GREEN HOUSE® Homes
The Role of the Nurse Research Study

Introduction

Nursing practice in skilled level GREEN HOUSE® homes is the focus of this report. The report describes a study that was conducted with 11 of the 14 GREEN HOUSE® homes that have skilled care settings and had been operating at least six months in 2008, when the project began. The study was conducted during 2008-9.

The impetus for the study was a concern expressed by many in the nursing community that the GREEN HOUSE® model might result in a weakening of professional nursing oversight. The concern arose from the GREEN HOUSE® vision and implementation of an empowered front line worker (the Shahbazim) and the elimination of a direct reporting relationship between the Shahbazim and the nurse. Unlike other skilled care settings, the front line workers in the GREEN HOUSE® homes do not report directly to the nurse. Their supervisor is, in all but one home, not a nurse. There were concerns within the nursing community that GREEN HOUSE® nurses could be marginalized in both their oversight of residents and their ability to supervise front line workers. Much of the care provided by front line workers in long term care settings is nursing care that has been delegated to front line workers. CNAs working in all 50 states engage in activities that are delegated from the registered nurse.

This report includes a brief description of the study and an overview of the findings, focusing on nursing practice in the GREEN HOUSE® homes that participated in the study. The report describes variations in how nursing has been structured in the GREEN HOUSE® homes and some of the consequences of these variations for both staff and residents. Implications for care and work life quality are also identified and discussed for each of the GREEN HOUSE® nursing model variations.

The study was funded by the Robert Wood Johnson. We would like to acknowledge the support and assistance of the GREEN HOUSE® staff in each of the 11 participating homes and their willingness to open their homes and generously share their experiences, particularly the eight homes selected for site visits. The research team found staff in each home to be helpful and open to exploring the model and improving practice. Consistent with the spirit we encountered in each of the homes, we offer our observations and suggestions as part of the ongoing effort by GREEN HOUSE® participants to improve the care they provide and the quality of work life for their staff. This report should be seen as a tribute to the hard work, creativity and compassion that GREEN HOUSE® staff bring to their work each day. We thank them.

Study Overview

In 2008, the GREEN HOUSE® team at NBC Capital Impact supplied the research team with a list of all 14 GREEN HOUSE® homes that had at least one skilled setting and had been operating at least six months. The research team contacted the Guides from all 14 sites. Guides at each of the sites were invited to participate in a phone interview about their experience with

the GREEN HOUSE® model. The research team was able to arrange phone interviews with Guides at 11 of the 14 homes. These 11 homes represented a variety of nurse staffing patterns, length of time in operation and total number of cottages on site. Guides were asked to describe their experience overall and specifically to discuss how nursing services (nurses and Shahbazim work) were organized in their cottages. Phone calls were recorded and transcribed. Each lasted about one hour.

The interviews were structured to encourage guides to talk about what they believed was most important about the model, their experience in implementation and to provide information on specific issues related to nursing care. Each interview began by asking the Guides to talk about whatever *they* believed was most important. The Guides were then asked to talk about each of the following areas:

- Overview and history of GREEN HOUSE® implementation
- Issues, challenges and barriers faced during implementation, particularly in relation to nursing care
- How nursing care issues were addressed and resolved
- The roles of Shahbazim and nurses in resident care
- Communication between nurses and Shahbazim
- Relationships between nurses and Shahbazim
- The role of the Guide, particularly in relation to nursing care and communication between nurses and Shahbazim

Based on analysis of these initial interviews, seven GREEN HOUSE® homes were chosen for follow up site visits. The decision about which homes to visit was made to maximize the variation of: difficulty implementing the model, degree of change in the model since initial implementation, Guide perceptions' about the relationships between Shahbazim and nurses, differences in staffing patterns, differences in size, and length of operation in the GREEN HOUSE® model. In particular, the research team selected homes to allow comparisons of different nurse/Shahbazim roles and relationships. Available remaining funds after the seven site visits allowed for the addition of one more site, bringing the total to eight.

