundwater management in the Murray–Darling Basin. *Water Policy*, *14*(4), 709-724.

Rubin, H. J., & Rubin, I. S. (2011). *Qualitative interviewing: The art of hearing data*. Sage.

Ruona, W. E. (2005). Analyzing qualitative data. *Research in organizations: Foundations and methods of inquiry*, *223*, 263.

Ryan, F., Coughlan, M., & Cronin, P. (2007). A step-by-step guide to critiquing research. Part 2: qualitative research. *British journal of nursing*, *16*(12), 738-745.

Saldaña, J. (2015). *The coding manual for qualitative researchers*. Sage.

Saliba, D., & Buchanan, J. (2008). Development and validation of a revised nursing home assessment tool: MDS 3.0. *Santa Monica, CA: RAND Health Corporation*.

Saliba, D., & Buchanan, J. (2012). Making the investment count: Revision of the Minimum Data Set for nursing homes, MDS 3.0. *Journal of the American Medical Directors Association*, *13*(7), 602-610.

Sangl, J., Saliba, D., Gifford, D. R., & Hittle, D. F. (2005). Challenges in measuring nursing home and home health quality: lessons from the First National Healthcare Quality Report. *Medical care*, *43*(3), I-24.

Scott-Cawiezell, J., & Vogelsmeier, A. (2006). Nursing home safety: A review of the literature. *Annual review of nursing research*, *24*(1), 179-215.

Seaton, D., & Edwards, C. (2012). Culture Change in Long-term Care.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for information*, *22*(2), 63-75.

Snowden, M., & Roy-Byrne, P. (1998). Mental illness and nursing home reform: OBRA-87 ten years later. *Psychiatric Services*, *49*(2), 229-233.

Sommers-Flanagan, J., & Sommers-Flanagan, R. (2012). *Clinical Interviewing: 2012-2013 Update*. John Wiley & Sons.

Spratt, K. (2009). Philosophy implementation barriers analysis: conceptual framework and pilot test in three countries.

Steiner, J.L., C. Eppelheimer, and M. De Vries. 2004. Successful Edenization through education. Nursing Homes, 53(3):46-49.

Stevenson, D. G. (2006). Nursing home consumer complaints and quality of care: A national view. *Medical Care Research and Review*, *63*(3), 347-368.

Talerico, K. A., & Swafford, K. L. (2003). Person-centered care. *Journal of Psychosocial Nursing and Mental Health Services*, *41*(11), 12-16.

Teddlie, C., & Yu, F. (2007). Mixed methods are sampling a typology with examples. *Journal of mixed methods research*, *1*(1), 77-100.

Thomas, E., & Magilvy, J. K. (2011). Qualitative rigor or research validity in qualitative research. *Journal for specialists in pediatric nursing*, *16*(2), 151-155.

Thomas, W. H. (2003). Evolution of Eden. *Journal of Social Work in Long-Term Care*, *2*(1-2), 141-157.

Thomas, W. H. (2006). *In the arms of elders: A parable of wise leadership and community building*. Acton, MA: VanderWyk & Burnham.

Thomas, W.H. (1996). *A life worth living*. Massachusetts: VanderWyk & Burnham.

Van Der Zaag, P. (2010). Water variability, soil nutrient heterogeneity and market volatility-Why sub-Saharan Africa's Green Revolution will be location-specific and knowledge-intensive. *Water Alternatives*, *3*(1), 154.

Vincent, G. K., & Velkoff, V. A. (2010). *The next four decades: The older population in the United States: 2010 to 2050* (No. 1138). US Department of Commerce, Economics and Statistics Administration, US Census Bureau.

Wagnild, G. (2001). Chapter 4 growing old at home. *Journal of Housing for the Elderly*, *14*(1-2), 71-84.

Wallace, R. B., & Herzog, A. R. (1995). Overview of the health measures in the Health and Retirement Study. *Journal of Human Resources*, S84-S107.

Walker, J., Pan, E., Johnston, D., & Adler-Milstein, J. (2005). The value of health care information exchange and interoperability. Health affairs, 24, W5.

Walshe, K. (2001). Regulating US nursing homes: are we learning from experience?. *Health Affairs*, *20*(6), 128-144.

Waring, J. J., & Bishop, S. (2010). Lean healthcare: rhetoric, ritual, and resistance. *Social science & medicine*, *71*(7), 1332-1340.

Warmth Surveys - The Eden Alternative®. (n.d.). Retrieved April 25, 2016, from http://www.edenalt.org/resources/warmth-surveys/

WHOQoL Group. (1993). Study protocol for the World Health Organization project to develop a Quality of Life assessment instrument (WHOQOL). *The quality of life Research*, *2*(2), 153-159.

Williams, C., Hadden, L., Mortimore, E., Nagy, F., Plotzke, M., & White, A. (2010, April). Measuring nursing home quality–the five-star rating system. In *Proceedings of SAS Global Forum 2010 Conference*.

Yeung, P. H. Y., Dale, M., Rodgers, V., & Cooper, L. (2016). The impact of person-directed care at Metlifecare-Application of the Eden Alternative. An interim report.

