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Culture Change Management in Long-Term Care: A Shop-Floor View

STEVEN HENRY LOPEZ

Advocates of culture-change management suggest that the right sort of managerial philosophy can transform nursing homes from impersonal institutions into safe, caring communities. However, participant observation carried out at Heartland Community, a nonprofit culture-change nursing home, suggests that culture change founders on the structural problem of inadequate staffing. Resource limitations imposed by Medicaid and Medicare reimbursement rates mean that even nonprofit facilities desiring to maximize staffing cannot afford to hire enough staff to live up to basic care standards. Thus, above-average staffing notwithstanding, Heartland's nursing aides could not complete their work on time without compromising the quality of care by breaking important care rules. Resource limitations also forced management to adopt a series of punitive personnel policies that actively undercut the rhetoric and aims of culture change, turning culture change into a rhetorical device for shifting blame for care problems from structural resource limitations onto the attitudes of nursing aides.

Keywords: *culture change; care work; nursing homes; staffing crisis; Medicare; Medicaid*

It is 8:10 a.m. at The Heartland Community,¹ a religiously-affiliated nonprofit nursing home in the Midwestern United States, where I am working as a nursing assistant. I am behind. I am supposed to have my assigned residents up, washed,

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dressed, and in the dining room by 8:00 a.m., but I am still frantically dressing Mrs. West as she lies in her bed. I am trying to get her ready before the breakfast cart appears in the hall. If she is not ready in time, I will have to leave her in bed while I feed my other residents in the dining room; then I will spend half an hour in Mrs. West's room coaxing her to eat. If that happens, I will still be behind at lunchtime.

Like many other residents at Heartland, Mrs. West is supposed to be transferred from bed to chair using a Hoyer lift—essentially, a hydraulic crane with a canvas sling that slides underneath her. This is a two-person operation; one person is required to operate the lift, while a second person guides the sling into the chair. I leave Mrs. West and roam the halls looking for another aide to help me. No one is free; today everyone is behind. I cannot wait. I return to Mrs. West's room and decide to transfer her by myself, without the Hoyer. This is a fairly common practice at Heartland, although it is strictly forbidden because of its risks for residents and workers alike. I first saw this maneuver performed by Christine, the aide who had “oriented” me on Mrs. West's assignment. Christine had said, “She don't hardly weigh anything, and I don't have time to mess with that Hoyer. I always do her like this.” I had been shocked then—but now, with time running out, I place one arm underneath Mrs. West's knees and the other underneath her shoulders, just as I had seen Christine do. I lift her out of bed and I carry her to her wheelchair—a reclining contraption with large, padded leg supports to accommodate her stiff body. I cannot believe how heavy this tiny, frail woman is, or how easy Christine had made this look. I almost lose my balance trying to lower her into the chair; I end up dropping her clumsily into it. Mrs. West is not hurt, but she is breathing in ragged gasps and staring wildly at me. I realize with shame that she is terrified, and I try to soothe her, try to tell her that she is OK; it is over. Still, despite the risks involved in this method of transfer, in the days and weeks ahead I continue to use it with her, because Christine is right: it is the only way to get everyone ready for breakfast on time. Soon I am as quick and confident as Christine, and it no longer upsets Mrs. West when I transfer her this way. If I were ever caught in the act by a charge nurse or unit supervisor, I would surely be disciplined. But this does not happen.

This anecdote illustrates how the quality of care at the Heartland Community is deeply compromised by the routine shortcuts that nurses' aides are forced to resort to in order to complete their work on time. Yet Heartland is not, by the standards of the nursing home industry, understaffed or poorly managed. In fact, Heartland is one of the best nursing homes in the city, its staffing is higher than the industry average, and its management is committed to the Eden Alternative, a “culture-change” philosophy that in many ways exemplifies modern human resource management (HRM).

Advocates of culture-change management suggest that the right sort of managerial philosophy can transform nursing homes from impersonal institutions into safe, caring homes and communities. These advocates often support national

nursing home staffing standards and more money to pay for better staffing, but they also view culture change as the most important requirement for improving the quality of nursing home care—and they assert that culture change can lead to immediate improvements in care quality even under the current regulatory framework. Unfortunately, my detailed ethnographic study of Heartland Community suggests that such optimistic visions are seriously flawed. Whatever the potential benefits, the experience of Heartland Community suggests that culture-change management founders on the structural problem of inadequate staffing—a problem that cannot be addressed at the facility level. This article demonstrates that if better staffing alone cannot guarantee better care, neither can culture-change management compensate for the fact that, at present, even good nursing homes like Heartland cannot afford to hire enough staff to meet basic care standards. Even worse, culture-change management may actually become part of the problem, focusing attention away from serious structural problems and encouraging managers to blame caregivers instead.

NURSING HOME CULTURE CHANGE AND HUMAN RESOURCE MANAGEMENT

The Omnibus Budget Reconciliation Act (OBRA) of 1987 contained an unprecedented package of comprehensive reforms aimed at “demedicalizing” nursing homes and ensuring that nursing homes provided for residents’ quality of life in addition to meeting their physical care needs.² But even as these sweeping new rules began to be implemented in the early 1990s, visionary reformers like William H. Thomas, a nursing home physician from New York, reached the conclusion that such “conventional approaches to quality improvement” could not succeed in transforming nursing homes from “total institutions [that] damage people” into caring communities.³ A deeper effort to achieve “fundamental culture change” within nursing homes themselves was needed in order to reinvent nursing homes as “places where elders feel at home, family members enjoy visiting, staff are respected, listened to and appreciated, the care is good, life is worth living, and legal action is unnecessary.”⁴ A collection of organizations and advocates, including Thomas’s Eden Alternative, the Wellspring Model, the Live Oak Regenerative Community, and advocates of Resident-Centered Care and Individualized Care, linked forces in the 1990s to pursue culture-change goals. In 1997, the Pioneer Network was organized to coordinate the emerging “culture change movement.”⁵

The vision of culture change promoted by this new movement is basically a version of human resource management (HRM), a modern-day descendent of the human relations school of management theory.⁶ From the late 1930s, human relations theorists argued that in place of naked coercion, workers could be better motivated through effective leadership, through efforts to satisfy their needs for “self-actualization,” and via the redesign of jobs to make them more interesting and less monotonous.⁷ Humanizing the workplace, it was argued, would lead to a

happy marriage of increased productivity and job satisfaction for workers. Subsequent empirical studies had difficulty confirming human relations postulates,⁸ and critics skewered the perspective for its assumptions of managerial rationality and worker irrationality, as well as for its failure to incorporate any analysis of power.⁹ Nevertheless, the perspective has remained influential for more than half a century and continues to periodically spawn new movements promising to humanize the workplace.

Contemporary HRM is based on an updated critique of industrial relations emphasizing new managerial concerns with flexibility, quality, and worker initiative. According to John Storey's much-cited conceptualization, HRM seeks to build consensus around organizational goals; this allows organizations to move away from management by contract, reduces managerial reliance on detailed work rules, and empowers workers to act proactively.¹⁰ Conflict, negotiation, and adjudication, formerly institutionalized in "pluralist" collective bargaining frameworks, are de-emphasized in favor of transformational leadership that seeks to change organizational culture. The more harmonious relationships in the culture-change organization allow fixed pay grades, elaborate divisions of labor, and rigid work rules to give way to performance-related compensation and teamwork.¹¹ Like advocates of the original human relations school, contemporary proponents of HRM (and related approaches such as Total Quality Management, or TQM) contend that these managerial approaches can humanize the workplace, redefine and improve quality, and increase workers' commitment, job satisfaction, and performance.¹²

Adapting these ideas to the nursing home setting, reformers make similar claims on behalf of nursing home culture change. They argue that culture change shifts the focus from providing physical care to supporting relationships between elders and care workers, and that this in turn empowers both front-line caregivers (by allowing them to participate in care planning) and residents (by allowing them to make more decisions about their care).¹³ In place of rigid job assignments, "everyone help[s] wherever needed . . . Anyone could, and should, do whatever need[s] to be done, except where professional expertise [is] required."¹⁴ Proponents claim that the resulting improvements in the human relationships of the nursing home translate into tangible results on outcomes measures—reduced medication rates, less use of physical restraints, and slower decline in physical health and cognitive function—and that these results can be attained without major expenditures, at existing levels of staffing.¹⁵ Culture change advocates, like proponents of HRM, view transformative leadership from above and "buy-in" from below as more important than infusions of new resources.