Site visits took place over a six month period, each lasting two to three days. Interviews were conducted with Shahbazim, nurses, assistant DoNs, DoNs, and administrators. At some sites, Guides, Sages and other staff such as social workers and therapists were also interviewed. The research team also shadowed Shahbazim and nurses during their daily work and spoke informally with many residents and family members. No personal care of residents was observed during the study. Staff on all shifts were interviewed. Overall, study participants included:

DoN/ADoN	Nurses	Shahbazim	Other	Participant Observation
N=8	N=29	N=68	N=11	N >200

Extensive field notes and transcriptions were collected for later analysis. Staff discussed how GREEN HOUSE® work differed from work in a more traditional setting, as most had prior nursing home experience. Their comments provided rich data and significant insights into how daily routines, coworker relationships, family interactions, time management, skills used and relationships with other nursing staff differed from what they had experienced in traditional nursing homes. They described their challenges, frustrations, rewards and successes.

The focus of this project was on nursing care processes. There was no resident outcome data collected. Therefore, insights into the quality of care must be interpreted from the processes engaged in by nurses and Shahbazim and the implications of those processes for care quality. The many hours of field work provided significant information on those processes. In particular, the researchers attended to the identification, communication and timely response to resident change in condition, follow through on care and treatment protocols, processes engaged in to prevent resident decline, and development of staff (Shahbazim in particular) skill.

Findings

The central question guiding this study was whether there was evidence that the quality of resident care is compromised by a model of care that shifts the direct reporting relationship of front line workers from the licensed nurse to another supervisor. For three of the four GREENHOUSE nursing models, there was no evidence that resident care quality was compromised. That is, we found clear examples of Shahbazim reporting clinical information to nurses. In these models, the Shahbazim saw the nurses as responsible for resident clinical care and saw it as their responsibility to bring clinical issues to the attention of the nurses. In that sense, the reporting relationship was similar to what is generally observed in more traditional settings. While there were instances when important information might not be effectively communicated between Shahbazim and nurse, the barriers to communication were similar to those found in most nursing homes.

In short, for most GREEN HOUSE® homes, the empowered Shahbazim model with direct report to a non-nurse Guide, did not prevent Shahbazim from reporting clinically relevant information to the licensed nurses. In one of the models observed (Visitor model), clinically relevant information was less reliably passed on to nurses. In some cases, for example, referrals were made to specialists without informing the nurses. Significantly, in one of the models (Integrated) there was evidence of practice patterns that at least have the potential to improve the quality of resident care.

How is the GREEN HOUSE® nursing model implemented?

To reiterate, the focus of this study is on nursing practice. The following discussion is about the variance in nursing practice operating within GREEN HOUSE® homes. Based on fieldwork and interviews, we identified four general GREEN HOUSE® nursing models. This section describes those four models, identifies some of the conditions that influenced their development, and explores the consequences of each model for resident care quality, work life quality, personal and professional development, and staffing patterns. The four general nursing models identified are: Traditional, Parallel, Integrated and Visitor. In each site visited, one of the models was often dominant, but at most sites there was at least some variation within the cottages in how nursing care was organized. At some sites, there was considerable variation across cottages or even

across shifts in a single cottage. For example, a particular cottage may operate in a more *traditional* nursing model, while another cottage may use a *parallel* nursing model. In some instances, staff in the same cottage and on the same shift were even implementing the nursing model differently. All homes demonstrated some variation. None used only one model of nursing care across all sites, shifts and workers.

It is important to understand that this report encompasses only models of *nursing* practice. There are many other aspects of GREEN HOUSE ® life that fall outside the direct nursing practice domain and are not necessarily consistent with the categories presented here. For example, in places where the nursing model is partly or even predominantly Traditional, many innovative approaches to resident life were observed.

