### The Four Stages of Culture Change

**The Four Stages of Culture Change** by Dr. Leslie A. Grant and LaVrene Norton, MSW  
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<table>
<thead>
<tr>
<th>STAGES</th>
<th>RESIDENT-DIRECTED DECISION MAKING</th>
<th>STAFFING ROLES</th>
<th>PHYSICAL ENVIRONMENT</th>
<th>ORGANIZATIONAL REDESIGN</th>
<th>LEADERSHIP PRACTICES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INSTITUTIONAL</strong></td>
<td>Decisions are made by top managers with little input from frontline staff, residents or family members. Group process to reach decisions isn’t used (i.e. self-led team decision making, consensus, group prioritizing). Daily activities, meals and baths are determined primarily by the needs of staff and efficiencies.</td>
<td>Nursing staff are not permanently assigned to the same small group of residents. Staff rotate (and are “pulled” based on policy or need). Staff roles reflect traditional functions and are defined by organizational departments such as food service, housekeeping, activities and nursing.</td>
<td>Often a large centralized dining room.</td>
<td>There is a hierarchical structure (Board of Directors, Administrator, Director of Nursing, Department Directors, Supervisors, and finally, the frontline workers.</td>
<td>A broad range of leadership skills are found at this stage. Leadership training typically excludes frontline staff. The administrator, DON and department heads comprise the leadership team.</td>
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*Note:* This model represents a set of tested principles of successful culture change in non-profit organizations that have been adapted for this audience. This is not a comprehensive list of practices. The roles of the various players are illustrated by the symbols used in the chart. Different symbols may indicate different roles and the roles may overlap. The roles are critical skills required to implement the organizational redesign process. These roles have been designed to support an operational model that was taken from acute care hospitals, most lack the architectural and interior design amenities (kitchen and increased private spaces).

| **TRANSFORMATIONAL** | Group process such as a “learning circle” is used to elicit input into decision-making but is more symbolic than truly shared decision making. Administrator and/or the DON typically make the final decisions on any new plans. | Staffing Roles are defined by the department in which the person works. Nursing staff are consistently assigned to the same unit or small group of residents. Some self-scheduling is allowed and encouraged but usually only for full-time staff. | This stage of typically involves low cost changes in decor, artwork, interior finishes, plants, and animals. | Department heads become more involved with residents and frontline staff. Department heads invite other staff to participate with them on leadership teams. | Members of the existing leadership team begin to grow in their ability to involve others in critical thinking and decision-making. Team leadership begins to emerge through more frequent use of group decision-making processes. “Natural” leaders begin to emerge. |

*Note:* Leaders begin to develop skills in conflict management and leadership teams begin to emerge through more frequent use of group decision-making processes. 

| **NEIGHBORHOOD** | Learning circles and other group processes encourage real input into decision-making. Real decisions around daily life involving residents and staff are determined. These decisions typically involve “aspects of daily life such as special celebrations, parties, group activities, staffing assignments and food choices and may include control over how to spend funds allocated to an activities budget for the neighborhood. | Nursing staff is permanently assigned to one or more neighborhoods within the same unit and rarely float across units. Staff works in self-directed teams with a neighborhood coordinator as the team leader. Non-nursing staff is also permanently assigned to the neighborhood and work as part of the team. Certification as a CNA for non-nursing staff is not required but encouraged to develop cross-trained workers. Some workers have blended roles that combine responsibilities of multiple departmental functions (e.g., activities and social services, nursing and housekeeping, or nursing and activities). | Decentralized dining in the neighborhood without a full kitchen. Lacking a full kitchen, choices and accessibility is increased by creative locations, use of small appliances – crock-pots, toasters, coffee makers, waffle makers, griddles, bread makers. Nursing stations and medication carts are still used but efforts to liberalize med plans and redesigning or reducing size of nurses stations can create additional living space. Downsizing of excess bed capacity often happens at this stage. | The role of “neighborhood coordinator” is formalized. Role is added to the to the person’s primary role on the work team. Organizational chart emphasizes a resident-centered approach. | Neighborhoods are frequently given names at this stage to create identity and a sense of community. Leadership teams become more decentralized. Many decisions are made by consensuses in neighborhood teams. Leaders begin to develop skills in conflict management and leadership teams begin to emerge through more frequent use of group decision-making processes. Conflict management skills are fully operationalized. Leadership skills are improved. |