Unfortunately, as yet there have been few studies of nursing home culture change, and those that have been conducted are of poor quality. In particular, culture change has not been examined from the perspective of the front-line care workers who are expected to "buy in" to it and to implement change on the ground—and this neglect of care workers' experience extends to the labor process

itself. Positive accounts of nursing home culture change either focus on outcomes measures of various kinds, or rely on vague descriptions of the labor process that make it impossible to evaluate exactly what care workers do or how they go about doing it. As a result, at present we do not really know how, or whether, culture change allows nursing homes to transform nursing home care with existing levels of staffing. Given that the average freestanding nursing home would have to improve nurse aide staffing by 44 percent in order to meet the minimum threshold for optimal care—estimated at 2.9 nurse aide hours per resident day (NA hprd) by the U.S. Department of Health and Human Services—this is an extremely important question.¹⁶

In order to understand the potential and limits of culture change for transforming the lives of nursing home residents and care workers, therefore, it is necessary to study the nursing home labor process directly. By plunging into the world of the nursing home aide, this article reveals how, even in a nursing home with above-average staffing, aides are forced to break important care rules, compromising the quality of care in the process, in order to complete their work on time. This article argues not only that culture-change management does not solve the staffing problem; but also that beyond this, the exigencies of running a nursing home in the real world—even given above-average staffing—lead management to adopt a series of punitive policies vis-à-vis front-line care workers that actively undercut the rhetoric and aims of the culture change movement. In this context, “culture change” can actually become a rhetorical device for shifting the blame for care problems from structural resource limitations to the work cultures of nurse aides.

RESEARCH SETTING AND METHODS

I chose The Heartland Community as a research site because of its local reputation for good care and good management, and because of its affiliation with the Eden Alternative, the largest and best-known nursing home culture-change organization. Founded in 1991 by New York nursing home physician Bill Thomas, Eden’s core insight is that most of the suffering endured by nursing home residents is caused not by physical pain but by boredom, loneliness, and helplessness. The “Edenization” process at Heartland involved an ongoing organizational self-critique aimed at creatively identifying and implementing new ways of addressing residents’ emotional and social needs—a process that proceeded from the explicitly and oft-stated premise that nurse’s aides cannot care compassionately for nursing home residents unless they are also accorded respect and dignity at work.¹⁷

A single-story, eighty-two-bed nursing home situated on an attractive campus that includes independent and assisted living high-rises and an adult day-care center, Heartland is a well-staffed facility by industry standards.¹⁸ Each day and afternoon shift aide cares for nine residents; at night, when residents are sleeping, the ratio is one to sixteen. There are also two “restorative aides” who assist residents

with exercise and range-of-motion on the day shift. These ratios mean that at Heartland there are 2.44 nurse aide hours per twenty-four-hour resident day (NA hprd)—short of the 2.9 NA hprd identified above as necessary for “optimum” care, but comparing favorably to the national average of 2.3 NA hprd for all nursing homes, and very favorably to the state minimum nurse aide staffing requirement of one nurse aide for every fifteen residents on all shifts (equivalent to 1.6 NA hprd).

From early April through the end of December 2004, I conducted nearly 1,000 hours of participant observation at Heartland. My activities were divided into three phases. During the first phase (in April and May of 2004), I volunteered four days a week with the activities department, assisting activities staff with the social and recreational program of the nursing home. During the month of June, I took and passed the state-approved nurse’s aide training course offered at Heartland, which included both classroom and practical instruction. In August I passed the state test and received my certification as a state-tested nursing assistant (STNA). From August through the end of the year, the period from which the data for this article is mainly drawn, I worked two shifts a week (thirty-six shifts total) as a nurse’s aide on the day shift, for which I was paid the usual starting wage of \$9.25 per hour.

I negotiated entrée to the site by pitching my project to the nursing home’s executive director, the administrator, and the director of nursing. I also agreed to meet with management at the conclusion of the study and provide feedback on the nursing home’s organizational practices. I made it clear up front that I would restrict my comments to organizational issues only and would not report on the performance of my coworkers, a condition to which management readily agreed, and which I also communicated individually to my coworkers when I told them about myself and my project. I told each of my coworkers about my dual role the first time we met; the project and my identity were common knowledge in the nursing home and I often spoke with coworkers and residents about it during the fieldwork.

Working regular shifts as a nurse’s aide—rather than relying on official records, interviews, or observations conducted on some other basis—was essential to the project. Very little of the interplay between organizational structures and everyday routines and interactions in direct-care areas of the nursing home is recorded in official organizational records. Also, since people’s descriptions of their own behavior are strongly influenced by social expectations and routinely diverge from their actual behavior, I considered this strategy to be superior to an interview-based approach. The labor process in question involved intimate physical care, and I needed to know not only how the work was officially supposed to be done, but also, in detail, how it was actually done and why it was done that way.

I carried out my duties as an aide to the best of my ability, while looking to my more experienced coworkers for crucial help and advice, without which I could

never have survived a single shift “on the floor.” My participation in routine rule violations, as well as the fact that I did not hide behind a façade of “neutrality” but instead honestly shared my views of organizational and managerial practice when asked by coworkers to divulge them, may have cemented my status as an (honorary) insider. Whatever the reasons, my coworkers overwhelmingly decided to trust me with the truth about what they did and how they did it, patiently instructing me in the tricks and shortcuts without which the work could not have been done. I have tried to honor that trust by carefully protecting the confidentiality of workers in my communications with management and in my writing, and by attempting to call attention, via this and other work, to the terrible choices our society forces on nursing home workers.

I recorded my observations in detailed field notes at the end of each shift. These were analytic field notes (Burgess 1982) consisting not only of detailed accounts or “thick description” (Geertz 1973) of everything that I did and observed during the shift but also of ongoing analysis of the meaning of, and questions raised by, these observations. I was influenced by the extended case method approach (Burawoy 1998), in which initial hypotheses are revised as field observations refute or modify them. Each successive entrance into the field, therefore, became an opportunity to test ideas formulated during analysis of the preceding day’s field notes.

CULTURE CHANGE MANAGEMENT AT HEARTLAND

In many ways the managerial regime at Heartland exemplified the principles of modern HRM. First and foremost, management at Heartland sought to exercise *transformational leadership*. Top staff viewed their commitment to the Eden Alternative as an ongoing effort to transform the culture of the facility, to recreate the nursing home as a caring community in which workers, not only nursing home residents, are members. Managerial interventions to this end were not limited to personnel matters but encompassed a *wide range of cultural, structural, and personnel strategies*. For example, during my time as a volunteer in the activities department, the activities director asked me to bake cookies several times a week and bring them around the floor on a cart. “I want this place to be filled with that wonderful aroma of baking cookies,” she said. “That’s one of the things that that makes someplace a home instead of an institution.” I was instructed to offer cookies to anyone who wanted one—residents and workers alike—thus reinforcing the idea that the community included caregivers as well as residents.