Nursing Model	Characteristics
Traditional	Hierarchical, nurse in charge, clearly defined roles, separate work for nurses and Shahbazim
Parallel	Non-hierarchical, clearly defined roles, separate work for nurses and Shahbazim
Integrated	Combined hierarchical and non-hierarchical, considerable collaboration between Shahbazim and nurse, some overlap in roles, shared responsibility
Visitor	Hierarchical, Shahbazim in charge, little collaboration between nurse and Shahbazim, clearly defined roles, nurse a visitor

Table 1: GREEN HOUSE® Homes Nursing Models

Common Features

A central feature of the GREEN HOUSE® philosophy is to promote quality of life for residents by creating a home like environment, making health care requirements a component of residents' lives (albeit an important component), rather than the single, overwhelming and life organizing concern. That is, the intent is to create a balance between what is needed to achieve quality of life and quality of care. One specific strategy used by GREEN HOUSE® is to alter the usual reporting relationship of the front line caregivers (Shahbazim). By implementing a reporting relationship for Shahbazim that does not go directly through nurses, it is thought that considerations other than health care and treatments might take on greater authority and lead to improved quality of life for residents.

The GREEN HOUSE® philosophy emphasizes creating a homelike environment for residents. This requires a flow of daily activity that is more like the way a family operates. It requires attention and responsiveness to each residents preferences and adapting to changes in circumstances as they unfold. This in turn requires a high level of spontaneity, creativity and flexibility. This flexibility can only be achieved if staff work together as a team to adapt to changing circumstances. It also requires support and oversight that will promote a flexible work

environment. Use of a universal worker, the Shahbazim, accommodates these requirements. It allows workers to respond to whatever the immediate needs are, rather than scheduling different workers to perform their separate designated tasks. The Guide position is intended to support and assist Shahbazim to achieve this teamwork. Designating a non-nurse for this role is designed to maintain the focus on all aspects of quality of life, not just health care.

The altered reporting relationship of removing the nurse from direct care worker oversight is a central design feature of the GREEN HOUSE® initiative and was operating in all of the GREEN HOUSE® homes visited. In each of the models Shahbazim reported directly and formally to the Guide. In only one site the Guide was a nurse, but not functioning in a nursing role. In all GREEN HOUSE® nursing models, the Shahbazim were responsible for daily operations of the home. Despite the structure of reporting to the Guide, there was considerable variation in how Shahbazim related to the Guides, the role the Guides played in Shahbazim work, and in how the Shahbazim then related to nurses, and nursing care, in the cottages. These differences will be explored below.

GREEN HOUSE® Nursing Models

The first two nursing models described below (Traditional and Visitor), were found sporadically. Sometimes they were found in a single cottage, sometimes on a particular shift, and sometimes as a model supported by some of the staff while most practiced within one of the other models. In several homes there were shifts or individuals who practiced within the Traditional model, while others did not. The Traditional and Visitor models were each found to be more predominant at only one site. There were also, however, examples of each of these models at other sites.

Traditional Nursing Model

Interviewer*: "Is working with the nurses any different than working with nurses in the nursing home?"*
Shahbaz: *"Not a whole lot. We're the main caregivers, you know. We have a nurse who goes back and forth and she's still the nurse, and who still oversees everything."*