*Note:* Members of the existing leadership team begin to grow in their ability to involve others in critical thinking and decision-making. Team leadership begins to emerge through more frequent use of group decision-making processes. “Natural” leaders begin to emerge. Mentors and other leadership training is offered to both formal and informal leadership. 

| **HOUSEHOLD** | Learning circles and other group processes are used to make most decisions that affect life in the household. Residents have “refugee rights” (increased choice and accessibility to food). Residents have greater influence about when and what to eat. Residents are given more control over their daily routines and activities (e.g., when to get up, when to go to bed, or how to spend the day). | Staff is permanently assigned to a single household. There are full-time, part-time and casual staff (i.e., those without regularly scheduled hours) that is assigned to each household. Household teams create their own work schedules. As a result, both shifts and staffing ratios begin to vary across households over time. Staff is no longer working within traditional functional departments. Staffing mix moves towards having more “versatile workers” (staff who serve in multiple roles encompassing housekeeping, nursing, food service and activities). So, CNA certification for all staff working within each household becomes increasingly vital. | Households are self-contained area with 16 to 24 (or fewer) residents, with more private rooms. Each household has its own full kitchen (with cook top, oven, microwave, refrigerator, freezer, dishwasher, sink, cupboards, dishes and utensils). Personal laundry is typically done within the household. A common dining room and living area. Staff work areas are better integrated into common areas. The nursing station and medication carts are gone. Most daily activities occur within the household. | Traditional departments (e.g., nursing, housekeeping, food service, activities) have been largely eliminated with these functions reporting into the household. Services offered by departments such as food service, building maintenance, contract therapy and business office are restructured so that they function as support services for each household. The administrator oversees these support services. | A new leadership team emerges at the facility level and includes the community mentor (administrator), the clinical mentor, the social mentor, nurse leaders and household coordinators from each department. Conflict management skills are fully operationalized. Leadership skills are improved. |

*Note:* This model represents a set of tested principles of successful culture change in non-profit organizations.
NOTES ON THIS STAGE OF CULTURE CHANGE:

What can be done to become more resident-directed in decision-making?

What can we do to strengthen staffing?

What about the physical environment? How can we renovate to the next stage?

Organizational Redesign. Our next steps are:

We need to continue growing leadership skills in self and others. What shall we do?

QUESTIONS WE MIGHT ASK OURSELVES:

**Bathing at our facility:** Discuss whether the residents really get to choose what time they want to bathe.

**Pleasure:** What would make the bathing experience better for the residents? Are there simple changes we could make?

**Privacy:** Do residents express concerns about privacy? Do you feel uncomfortable when you put yourself in their shoes?

**Residents’ Rooms:** Private spaces – how can the Neighborhood Teams help residents make their personal spaces more pleasant?

**Dining at Home:** How can we increase choices in dining?

**Pleasant moments:** What can we do to bring more enjoyment to residents during mealtimes?

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OUTCOME OBJECTIVES

At the conclusion of the program the participants should be able to:

- Speak about the history of culture change
- Identify at least two innovative models
- Identify the four stages of culture change and describe at least 3 attributes of each stage
- Identify where one’s own facility is within the stages of change
- List at least two actions that their facility can take to begin the journey of culture change
- List at least one activity per attribute of each stage of change that could progress the organization toward the next stage of change
- Utilize the Learning Circle to gain individual commitment to the next steps for culture change in the organization

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RESIDENT: Interviewed by:

Daily Pleasures Interview

Ask the Resident if you can take a few minutes to ask a couple of questions. Say: “We all have daily pleasures that help us get through our day – things that are important to us – that make our day unique. It could be that first cup of coffee in the morning, or walking the dog, or working in the garden, or watching a certain show on TV.

Before you came to live here, what were some of your daily pleasures?

Are you still able to enjoy that daily pleasure? If not, why not?

Thinking about the little things in your day, what do you enjoy the most each day here?

What little things would make your life here more enjoyable?

Is there anything we could do, as a team, to make your life happier?