However, the caring community was explicitly not conceived as a democratic community or a community of equals. Rather, management reserved to itself the right to make rules and policies and to enforce them as necessary. Terms and conditions of work, for example, were not collectively negotiated; instead management exercised *unilateral* control over these matters. Management believed

that it made such decisions in the interest of the entire community, not simply in its own narrow interest. Indeed, the idea of the caring community at Heartland *de-emphasized* conflict, eclipsing any recognition of opposing interests.

Management clearly expected workers to go "*beyond contract*"—that is, beyond the narrowly defined terms of their job descriptions and assignments. If caring meant trying holistically to meet the human needs of nursing home residents, top staff emphasized therefore that no one should ever reply that "she's not my resident" or "that's not my job" if a resident—or a fellow worker—was in need of help and a staff member was in a position to lend assistance. Thus, *teamwork* was emphasized over a rigid division of labor. Although workers had their individual assignments, they were also encouraged to help one another—and some tasks, such as bed-to-chair or chair-to-bed transfers using mechanical lifts, explicitly required teamwork. This teamwork was not institutionalized in a formal system but rather was negotiated informally on the shop floor on an emergent basis—which could be frustrating at times, but which also represented a limited form of job autonomy. Job evaluation and rates of pay were not determined on the basis of fixed grades but rather on the basis of *performance*; each worker had an individualized annual review, upon the outcome of which her annual raise depended.

Management for its part viewed its job in terms of *nurturing* caregivers and *facilitating* their work as much as monitoring their behavior. And in my experience, top staff and line managers (i.e., charge nurses) did in fact generally live up to this principle. When they needed something done, they always asked nicely; I never ever saw anyone ordered about. Managers were often responsive and effusive with thanks as well. For example, one day I noticed an error in a daily assignment sheet about whose job it was that day to pass lunch trays to residents who took their meals in their rooms. The job had been mine but the assignment sheet was wrong and so the lunch cart sat in the hall for about twenty minutes before anyone noticed it. I went to the charge nurse and showed her the error on the daily assignment sheet, which was posted in the hub. She said, "Thank you very much for pointing that out, Steve—I'll make sure this gets fixed. The aides who have regular assignments don't even need to look at the sheet, but since you're a float—really, any time we have new aides it needs to be right or there'll be confusion." And she did follow up and fix the problem, thus showing her commitment to facilitating aides' work.¹⁹

Managers also regularly offered praise for work well done. On one occasion, I was following a resident's instructions for helping her get positioned comfortably in her heavy, powered wheelchair. A unit supervisor happened to observe the interaction and stopped me afterward to say, "Steve, you're doing a really great job. You're an important part of our community—I'm really glad you're here!" Of course, there were also occasions when management intervened in other ways, as when workers made mistakes. In this, too, I found managers to be sensitive and kind. One day, for example, a unit supervisor called me over and said, "Steve, I

just came in and noticed something that really is not OK. Would you come with me for a minute?" She led me to a room where one of my residents was sleeping. "Now," she said, "What's wrong with this picture?"

I looked at the resident and said with dismay, "Oh no, I left her side rail down." Whenever a resident was left unattended in bed, the side rail was supposed to be raised to prevent a fall.

"Right," said the supervisor. "And what else?"

I looked but did not see anything else wrong. "I'm not sure," I said hesitantly.

"You left the bed raised up to the highest position instead of lowering it when you were done," she said gently. Again I expressed remorse. She continued, "I know you're trying hard and you're doing fine. Pretty soon these details will be natural for you. Even experienced aides make mistakes like this too, so don't feel too bad." It was an important issue that needed to be brought to my attention, and I felt that the supervisor handled it sensitively, kindly, and in a way that reinforced my sense of myself as basically a good aide despite the mistake. In short, she handled it in a way that exemplified William H. Thomas's call for nursing home managers to make sure that aides are "respected, listened to and appreciated."²⁰

LABOR PROCESS IMPOSSIBILITIES

The positive features of the managerial approach at Heartland, however, did not address the most basic and fundamental problem of the nursing home: the fact that workers could not complete their work tasks in the time allotted if they followed official care rules and procedures. This was particularly the case on the day shift during the crucial period of "a.m. care," between the beginning of the shift at 6:30 a.m. and breakfast at 8:00 a.m., when residents were awakened, washed, dressed, and readied for the day. Especially during this intense period (but also at other points throughout the day), aides at Heartland were forced to devise their own work methods, violating official rules in order to match the workload with the time available. This resulted in an ironic situation: all of the workers justly felt that there was too much work and not enough time, even though experienced workers could complete their work in the given time by using shortcuts.

In order to understand why workers were forced to take matters into their own hands, it is useful to examine exactly what aides were officially required to do, and why it was impossible for aides to do these things in the officially prescribed manner. I focus here on a.m. care because it was the most difficult and intense part of the day shift, and because the conditions of work during a.m. care set the standard of care for the rest of the shift. Since official rules *needed* to be ignored during a.m. care, employees did not then become scrupulous about following every rule in the less intense afternoons.

A.m. care followed the same basic pattern for all residents (although there were variations depending on how much residents could do for themselves). It is necessary to describe these tasks at a level of detail that will allow the reader to

understand as precisely as possible what was involved and the amount of time it could reasonably be expected to take. Note that at this point I am describing not how the work was actually done but rather how the work would have been done if official rules had been followed. In the next section I will discuss real-world deviations.

The first thing aides were supposed to do when their shift began at 6:30 was “rounds.” Incoming aides were supposed to go from room to room, physically checking all residents—even those who were still asleep—to make sure that they had been recently changed or toileted by night-shift staff. This meant washing and drying one’s hands, donning latex gloves, checking a resident’s perineal area, stripping off the gloves and tossing them in the trash, and washing and drying once more. Aides were required to wash both before *and* after touching each resident to prevent carrying germs from one room to the next. Next, aides went to the linen room and collected all of the towels, facecloths, bed pads, and bedclothes that would be needed for the morning round of care, and brought these supplies to each resident’s room. Once the “linen pass” was completed, aides were ready to begin a.m. care on their first resident.

After knocking on the door, entering, and greeting the resident, the aide was required to wash and dry her own hands and don a pair of gloves. Next, the aide was supposed to fill two plastic washbasins at the sink in the resident’s bathroom—one with warm, soapy water, the other with warm clear water—and place a facecloth in each basin. These two basins, along with facecloths and towels, were to be placed on the resident’s bedside tray table. The bed was then raised to working height and the side rail lowered. The first task was to wash the resident’s face (using the unsoaped washcloth), and hands, underarms, and beneath her breasts (using the soapy washcloth), before rinsing and patting each area dry with a towel.

The aide next peeled back the bedclothes and the hospital-type gown in which residents slept, and washed the resident’s perineal area, front and back. Wipes were used to clean feces if present; dirty wipes were disposed of in a clear plastic bag; then the perineal area was washed with the soapy washcloth. According to the training course, the perineal area was supposed to be washed with nine separate front-to-back strokes, using a different area of the washcloth each time. Once this area was clean, the aide disposed of the soapy washcloth in a second clear plastic bag, and used the nonsoapy washcloth to rinse before patting dry with the towel. If the resident could not turn onto her side by herself to expose the buttocks, the aide rolled the resident gently away from her, and held the resident on her side with one hand while washing, rinsing, and drying with the other. The aide then applied any medicated creams left by the nurse (in the same kind of tiny paper cups like those used at Wendy’s for customers to dispense ketchup). After applying the cream, aides needed to put on clean gloves; some aides simply wore two pairs so they could remove one pair and keep going.