Yeung, P., Rodgers, V., Dale, M., Spence, S., Ros, B., Howard, J., & O'Donoghue, K. (2016). Psychometric Testing of a Person-Centred Care Scale–the Eden Warmth Survey in a Long-Term Care Home in New Zealand. *Contemporary Nurse*, (just-accepted), 1-41.

Yin, R. K. (2013). *Case study research: Design and methods*. Sage publications.

Zimmerman, D. R. (2003). Improving the nursing home quality of care through outcomes data: the MDS quality indicators. *International journal of geriatric psychiatry*, *18*(3), 250-257.

Zimmerman, S., Anderson, W. L., Brode, S., Jonas, D., Lux, L., Beeber, A. S., ... & Sloane, P. D. (2013). Systematic Review: Effective Characteristics of Nursing Homes and Other Residential Long-Term Care Settings for People with Dementia. *Journal of the American Geriatrics Society*, *61*(8), 1399-1409.

Zimmerman, D. R., Karon, S. L., Arling, G., & Clark, B. R. (1995). Development and testing of nursing home quality indicators. *Health care financing review*, *16*(4), 107.

Appendix A: Letter to Facilities

Date

Mr./Ms. X

Head of Center

Address

RE: Permission to Post Flyers to Recruit Research Participants

Dear Mr./Ms. X:

I am writing to request permission to post flyers to recruit participants for my research study, “Challenges of implementing person-centered care to non-clinical staff in Skilled Nursing Facilities”. The transition from an institutional model to the Eden Alternative model can be difficult. Non-clinical directors can offer valuable insight from their unique experiences during the Eden implementation. I am asking for your permission to **post a flyer** that advertises my study to recruit managers and directors of non-clinical departments as research participants.

I do not want to disrupt any work productivity and will work hand in hand to address any questions or concerns you have throughout this process. Your approval for me to recruit participants from your facility will be greatly appreciated. If you have any questions or concerns please contact me directly at my email provided below. Posting the flyers in your facility implies your approval and no further action would be required.

Sincerely,

Keith George, Walden University

Enclosures

cc: Dr. Magdeline Aagard

Appendix B: Letter of cooperation for the Eden Alternative

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EDEN ALTERNATIVE®

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November 15, 2017

To: Mr. Keith George
Subj: Permission to Use Eden Alternative Warmth Survey

Dear Mr. George,

I am writing to grant you permission to use the Eden Alternative Warmth Survey as part of your doctoral study. The Warmth Survey is available for employees, Elders, and family, and you are being granted permission to use all versions in your study.

Sincerely,

Christopner D. Perna
Presidnet & CEO

Appendix C: Interview Questions

I: Hello There - thank you for joining my dissertation study regarding the Eden Alternative implementation process. I will be asking you a series of questions that may last up to but no longer than an hour. At any time if you have any questions or want to repeat a question or retract an answer please let me know. If you are ready we will begin the interview is that ok?
I: How many years of experience have you had in the field? Tell me a little about your background.
I: What made you decide on this career path?
I: When did you first hear about the Eden Alternative philosophy?
I: What were your initial thoughts on an Eden alternative implementation?
I: What were some of the steps you took to prepare for an Eden alternative implementation?
I: Can you describe, in your own words, what's different from the Eden approach compared to the way the department was run before?
I: How long did this process take?
I: What were some advantages that you experienced in having the Eden Alternative approach versus the usual approach to problems?
I: What were some disadvantages that you experienced in having the Eden alternative approach versus the usual approach to problems?
I: What were some of the biggest challenges of implementing the Eden Alternative model?
I: Did you feel like other departments had similar or different challenges?
I: Can you list any of the challenges that you've experienced from a staffing, financial or risk management perspective?
I: What was done to address these challenges when they appeared?
I: What do you feel are the differences between your department and a clinical department?
I: What would you have changed or done differently when implementing the Eden Alternative philosophy?
I: How was the Eden alternative philosophy introduced to you and how did you introduce it to your staff?
I: What were you told would be different if you went with the Eden Alternative philosophy as opposed to the way things were currently run?
I: Describe your department demographics.
I: What are the skills and requirements to work in your department?
I: Do you believe your team was committed to the new changes? Why or why not?
I: Was there an increase in disciplinary actions because of the new philosophy?
I: Did any of your staff struggle to adapt to the new changes?
I: How did you keep your staff motivated or encouraged throughout this process?
I: How long did the entire implementation process take?
I: What do you think are the most pressing issues currently in your department?
I: How did your department do during annual state survey inspections?
I: Any deficiency or citations?
I: Did your department get better or worse after Eden implementation?
I: What were the reasons behind your department's deficiencies or citations?

I: How do you think they could've been avoided? What was your proposed plan of action to correct it?
I: When you reflect back on the Eden alternative implementation process, what do you feel could've been done differently?

I: Would you recommend the Eden alternative philosophy to be used in other nursing home facilities? Why or why not?
I: Do you prefer the old way things were running or the Eden alternative philosophy approach to healthcare delivery?