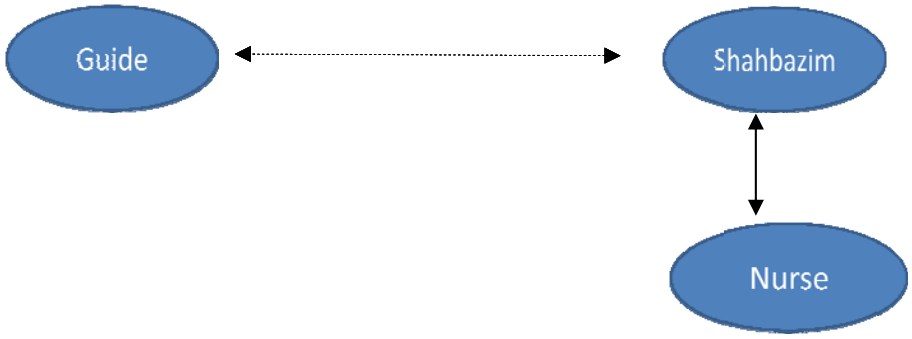

Figure 1. This figure represents the predominant reporting relationships in the Traditional model, with the Shahbazim reporting to the nurse regarding most matters, and the nurse managing the Shahbazim similarly to a charge nurse in a traditional nursing home. Staff in this model were often unclear about the Guide's role.

Clarity, Structure and Content of Roles

Although unusual within the GREEN HOUSE® community, some staff, homes or shifts remained quite traditional in the way they implemented nursing practice. In these cases, the

nurses and Shahbazim interacted in ways that were similar to the hierarchy traditionally found in nursing homes.
The nurses maintained an oversight responsibility, both for resident care and for Shahbazim work. While nurses tended not to get involved in oversight of activities that were not traditionally CNA work (meals, activities, laundry), they continued oversight of all resident care activities. That is, nurses continued to 'check on' whether the Shahbazim had completed the tasks they were responsible for such as bathing, ambulating, turning, and vitals. The nurses viewed themselves as ultimately responsible for both their own work and the work of the Shahbazim. The nurses were clearly "in charge." This oversight encompassed the non nursing activities that were traditionally under the purview of nurses in nursing homes but were not 'nurse delegated' work. Activities in this category that were most often described included room cleaning and conflicts among Shahbazim.

> *Shahbaz: "If they [nurses] go in and see a spill or something, they ask, 'Can you go clean that up?' Yeah, I can but you found it."*

In this model, the boundary between the roles of nurses and Shahbazim were clear. Nurses consistently expressed the belief that it was their responsibility to oversee all Shahbazim work, and to make sure that the care was provided as intended.

> Nurse*: "I think, you know, with time, people take advantage of certain situations. Down here I think things started off really good, but kind of got relaxed and nobody's really checking up on them. I think that had to start coming back into play where we got more and more responsibility for making sure people were turned and checked on and things like that."*

There seemed to be little confusion over what was expected of each and how decisions would be made or carried out. Nurses tended to; give direction to Shahbazim, check up at the end of each shift to see that the Shahbazim had completed their work, comment on the quality of the housekeeping, and less frequently, become involved in Shahbazim conflicts. As in traditional skilled nursing facilities, nurses rarely answered resident lights. Instead, they generally responded to a light by indicating to Shahbazim that a resident light needed to be answered. If there was no Shahbazim available, nurses either sought out a Shahbazim or asked what the resident wanted, and then sought out a Shahbazim, unless the request required a nursing intervention.

Shahbazim reliably summoned nurses to make decisions about; resident care problems and family conflicts, to initiate family contacts, and to suggest or direct changes in the care plan. They viewed the nurses as 'in charge' of the homes and the care. They described their work as basically no different than when they worked in a traditional nursing home, other than taking on several new responsibilities.

Hiring and Filling in

Whether Shahbaz or nurse, replacing staff was approached using the same criteria that were used for replacing nursing home staff. When hiring new Shahbazim, CNAs with good attendance records, who were independent, needed no prodding and little oversight, had few or no complaints lodged against them by residents or families, and known to complete their work on

time were seen as most appropriate for GREEN HOUSE® work. A major focus was on attendance record. Generally getting on well with other staff was seen as desirable but was not central.

When finding a 'fill in' for Shahbazim, another GREEN HOUSE® worker (Shahbaz) was generally the first choice. However, neither GREEN HOUSE® nursing staff nor administrators expressed serious concern over 'pulling' a CNA from the nursing home to fill in for a shift or two. Some, but not all, Shahbazim objected to pulling a fill in CNA who was not familiar with the GREEN HOUSE® model, nor had the training required to prepare meals, as the replacement worker was unlikely to understand the range of tasks expected of Shahbazim. When this occurred, it often meant more work for the other Shahbaz in the cottage.