At this point the aide pulled the old bed pad out from under the resident (it was supposed to go directly into the dirty linen bag without touching the floor), and placed a clean diaper alongside the resident's buttocks so that when she returned to a supine position the diaper would be centered underneath her. The diaper was then fastened (a process that required pulling the front part of the diaper through the resident's legs, fastening the side closest to the aide, and then rolling the resident toward the aide in order to pull the other flap clear and fasten that side). Perineal care completed, the aide could finally remove the latex gloves, deposit them in a clear plastic garbage bag, and wash hands.

The next step was to dress the resident. Some residents could make decisions about which clothes they wanted to wear; with others the aide simply went to the closet and picked out an outfit. The aide began with socks; then pulled the resident's slacks up as far as they would go without rolling her; then put on the resident's shoes. Pulling slacks up over the resident's hips required rolling her once more in each direction. This was sometimes a difficult process, especially with residents whose limbs were stiff from muscle contractures. One resident's legs, for example, were permanently crossed, and no matter how hard I tried to pull them apart they always returned immediately to a crossed position. This made getting her slacks on a difficult and slow process.

Now the resident, bottom half fully dressed, wearing a gown on top, was transferred to her wheelchair. First the aide positioned the chair alongside the bed, then helped the resident to a sitting position on the edge of the bed. Using a "gait belt"—a wide cloth belt with an adjustable clasp—around the resident's waist, the aide was supposed to help the resident stand, pivot, and sit in the chair. Once the resident was safely in the chair, the aide was supposed to remove the gait belt and sling it back around her own waist. Then the aide removed the resident's gown, placing it in the dirty linen bag, applied deodorant (if used by the resident), and helped the resident don brassiere, blouse, and usually a sweater.

Once the resident was fully dressed, the aide performed "mouth care"—either brushing the resident's teeth (making sure to place a towel over the resident's clothes first) or applying dentures—and "hair care." Hair care could mean simply a quick hair-brushing or combing, but some residents had long hair that needed braiding, or a wig that needed to be put on and adjusted. If the resident wore makeup and/or perfume or needed a shave, the aide performed these tasks next. Then, after installing the resident's wheelchair footrests and positioning her feet on the rests, the aide transported the resident to the dining room for breakfast, where she put the resident in her bib (or "clothing protector," as we were required to call it).

Returning to the resident's room, the aide had a few final tasks. She made the bed, stripping off any bedclothes that were soiled or wet and placing a clean pad underneath the top sheet. She was now supposed to empty, wash, and dry the washbasins and put them away. The final job was to tie up the dirty linen and gar-

bage bags and take them to the utility room. After throwing them in the proper bins, the aide washed her hands again before leaving the utility room. Now she was ready for the next resident.

The main variations on this pattern dealt with two groups of residents: those who could stand and pivot on their own, and those who were too heavy, fragile, or immobilized to transfer using a gait belt. The former group could be helped into wheelchairs and taken to the bathroom, while the latter group had to be transferred to their chairs using a hydraulic lift and sling. This second group generally required more time in the morning since two workers were required to transfer them. An aide with this type of resident had to go hunting for another aide to help her. But even those who could stand and pivot were not necessarily quicker or easier to care for. Such residents typically moved slowly, required a good deal of encouragement, and could not be rushed too much. In other words, although not all residents required total care, more able residents did not necessarily require less time.

The question of how long it would take to perform all of these tasks is an important but somewhat hypothetical one, since, as noted above, aides did not in fact do things as described above. Timing myself performing the required tasks for rounds yielded a result of about one minute per resident (this of course assumes that none of the residents had any problems or requests that needed immediate attention). Given nine residents per assignment, approximately the first ten minutes of each shift were thus supposed to be spent on rounds. Passing linen to residents' rooms consumed another five minutes. Thus, aides following official procedures had used up about fifteen of the ninety minutes before breakfast, leaving about seventy-five minutes for the work of a.m. care itself.

How many residents actually received a.m. care from each aide during this period of time each morning? To answer this question, we have to know about the workload on each of the nine different assignments in the facility. Each assignment consisted of nine residents (except for Assignment Two, which had ten), but not all residents required a.m. care. Of the eighty-two residents in the nursing home, ten were independent and required no a.m. care, or minimal assistance. In addition, eight Heartland residents took their breakfasts in bed, and thus did not usually require any care until after breakfast. And night-shift workers performed a.m. care for twenty-one residents in the last two hours of their shift (between 5:00 and 7:00 in the morning). Thus, forty-one of the facility's eighty-two residents actually required a.m. care on the day shift before breakfast. Table 1 summarizes the distribution of residents from each category across the nine assignments in the facility.

Table 1 immediately reveals the great variation across assignments in the amount of work that aides had to perform between 6:30 a.m. and 8:00 a.m. At one end of the spectrum, day-shift aides on assignments 3, 5, and 9 each had six residents who required a.m. care before breakfast (known among the aides as "get-ups"), and assignments 1 and 8 had five such residents each. Assignments 4 and 7

Table 1
A.M. Care at Heartland, Day Shift, by Assignment

Assignment	1	2	3	4	5	6	7	8	9	Totals
Residents	9	9	10	9	9	9	9	9	9	82
Independent residents	2	5	0	1	1	1	0	1	1	10
Residents receiving a.m. care on night shift	2	2	2	4	2	3	3	2	1	21
Residents receiving a.m. care after breakfast	0	0	2	0	0	2	2	1	1	8
Residents receiving a.m. care on day shift before breakfast	5	2	6	4	6	3	4	5	6	41
Minutes per resident (assuming seventy-five minutes for a.m. care before breakfast)	15	37.5	12.5	18.8	12.5	25	18.8	15	12.5	16.7

had four “get-ups” each, while assignment Six had only three get-ups. The aide on assignment 2, the easiest assignment, had just two get-ups. Thus, the number of minutes of care available to each of the forty-one residents who received a.m. care on the day shift before breakfast varied from as few as *12.5 minutes per resident* on the three most difficult assignments to as many as *37.5 minutes per resident* on the easiest—with five of the nine assignments permitting *15 minutes or less per resident*. This variation led to significant differences in both the quality of worklife experienced by aides, most of whom were permanently assigned to a particular assignment, and the quality of care experienced by residents on different assignments.

My observations revealed that experienced aides at Heartland could complete a.m. care on most residents in fifteen minutes; some residents, who needed less assistance, could be done more quickly. This closely matches the conclusions of time-motion studies in which experienced aides were timed performing a.m. care, yielding a minimum figure of fourteen minutes for a.m. care for the 70 percent of nursing home residents who need the most assistance.²¹ However, at Heartland experienced aides managed to perform a.m. care in fifteen minutes *only through the use of prohibited shortcuts, by skipping steps, and by ignoring rules*. It seems likely that aides whose work has been timed in studies of a.m. care did the same because, in my judgment, it would be otherwise quite impossible to complete a.m. care on less-able residents in fourteen minutes. I myself was never able to do it in fewer than twenty minutes, *even using* all the shortcuts, tricks, and deviations from official procedure that I learned. Based on my own experience and my observation of and discussions with experienced aides, I estimate that it would take an experienced aide at least twenty-five minutes to perform a.m. care on any but the most independent residents if it were necessary to eschew the use of routine shortcuts and rule violations and instead to follow all official rules.