Appendix D: Aligning Interview Questions with Research Questions

Research Question	Interview Questions	Justification
Intro questions (background)	What's the title of the job you currently hold?	**Opening**
	How many years of experience have you had in the field? Tell me a little about your background.	
	What made you decide on this career path?	
	When did you first hear about the Eden Alternative philosophy?	
RQ1 What are the specific challenges that affect non-clinical staff from a staffing, operating, and risk management standpoint when implementing the Eden Alternative model?	What were some of the biggest challenges of implementing the Eden Alternative model?	Straight forward - allow the director to express all the issues
	Can you list any of the challenges that you've experienced from a staffing, financial or risk management perspective?	experiences leading non-clinical department
	How long did the entire implementation process take?	the length of time

	What do you think are the most pressing issues currently in your department?	outcomes after implementation
	What was done to address these challenges when they appeared?	addressing challenges can be challenging
RQ2 Will identify the challenges of adopting the Eden Alternative model from a non-clinical perspective be a determinant as to whether complete transition achieves Eden Certification?	Did your department get better or worse in regards to measured quality outcomes after Eden implementation in regards to complaints and outcome measures?	Opening dialogue about personal concerns
	What were some advantages that you experienced in having the Eden Alternative approach versus the pre-Eden implementation approach to problems?	highlights positives between usual approach vs. expected new approach
	What were some disadvantages that you experienced in having the Eden alternative approach versus the usual approach to problems	highlights negatives between usual approach vs. expected new approach
	What were the reasons behind your department's deficiencies or citations?	Successful implementation means good survey results because that's what the Eden alternative promises if facilities choose to elect the philosophy.

	How did your department do during annual state survey inspections?	Highlights deficiencies and shortcomings of departmental policies and practices
	What would you have changed or done differently when implementing the Eden Alternative philosophy?	specific identification of challenges
	Did your department receive any deficiencies or citations?	Highlights deficiencies and shortcomings of departmental policies and practices
	Did you feel like other departments had similar or different challenges?	Compared to clinical challenges that may have been addressed
	What were the reasons behind your department's deficiencies or citations?	identifying challenges
	How do you think these citations or deficiencies could've been avoided? What was your proposed plan of action to correct it?	Were the challenges acknowledged as reasons for the deficiencies?
	What do you feel are the differences between your department and a clinical department?	Compared to clinical challenges that may have been addressed
RQ3 What are the internal and external motivations that influence non-clinical departments to commit to new philosophy implementation?	Do you believe your team was committed to the new changes? Why or why not?	Internal and external motivations
	How did you keep your staff motivated or encouraged throughout the Eden implementation	Leadership question

	process?	
	What were you told would be different if you went with the Eden Alternative philosophy as opposed to the way things were currently run?	external motivations - promises, expectations
	What were your initial thoughts on an Eden alternative implementation?	Applies to bias and preconceptions of process
	What were some of the steps you took to prepare for an Eden alternative implementation?	Applies to bias and preconceptions of process
	Can you describe, in your own words, what's different from the Eden approach compared to the way the department was run before?	Applies to bias and preconceptions of process
	How long did this process take?	Applies to bias and preconceptions of process
	How was the Eden alternative philosophy introduced to you and how did you introduce it to your staff?	Applies to bias and preconceptions of process
	What were you told would be different if you went with the Eden Alternative philosophy as opposed to the way	external motivations - promises, expectations

	things were currently run?	
	Describe your department demographics.	background info related to question
	What are the skills and requirements to work in your department?	background info related to question
	Was there an increase in disciplinary actions because of the new philosophy?	Did it affect motivations?
	Did any of your staff struggle to adapt to the new changes?	Did it affect motivations?
Exit questions	Do you prefer the old way things were running or the Eden alternative philosophy approach to healthcare delivery?	**Closing**
	Would you recommend the Eden alternative philosophy to be used in other nursing home facilities? Why or why not?	
	When you reflect back on the Eden alternative implementation process, what do you feel could've been done differently?	

Appendix F: Participant Screening Questions

- What is your title?
- How long have you been with your current organization?
- Were you manager of your department before the Eden implementation?
- Were you the manager the entire time during Eden implementation?
- Are you currently the manager of the same department currently?
- Is your organization located in the United States?
- Did your organization complete a Warmth Survey?
- Do you know Keith George?

Appendix G: Eden Alternative Flyer Sample

EDEN ALTERNATIVE PHD STUDY!

Participants will receive a $15 Starbucks Gift Card!

Are you a Manager who underwent the Eden transformation?

I am currently enrolled in the College of Health Sciences at Walden University and I am in the process of writing my Doctoral dissertation. The study is entitled "Challenges of implementing the Eden Alternative model for non-clinical staff."

If you are interested in participating in this Doctoral research study, all you have to do is answer a few questions about your experiences transitioning from how things were before Eden to how things were after.

I am seeking managers of non-clinical departments to answer questions about some of their personal challenges transitioning to the Eden Alternative philosophy. You will be asked questions about staffing challenges, risk assessment, and even about your history as a manager.

Everything will be completely confidential and you will have complete control over your involvement at all times!

If this is something you would like to be a part of, please feel free to contact me at Keith.George@waldenu.edu

Thank you so much and I look forward to possibly working with you!