Both Shahbazim and nurses saw GREEN HOUSE® nurses as relatively interchangeable. Strong clinical skills, the ability to multitask, and self reliance were the most highly prized characteristics for selection of GREEN HOUSE® nurses, whether permanent or temporary replacements. Despite the emphasis on collaboration and teamwork in the GREEN HOUSE® model, a history of positive relationships with CNAs was not generally considered vital for a GREEN HOUSE® nurse. While many Shahbazim found it difficult to work with CNAs who had no GREEN HOUSE® experience, nurses without such experience were much less likely to be seen as problematic. The staff, (Shahbazim, nurses and administrators) generally saw little difference between the role of the nurse in traditional settings and the role of GREEN HOUSE® nurses.

Role of the Guide

Nurses who practiced within the Traditional model were often unclear about the role of the Guides. But the relationship between the nurses and the Shahbazim was clear and direct. These nurses dealt directly with Shahbazim. Guides were sometimes consulted by Shahbazim to address daily operations. In the one home with a predominantly Traditional nursing model, the Guide was relatively 'hands off,' stopping in the cottages to check if anything was needed by the Shahbazim. The Guide was available to Shahbazim and remained in a direct supervisory role, however, resident care issues were directly dealt with between nurses and Shahbazim and other issues were addressed among the Shahbazim with minimal input from the Guide.

Implications of Traditional Model

Nurse Work Life Quality

Shahbazim in this model deferred to the nurses and generally did not (at least openly) question what the nurses' authority to direct them, even when they disagreed with the decision or believed it was at odds with the GREEN HOUSE® philosophy. Although this hierarchy is inconsistent with the stated intent of the GREEN HOUSE® philosophy, most of the nurses practicing within the Traditional model were quite comfortable with their role. They stressed that they were accountable for making sure care was delivered appropriately and that quality of care was maintained. Most also suggested that their relationships with Shahbazim were quite positive, that there was little tension between the two groups and that the model operated smoothly. Nurses practicing in a more traditional manner were more likely to wear traditional uniforms to use medication carts, and to have a traditional nursing appearance. Not all nurses maintaining a traditional appearance, however, practiced within the Traditional model.

Nurses working in the Traditional model generally described the workload as greater than in the nursing homes where they had previously worked. In particular, they spoke about the consequences of not having other nurses around to back them up or to temporarily take over some of their responsibilities if they were busy with a resident problem or an emergency. They also maintained many of the traditional front line worker oversight and checking to see that work had been done. Night shifts, when there were fewer nurses around, was most likely to result in a higher work load.

Shahbazim Work Life Quality

Shahbazim working within the Traditional nursing model were noticeably less excited about their work than were Shahbazim in working within any of the other nursing models. For the most part, they continued to enjoy their work but did not see it as much different than working in a nursing home. This was markedly different from the level of excitement conveyed by Shahbazim in many of the other sites. These Shahbazim also tended to see their work as more demanding than it had been in their prior nursing home work as there were more tasks to complete.

Shahbazim were divided on their support for the Traditional nursing model. Some were quite supportive, expressing a strong belief that it was "the nurse's job to be in charge." Shahbazim who were very supportive explained that the nurse was responsible for care decisions and outcomes, that the nurses had information Shahbazim did not have access to, and that it was inappropriate for Shahbazim to initiate contact with families. Although most found it annoying to be asked, these Shahbazim believed that it was the nurse's responsibility to check that the Shahbazim had completed their assigned work by the end of the shift.