If this is correct, and if aides actually followed all care rules, they could reasonably have been expected to perform a.m. care on an average of *three residents*

before breakfast, given that there were only seventy-five minutes available for a.m. care before breakfast. Thus, workers on the three most difficult assignments would have needed *twice* as much time (or half the number of residents) in order to be able to follow official care rules. Only workers on assignments 2 and 6 had enough time to perform a.m. care in the officially prescribed manner—an important finding in its own right. If my analysis here is correct, current estimates of minimum staffing required for “good care” (a minimum of 2.9 NA hrpd, which would already require large increases in nursing home staffing as noted above)—are too low, because it is virtually certain that the aides in the time studies on which the estimates are based achieved realistic task completion times by deviating from official rules. If we would like nursing homes to be staffed at a level that would enable aides to actually follow all care rules, it is likely that nursing home staffing would have to be even higher than 2.9 NA hrpd.

CARE AS TRIAGE

The mismatch between time, tasks, and official rules documented above raises an obvious question: what shortcuts did nurse aides adopt in order to get their work done on time? What were the real-world effects of “above-average” staffing? When I oriented with Sheryl on assignment 3 (the most difficult assignment), we split up the residents—I took two and she took four. Working side by side, we just managed to get everyone to the dining room in time for breakfast. I commented on this and asked her how she managed it by herself. “Makes you wonder, don’t it?” she said. “I wish the nurses would ask themselves that question. . . . Since I had help today I had time to do a few things that I usually just have to skip.” This section examines in detail the kinds of things that workers were routinely forced to skip at Heartland.

The first observation in this connection is that no one ever did rounds at the beginning of the shift. The idea of rounds was covered in the state-approved training course—but the first time I ever heard it mentioned on the floor was by a charge nurse, about a month into my stint as a shift worker. The night shift had been shorthanded that morning, and about 8 a.m., a physical therapy aide reported to me that one of my residents, who had been up since the night shift awakened and dressed (presumably at some time after 5 a.m., but there was no way to know for sure), was soaking wet. Night shift was supposed to have changed her before going off at 6:30 that morning, but evidently it had not happened. The resident’s diaper, filled to its absorbent capacity, had leaked and her slacks were soaked. The restorative aide said, “If I was you I’d go straight to [the charge nurse] and complain. Night shift gets her up, and they’re supposed to make sure everyone’s dry when they leave.”

I approached the charge nurse and explained the situation. She replied, “Did you do your rounds?”

“Rounds?” I said.

"I know, no one does them," she said. "But you really need to do it, otherwise when stuff like this happens you can't prove that the resident was that wet when you came on shift. You need to check every one of your residents, physically go in and check their Depends, first thing when you come on, otherwise you're responsible." I did not tell her what I was thinking: that the reason no one did rounds is that there simply was not time.

Another way aides saved time was by eliminating the entire business of the two plastic basins (one with soapy water, the other with clear) for washing residents. Instead, aides simply turned on the hot water tap at the resident's sink as soon as they entered the room and dropped a facecloth in the sink. By the time they were ready to wash, the water was running hot and the facecloth was wet. They grabbed the facecloth, splooped some soap on it from the wall dispenser, and dropped a second facecloth in the sink for rinsing. This saved several crucial minutes that would have been spent filling up two washbasins at the larger, bathroom sink and carrying them in, one at a time, to the bedside table, and additional time emptying and washing them out afterward. However, residents' sinks were not necessarily clean, so from an infection-control point of view this solution was not ideal.

When working with residents who wore pull-ups instead of diapers and used a toilet or bedside commode, aides saved time by putting the resident on the toilet, then working with the next resident for five minutes or so. In the training class we were told that it was absolutely never allowed to leave a resident alone in the bathroom, because of the danger that the resident might fall, but on most assignments there was no time to stand around waiting. The only way to complete a.m. care on time was to do other work while residents who could use the toilet did so. In some cases, residents who were supposed to be toileted could not be counted on to remain seated but would try to get up. Like other aides, I simply put these residents' pull-ups on in bed instead of taking them to the toilet. This was faster and safer—but of course it rendered moot official care plans directing that aides were supposed to encourage these residents' continence.

I never saw an aide use a gait belt to transfer a resident from bed to chair (or chair to bed) during the entire period of my fieldwork, and I never used one. The problem with the gait belts was that they took too long to adjust. They needed to be fairly tight, otherwise when the resident stood up the belt would be too loose and would end up underneath her armpits. But of course the belt could not be too tight either. In the time one would have spent fussing with and adjusting the belt, experienced aides could transfer a resident from the bed to the chair and back twice over simply by leaning in, saying, "OK, give me a hug," locking their arms behind the resident's upper back, standing up, turning, and then sitting the resident down. This method was of course harder on workers' own backs as well as riskier for residents—but it was faster.

Another way aides trimmed precious minutes was by taking bags of dirty linen, clothes, and garbage (including human waste) from room to room with them instead of walking all the way down the hall to the utility room and back with

each residents' refuse. "We're not supposed to take bags from one room to another," Danielle told me as she oriented me on her assignment. "But unless it's really poopy and gross, we do it to cut down on the number of trips." There were sound public-health reasons for this rule; with eighty-two residents, there was usually someone suffering from the flu or a cold at the very least, and it was important to try to prevent bacterial and viral infections from spreading throughout the facility every time someone came down with something. Aides like Danielle understood this and would rather have not cut this particular corner, but they were forced by exigency to choose between this compromise and worse ones.

Perineal care was yet another area that received short shrift as a result of time pressure during a.m. care. Instead of folding and refolding the washcloth to expose nine clean wiping surfaces, as I was taught to do in the training course, aides simply made a single quick swipe between residents' legs. Many residents, especially those suffering from dementias, resisted and struggled against "peri care," and I noticed that aides did not always take the time to pry their knees apart and make sure they were really clean.²² This was one shortcut that actually had immediate health effects: poor peri care is one of the main causes of urinary tract infections (UTIs). Indeed, during the period of my fieldwork, Heartland experienced a spike in UTI rates that showed up in its official quality indicators. Management addressed the problem by scheduling mandatory individual "brush-up" trainings on peri care with Maureen, the director of staff development (a registered nurse who also taught the training course).

When I went down to the classroom to take the brush-up training, Maureen first asked me to show her how I did peri care on a female resident, demonstrating on an anatomically-correct dummy. I decided that I had better do it the way I had been trained, so I got out the two basins, folded my washcloth in the approved manner, and made the nine separate swipes, refolding the cloth each time to expose a new surface. Maureen said, "That's very good! You're doing peri care correctly. We need to make sure that we do it this way every time." Then she went on to explain about the rise in UTI rates, and said, "A lot of aides have just gotten out of the habit of doing it the proper way. They just need a reminder, you know, to get back on track." I held my tongue, unable to believe that Maureen actually thought that aides could go through this whole routine every time they changed someone.

Some of my coworkers, though, appreciated the training. "Well," one said, "I thought it was good, you know, to make sure that we are doing things the proper way, taking time to do it right." I asked her whether she was now doing peri care in the officially approved manner, with the two wash basins and the nine passes with different faces of the washcloth each time. "Hell, no" she said. "There's no time for that—I just took it as a reminder to try and make sure I get 'em clean." Interestingly, in the wake of the brush-up training, the UTI rate did improve. From one perspective this might be viewed as confirming the effectiveness of the intervention. It seems obvious, however, that any additional time workers spent on peri care was necessarily being stolen from something else. Treating the issue as if the

problem was workers' forgetfulness was like playing whack-a-mole. This problem might get better for a while, but something else would, necessarily, get worse.

I believe that management understood these issues. Maureen, after all, was an experienced former nurse aide herself and understood very well the realities of the floor. Despite my initial, incredulous reaction, it now seems unlikely to me that she was as naïve as she seemed. The notion that workers generally followed the rules but perhaps needed periodic reminders and refreshers, however, was a necessary fiction for managers like Maureen because they simply could not afford to hire enough staff to enable aides to follow the rules.

To understand why this is so, it is necessary to consider some basic facts about the way that nursing home care is paid for. Approximately 80 percent of nursing home revenues come from Medicare and Medicaid.²³ Medicare pays for short-term stays only, while Medicaid pays for long-term care for the indigent. Medicaid pays for nearly 70 percent of all nursing home care—but because Medicaid reimbursements are substantially less generous than Medicare reimbursements, Medicaid payments account for less than half of nursing home revenues.²⁴ According to the U.S. Department of Health and Human Services, even if all nursing home care was reimbursed at the substantially higher Medicare rate, this would still not be enough to cover the nursing costs associated with a hypothetical minimum nurse aide staffing level of 2.9 NA hrpd.²⁵ Given these realities, managers like Maureen know that no level of staffing that their facility could afford—at least under the current reimbursement system—would allow nurse aides to actually follow official care rules and policies. And yet, since these policies are imposed by federal and state regulations and (at least theoretically) enforced by state inspection agencies, managers must forget what they know and pretend that policies are indeed being followed.

RESOURCE LIMITATIONS AND WORKER MORALE

The fundamental resource limitations within which the nursing home operated undercut the optimistic vision of culture change in several ways. First, the gap between managerial rhetoric about culture change and the reality of work on the floor led workers to view upper management with a combination of cynicism and contempt. The feeling that upper management was remote, distant from the concrete problems of the floor, that top managers did not understand the everyday impossibilities that aides somehow resolved—pervaded the facility. Right or not, aides felt that management was not really interested in understanding the work that they did or the problems they faced on the shop floor. I asked this question in various ways to every aide I worked with; none of them said that management understood the problems they faced on the floor. One aide, for example, said, "I wish [the administrator] would come over here and for just one day, work a regular shift. Then she would see what we go through every single day." Another said, "They don't care. They don't give a shit about us."

My own informal conversations with top managers suggested that they did understand what aides “went through,” perhaps more than aides realized—but, crucially, managerial statements reflecting their desire to “change the culture,” far from inspiring aides, actually reinforced their belief that management was delusional. Given the corners aides already had to cut in order to get residents ready for breakfast on time, some managerial ideas—even ideas that were good in principle—seemed positively outlandish. For example, on several occasions top staff emphasized the importance of helping residents walk to and from the dining room and activities, instead of simply wheeling them in to save time. Everyone understood that assistance with walking was good for residents and would help them maintain mobility and slow their decline, and no one was opposed to it in principle—but the impossibility of carrying it out was immediately evident. Aides who heard such pronouncements rolled their eyes in disbelief—after the manager was gone.

Resource limitations created other resentments as well. Heartland’s wages, though well above minimum wage, were actually lower than some competing homes (where, admittedly, staffing was significantly worse). The starting wage for STNAs at Heartland was \$9.25 per hour, or \$19,240 per year for a full-time worker—just \$83 more than the 2004 federal poverty threshold for a family of four (\$19,157). Management openly discussed this tradeoff, telling new hires that sometimes people left for elsewhere because they could get an extra dollar or two an hour, but soon returned because they discovered that the extra pay was not worth it, if it meant having a dozen or more residents to care for. At Heartland, in other words, management had decided to pay a little less than some of its competitors in order to have better staffing because it was not possible to maximize both. And this was in many ways a defensible choice, since it maximized staffing without creating any major problems with employee turnover. But, even though workers stayed, they still felt that their paychecks reflected management’s opinion of what they were worth. Workers routinely complained about their wages; I did not speak with a single worker who felt that she was paid enough. “For what we do?” one aide said, “we should be making more. A lot more.” Another worker, who said that overall Heartland was a good place to work, emphasizing that “the bosses are nice here, no one is yelling at you or anything like that,” also said, unprompted, “The main problem is the pay—it is too low.”

With the exception of a few single, younger workers with fewer expenses, aides at Heartland were not paid enough to regularly dine out at (even inexpensive) restaurants, or even to go out to the movies once or twice a month. Aides with small children could not afford licensed child care; instead, they relied on relatives or neighbors to watch their children for free or for a pittance. And although Heartland offered a decent health care plan, the co-payment for family coverage (about \$130 per month) was prohibitively expensive for many of these workers. Indeed, several aides with children elected not to participate in the health care plan despite having no other health insurance. One morning while waiting for the lunch cart to appear, I noticed that one of my coworkers, Amy, had a nasty cough. I

asked her how she was feeling. “Awful,” she said. “I’ve been coughing like this for two weeks now.”

Concerned, I said, “Wow, have you been to the doctor?”

“I don’t go to doctors,” she said. “I don’t have insurance, so I just work through it.”

“But you could have bronchitis or pneumonia or something. You might need antibiotics,” I said.

“I had pneumonia last month,” she said. “At least that’s what I think it was. It got better for a while, but now I have this cough again. I just deal with it.” I asked her why she did not take the health benefits offered by the facility. “It’s \$130 a month,” she said. “I can’t afford that on what I make. And I can’t take any more sick days.”²⁶ One might take the position that Amy’s decision not to pay for health coverage for herself was unwise; on the other hand, given how little she earned, I did not think I was in any position to suggest that her priorities were wrong. Amy should not have been at work that day—not only for her own sake but also for that of the residents we cared for. But although top staff often reiterated how dedicated we all should be to maintaining the health of the residents we cared for, workers did not make enough money to take care of their own health.

The attendance policy was another source of resentment. Even with above-average staffing, Heartland was run on a knife edge. As I discovered on several occasions, even one call-off meant chaos as aides struggled to “pick up” extra residents in the middle of their already busy morning routines. Management did not have the luxury of staffing at a level that would allow a relaxed attitude toward attendance; therefore, Heartland policies enforced a tough line that belied culture-change rhetoric about worker empowerment. After the ninety-day provisional period, workers were allowed two “excused absences” per year for doctor’s appointments, medical emergencies, court dates, or school meetings. Once these two excused absences were used, any additional absences were treated as unexcused, regardless of the reason. Employees earned one “occurrence” for each unexcused absence, unless they failed to call in more than two hours before the beginning of their shift, in which case a single absence was worth two absences. Consequences for each unexcused absence escalated from a “conference/reminder” for the first one to automatic termination for the fifth. Thus, once the two excused absences were used, a car accident on the way to work, or a medical emergency with a child the morning of a work day, would count as two occurrences and result in a written warning for a worker with one unexcused absence; two such incidents in a year would result in automatic termination.

Management viewed the attendance policy as necessary to guarantee that workers did everything they could to show up for work. “I know it seems harsh,” the administrator told me, “but you know, someone has to care for the residents every day. They don’t have the luxury of saying, ‘that’s OK, I don’t need you today.’” To workers, however, the implacable and impersonal nature of the attendance policy undermined management’s claim that workers were equal members

of the community. Workers resented in particular the fact that the policy made no attempt to distinguish between legitimate and illegitimate reasons for calling off. "They call it a 'no fault' policy," one worker grumbled. "But it's really a 'your fault' policy, because no matter what the reason for the absence, you're gonna get an occurrence anyway."

During the first ninety days of employment, the policy was even stricter. During this period, there were no excused absences; the third absence—for any reason—resulted in termination. I myself ran afoul of the policy during my ninety-day provisional period when my wife came down with a bad case of the flu. She was too sick to get out of bed, and we had no one else to care for our two small children. I followed the procedures for "calling off" the night before I was scheduled to work, and a few days later I received a written warning. The nurse who administered it did so nicely, with no hint of reproach. She even asked me if my wife was feeling better. But the fact remained that I was now a flat tire away from dismissal, and I had done nothing wrong. I felt some resentment; the implicit message, it seemed to me, was that while the residents could be (and were often) sick, my family was not allowed to be sick.