Other Shahbazim were disappointed that the GREEN HOUSE® model had not been implemented the way they had expected. In particular, some expressed a desire for more autonomy, objecting (not openly) that nurses continued to be authoritarian and 'bossy,' or that much of the oversight from nurses was unnecessary or even demeaning. As one Shahbaz said,

> *"I don't think it's right that a nurse asks me at the end of the shift whether I have gotten my vitals. I have been doing this for 15 years. I have gotten vitals every day. Why wouldn't I get vitals? Why does she have to ask me that?"*

Resident Care Quality

We found no evidence that the quality of clinical care was compromised in the Traditional model of nursing practice in any of the GREEN HOUSE® homes. Resident clinical conditions were identified and communicated to the nurses, much as they had been in other settings. Where the Traditional model was the predominant model, Shahbazim reported to nurses in the same way that had done when working in a traditional nursing home. They viewed the GREEN HOUSE® nurses as their primary supervisors despite the altered formal reporting relationship. Nurses were clearly responsible for responding to changes in resident conditions. Nurses were also primarily responsible for identifying changes in resident conditions and, accordingly, monitored residents closely.

As the relationship between nurses and Shahbazim was similar to that found in traditional skilled nursing facilities, the follow through on care and treatment was similar as well. Nurses practicing within the Traditional model continued to practice as they had in prior work settings. For example, nurses who had always checked on whether CNAs had followed through on resident care (walking, turning, etc) continued to do so. Those who had always assumed that CNAs did their work without prodding or oversight, continued to do so.

When questioned about ongoing education and skill development, both nurses and Shahbazim practicing within this model did not see the nurses as major sources of education or skill development. In fact, most Shahbazim and nurses believed that skills of both nurses and Shahbazim were sufficient to provide high quality care for residents. All said they had access to educational programs at the facility and sometimes participated in these programs. None of the nursing staff believed it was primarily the nurses' role to identify learning needs for Shahbazim. All saw this as a role for staff development personnel in the legacy facility. While seeing some variation across Shahbazim, the nurses generally viewed the Shahbazim as competent and well prepared.

Visitor Nurse Model

"He had a fractured hip so he should've been turned or repositioned because he's in his room and he was like, 'I don't want to,' and nobody (Shahbazim) was taking care of it. At that time, I (nurse) called the Guide to come down and take care of it."

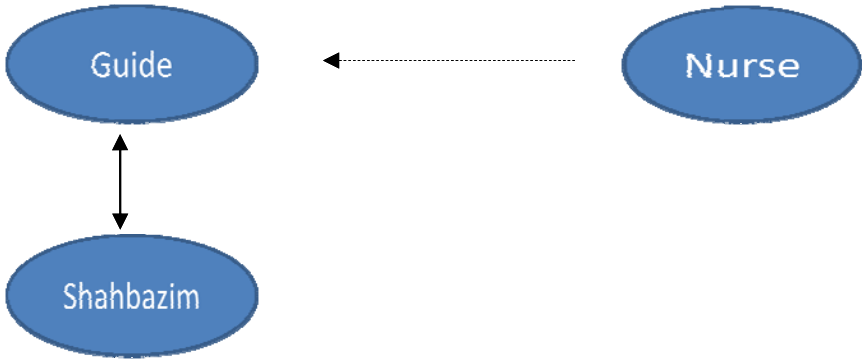

Figure 2. In the Visitor model, the Shabazim were seen as "in charge" and would bring problems with the nurses to the Guide. The nurse was seen as an "outsider" by the Shahbazim and only essential for the med pass and treatments. There is little communication between Shahbazim and nurses.

A fourth nursing model, the Visitor nurse model, is characterized by a clear division of labor that places the Shahbazim as central to decision making about resident care issues. Nurses are brought in as the Shahbaz deem appropriate. Although nurses have access to residents on their own, Shahbazim rarely relied on nurses or collaborated with nurses in decision making. Shahbazim viewed themselves as 'in charge' of the home, using nurses as consultants when they chose to.

> Shahbaz: *"Basically, I just see her (nurse) pass pills and if somebody wants, pain meds, or something, then we'll call her…"*

Shahbazim saw nurses as having no authority over Shahbazim work.