Indeed, this experience enabled me to see how the attendance policy operated as a filter on new employees. New employees without dependable transportation, those without reliable child care, and those with family problems rapidly got into trouble with the attendance policy and were terminated. This is what happened to Carol, a new aide who had taken the STNA course alongside me and was then hired. Carol was a middle-age woman, a former nursing home aide returning to the workforce after raising a family. During the STNA course, however, she missed some days because a sister was dying of cancer in another state. Her painful struggle with her sister's death continued to affect her attendance and she was fired within the first month, never to be seen again. I found it difficult to reconcile management's rhetoric of "community" with its lack of flexibility when it came to tragedies and crises experienced by aides.

This inflexibility extended also to workers who experienced any extended illness, childbirth, or injury during their first year of employment. During that period, any absence of longer than two weeks (regardless of the reason) resulted in termination. The implications of this policy were driven home to me when I heard John's story. John was a charge nurse who had suffered a ruptured appendix after ten months on the job. He had had surgery to remove his appendix, and remained in the hospital, battling infection for three weeks. When he finally was able to talk to the director of Staff Development in the HR department, she told him that his employment was terminated in keeping with the policy, but that he was invited to reapply. "But guess what?" John said bitterly. "When you lose your employment you also lose your health coverage—right when I needed it most." He was able to retain his coverage only by paying the full premiums himself until he was reinstated. "Terminating someone and denying them health coverage because

they come down with appendicitis?" John said. "I don't care who you are, that's just wrong." John was so upset about this that he was looking for another job and later left Heartland.

At every turn I was surprised at the way management handled attendance issues. Take the issue of tardiness: workers were considered officially tardy if they clocked in one minute late. This in itself is not remarkable, but the unyielding way the policy was implemented did not comport with the idea that aides were members of a caring community. On one occasion, a group of aides and I were clocking out at the end of the day, but Cheryl's badge would not scan properly. She kept running it through the card reader and it kept saying "unrecognized card." This went on for several minutes, until finally another aide took the card from her, wiped it off carefully, and swiped it again. This time it worked. "Good thing it wasn't 6:29 in the morning," she said.

"Yeah," said Paul, laughing. "You'd have a tardy on your record."

Not believing they could be serious, I said, "Yeah, but if it was a malfunction with the card or the machine, they wouldn't give her a tardy, would they?"

"What? Sure they would," said Paul. "They're not going to take her word for it."

"But she'd have witnesses—we all saw what happened," I protested.

"But we are her friends," he said, as if explaining something to a child who is having trouble understanding something simple. "They would just say that her friends were backing her up." Management, in other words, simply would not trust that a group of aides was telling the truth about something like this.

This was driven home a few days later, when an aide named Maria got to work on time but realized she had left her ID card at home. To get into the building in the morning aides had to swipe their ID card; therefore Maria had to pound on the door until someone heard her. She got inside at 6:25 but still had to find the nursing supervisor, who had to document that she had arrived for work on time. "I looked all over the place," Maria said in exasperation later. "I couldn't find the supervisor. By the time I found her it was after 6:30 and she said I was late. I said, 'I'm not late, I've been looking for you for ten minutes!' But she said there was nothing she could do since she didn't see me until after 6:30."

These considerations underline something important about human resource management that goes beyond constraints imposed by resource limitations. In the eyes of management, the primary obstacle to the creation of a caring community was not understaffing, or low wages, or an authoritarian attendance policy. Perhaps because there was not much they could do about these issues, managers preferred not to see them. It was, perhaps understandably, easier to believe that the main problem was the work culture of the aides. Therefore, top staff preferred the idea that too many of the aides saw the work as "just a job"; top management was concerned (and expressed this concern to me directly) that a "core group" of aides with "bad attitudes" was "controlling" the other aides, discouraging them from

rising above the minimal performance of job duties. Indeed, shortly after I made the transition from student aide to shift worker, the director of staff development (who taught the nurse aide course) told me that my “attitude” seemed different since I had started working on the floor, that I seemed “less enthusiastic, less upbeat.” I mumbled something about trying to fit in; she replied, “Now you can see why it’s so hard to change things. The old culture is so pervasive and entrenched, those old attitudes, and new people come in and they get contaminated by it. You should really focus on that—that’s the key, figuring out how to change that culture.” At this point I realized that she thought the “bad attitudes” of other aides had now rubbed off on me. Culture change, in this formulation, no longer meant that management should engage in self-criticism, but served as a convenient device for blaming aides for the structural problems of the nursing home system.

CONCLUSION: HUMAN RESOURCE MANAGEMENT AND WORKER VOICE

I have argued in this article that culture-change HRM was not able to confront the really serious problems of the nursing home—that is, the resource limitations that are structurally embedded in the nursing home industry—but in the preceding discussion I think we see that the problem with HRM goes a bit deeper. Management had the luxury of defining workers and their “bad attitudes” as the problem because, to the extent that HRM incorporates workers’ interests and concerns, it does so paternalistically and on management’s terms. HRM’s rejection of pluralist bargaining and negotiation in favor of “consensus,” in other words, is part of the problem because the rights to define organizational goals and to set the terms of the hoped-for consensus are reserved to management. In this feature of HRM we see a deep ambivalence about workers, an abiding reluctance to grant them any real power, and a tendency to infantilize them rather than to treat them as equal partners. At Heartland this was particularly visible in the way that top management continually expressed a desire for “dialogue” with workers but resolutely insisted that issues of staffing, wages, and the repressive attendance policy were not open for discussion. Thus, instead of giving workers a voice, culture-change management at Heartland silenced them. It provided a way for management to avoid talking about the obvious fact that aides were forced to break important care rules every day, and gave management something else to talk about instead. My analysis thus suggests that the endemic problem of poor nursing home care cannot be solved by culture-change management but requires instead substantial improvements in staffing levels underwritten by concomitant increases in Medicare and Medicaid reimbursement rates. But how could this be achieved?

Nursing home reform organizations like the National Citizen’s Coalition for Nursing Home Reform (NCCNHR) have long supported legislation that would create national minimum staffing standards for nursing homes (specifically, NCCNHR supports the proposed 2.9 NA hprd standard, plus additional standards for RN staffing), provide the necessary funding for staffing improvements, and

contain safeguards to ensure that funding increases are used to increase staffing rather than profits. It is conceivable that a coalition involving NCCNHR and other advocates for the elderly could successfully press for these reforms, but the obstacles to success are considerable. It seems to me that if success is achieved it will likely hinge not only on the efforts of consumer and elderly advocates but also on the ability of nursing home workers to make their voices heard.

As I have documented elsewhere, since the late 1980s, when advocates succeeded in passing the OBRA reforms, the labor movement—despite its overall decline—has made important inroads in the nursing home industry.²⁷ In fact, since the early 1980s, the Service Employees International Union (SEIU) in particular has been successfully organizing low-wage nursing home workers—not just around bread-and-butter issues but also around dignity, respect, and the quality of care. Two decades of collective mobilization by nursing home workers raises the possibility that nurse aides themselves may be able to play a new role in further efforts to reform the nursing home industry.

As we have seen in this article, the entire system of long-term care depends on the willingness of nurse's aides to break the rules in order to create the illusion that the system is functioning. If a single aide insists on following the rules, the result is predictable: she is disciplined, and if she persists she is eventually fired for poor job performance. If workers at a single nursing home insist on following the rules, they might create chaos but not much more; management cannot provide enough staff to make it possible to follow the rules routinely. But if nurse aides at hundreds or thousands of nursing homes began to insist, in a coordinated way, on following the rules—and if it were part of a larger movement for justice for nursing home workers and nursing home residents—they might make it impossible for policy makers to continue to ignore the nursing home staffing crisis. If so, perhaps such an authentic expression of worker voice—so missing from HRM in general and culture change in particular—could turn out to be the key to a more meaningful nursing home transformation.

NOTES

1. All names in this paper are pseudonyms.

2. Bruce Vladek, "Unloving Care Revisited: The Persistence of Culture," 1–9 in Audrey Weiner and Judah Ronch, eds., *Culture Change in Long-Term Care* (Binghamton, NY: Haworth Press, 2003).

3. William H. Thomas, "Evolution of Eden," 141–157 in Weiner and Ronch, eds., *Culture Change in Long-Term Care*.

4. *Ibid.*, 144 and 142.

5. Rose Fagan, "Pioneer Network: Changing the Culture of Aging in America," 125–140 in Weiner and Ronch, eds., *Culture Change in Long-Term Care*.

6. Fritz Roethlisberger and William Dickson, *Management and the Worker* (Cambridge, MA: Harvard University Press, 1939); Elton Mayo, *The Social Problems of an Industrial Civilization* (Cambridge, MA: Harvard University Press, 1945); George Homans, *The Human Group* (New York: Harcourt & Brace, 1950).

7. Robert Bales, *Interaction Process Analysis: A Method for the Study of Small Groups* (Cambridge, MA: Addison-Wesley, 1950); Robert Blake and Jane Mouton, *The Managerial Grid: Key Orientations for Achieving Production Through People* (Houston, TX: Gulf Publishing Co., 1964); Douglas McGregor, *The Human Side of Enterprise* (New York: McGraw-Hill, 1960); Frederick Herzberg, *Work and the Nature of Man* (Cleveland, OH: World Publishing Co., 1966).

8. For reassessment of the original Hawthorne data, see Michael Argyle, "The Relay Assembly Test Room in Retrospect," *Occupational Psychology* 27 (1953): 98–103; also see Alex Carey, "The Hawthorne Studies: A Radical Criticism," *American Sociological Review* 32 (1967): 403–416. For a good review of later studies failing to confirm the Hawthorne findings, see Charles Perrow, *Complex Organizations: A Critical Essay* (Glenview, IL: Scott, Foresman & Co., 1986).

9. Henry Landsberger, *Hawthorne Revisited* (Ithaca, NY: Cornell University Press, 1958); Philip Selznick, *Law, Society, and Industrial Justice* (New York: Russell Sage Foundation, 1969).

10. John Storey, *Developments in the Management of Human Resources* (Oxford: Blackwell Publishers, 1992).

11. *Ibid.*, 34.

12. Peter Cressey, John Eldridge, and John MacInnes, *Just Managing: Authority and Democracy in Industry* (London: Open Industry Press, 1986); Tony Dickson, Hugh McLachlan, Phil Prior, and Kim Swales, "Big Blue and the Unions: IBM, Individualism, and Trade Union Strategy," *Work Employment and Society* 2(1988): 506–520; Leonard Schlesinger and James Heskitt, "Breaking the Cycle of Failure in Services," *Sloan Management Review* 32 (1991): 17–28; John Bank, *The Essence of Total Quality Management* (London: Financial Times Prentice Hall, 2000); Barrie Dale, Ruth Boaden, and David Lascelles, "Total Quality Management: An Overview," 3–40 in Barrie Dale, ed., *Managing Quality* (New York: Prentice Hall, 1994); John Paul MacDuffie, "Human Resource Bundles and Manufacturing Performance: Organizational Logic and Flexible Production Systems in the World Auto Industry," *Industrial and Labor Relations Review* 48(1995): 197–221; Eileen Appelbaum, Thomas Bailey, Peter Berg, and Arne Kalleberg, *Manufacturing Advantage: Why High Performance Work Systems Pay Off* (Ithaca: Cornell University Press, 2000).

13. Fagan, "Pioneer Network," p. 134.

14. James Brennan, Patricia Brancaccio, and Pauline Brecanier, "Teresan House: Using the Environment to Support Cultural Change," 223–231 in Weiner and Ronch, *Culture Change in Long-Term Care*.

15. William Thomas, *Life Worth Living* (Acton, MA: Vanderwyk and Berman, 1996); Charlene Boyd, "The Providence Mount St. Vincent Experience," 245–268 in Weiner and Ronch, eds., *Culture Change in Long-Term Care*.

16. U.S. Department of Health and Human Services, "Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase I," Washington, DC: Centers for Medicare and Medicaid Services, 2000, <http://www.cms.hhs.gov/medicaid/reports/rp700home.asp>.

17. William Thomas, *Life Worth Living* (Acton, MA: Vanderwyk and Berman, 1996).

18. Heartland also has a ten-bed "special care" unit for residents with severe dementia; this is officially part of the nursing home but it is physically separate from the rest of the nursing home and I did not spend any time working there. Thus all aspects of my discussion, including staffing figures, apply only to the main floor of the nursing home and not to the special-care unit.

19. I considered the possibility that in this and other interactions managers might have been nicer to me than they would have been to an ordinary worker, since they knew I was a professor doing field research. I do not believe that this was the case in any of these interactions. In conversations with other aides about the managers in question I heard similar stories from them and quickly learned which managers were best and least well liked. Not all managers were equally well liked but none of them was abusive to aides. Indeed, one of the least liked managers was reviled not because she was not nice but because her efforts to be nice did not come across as sufficiently sincere.

20. Thomas, "Evolution of Eden," p. 142.

21. U. S. Department of Health and Human Services, "Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase I," Washington, DC: Centers for Medicare and Medicaid Services, 2000, 14–21. <http://www.cms.hhs.gov/medicaid/reports/rp700hmp.asp>.

22. It is easy to use a phrase like "pry their knees apart" nonchalantly once one has become an experienced aide; this is what aides do. I write about it this way in part to convey the reality of the job, but in truth, this was one of the most difficult things for me to deal with in becoming an aide. I did not initially realize the extent to which some residents with diagnoses of dementia resist being changed; yet it must be done. Other aides showed me tricks such as wrapping a struggling resident's hands up in their gown and holding them with one hand while wiping and changing with the other. Absent tricks like this, aides may find themselves being punched and slapped—I did get punched in the jaw once—or the resident may dig into her own feces, which of course complicates and slows down the process. I never did become totally inured to the difficulty of these moments, and at times the care process felt uncomfortably like an assault, even though I was simply trying to provide basic physical care as kindly and as gently as I could.

23. U.S. Department of Health and Human Services, "Appropriateness of Minimum Nurse Staffing Ratios, Phase II," 14–1.

24. Ibid; Jeffrey Rhoades and John Sommers, *Nursing Home Expenses*, 1987 and 1996. Rockville, MD: Agency for Healthcare Research and Quality, 2001. MEPS Chartbook No. 6, AHRQ Pub. No. 01-0029, p. 8.

25. U. S. Department of Health and Human Services, "Appropriateness of Minimum Nurse Staffing Ratios, Phase II."

26. Because Amy's annual income for herself and her two children was less than 150 percent of the Federal Poverty Level (FPL) for a family of three, the children were covered by Ohio's Healthy Start program; however, Amy herself was not eligible for coverage under Ohio's Healthy Families program because her income was more than 100 percent of the FPL for a family of three (\$15,260 in 2004).

27. Steven Lopez, *Reorganizing the Rust Belt: An Inside Study of the American Labor Movement* (Berkeley: University of California Press, 2004).

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