Clarity, Structure and Content of Roles

In the Visitor nursing model, the Shahbazim viewed their role as clear, seeing themselves as 'empowered' to make decisions and, in many cases, to determine whether a resident condition required nursing intervention or referral. When in doubt about how to respond to a resident problem, they usually consulted the Guide. Shahbazim and nurses both described many occasions when referrals were made and decisions were made about changes in resident care without consulting or even informing the nurses. Specifically, referrals were made to therapists and families were notified of changes or problems, with nurses finding out only after decisions had been made.

> Nurse: *"The Shahbazim had been talking to the Guide, telling the Guide about a resident who was having trouble swallowing. They made a referral to the speech therapist. No one told me anything. I was the last one to know. I should have known the resident was having that problem. But no one told me."*

Both the Shahbazim and the Guide were supportive of this general process. The nurses consistently were not.

Hiring and Filling In

In the Visitor model, Shahbazim took responsibility for most of the training or 'breaking in' of new Shahbazim and were involved in the selection of new Shahbazim. In a few cases, new Shahbazim had not worked out. The decision to terminate the Shahbazim was made with strong input from the other Shahbazim. The nurses were not involved in the decision. Filling in and hiring of nurses was done primarily by the DoN. Nurses were selected primarily for their clinical ability. Unlike in some of the other models (Integrated in particular), team collaboration and quality of past relationships with CNAs was not considered central when hiring new GREEN HOUSE® nurses.

Role of the Guide

In the one home where this model was dominant, the Guide communicated primarily with the Shahbazim. When nurses communicated with the Shahbazim, they generally did so through the Guide.

> Nurse: *"I kind of stepped on people's feet because I went directly to the Shahbaz on certain occasions and was met with a bit of resistance. I was told, 'If you are having problems with so and so, please go through the Guide.' "*

The Guide did not bring nurses and Shahbazim together to discuss either resident care or interpersonal issues. If care that the nurse believed was important was not provided by a Shahbaz , the nurses generally completed the work themselves and said nothing to the Shahbaz.

Implications of Visitor Model

Shahbazim Work Life Quality

This model is distinguished from the others by a clear difference between perceptions of Shahbazim and nurses on how well the model was working and on work life quality. Shahbazim

were generally quite positive about their work lives. Although there was some dissatisfaction with in house assignments (shopping, scheduling etc), all Shahbazim who were interviewed agreed that their independence, autonomy and authority contributed to the high quality of daily work life. There was general satisfaction with the model and how it operated. There was a strong team identity among Shahbazim while the nurses were not seen as team members and were kept at some distance.

Nurse Work Life Quality
In sharp contrast, the nurses working within this model expressed a high level of frustration and a lower level of work life quality than was found in the other models. These nurses felt marginalized, unappreciated and provided several examples of resident care decisions that had been made without their input. The consequences were that they felt generally uninformed about what was happening with residents and, in particular, described the awkward position they were in when communicating with family or physician about the resident. They described themselves as 'often the last ones to know' what was going on.

Resident Care Quality
In addition to being generally unhappy, and feeling unappreciated, nurses working in the Visitor model were concerned about the quality of care in the homes and did not believe they had any authority to intervene in what the Shahbazim were doing. Nurses were able to describe many clinical problems that had not been brought to their attention, and were consequently, not addressed in a timely manner. During both interviews and field work with Shahbazim, the research team was able to identify clinical situations that were clearly in the domain of nursing care that were not shared with the nurses. In this model, the nurses were effectively excluded from many care decisions and did not have current information about residents. Shahbazim described a few situations which clearly required nursing intervention where they had not communicated with the nurse and did not believe it was necessary. Nurses in this model felt very strongly that they had no authority to intervene in what a Shahbaz was doing or a decision that had been made about a resident.

Parallel Nursing Model

"A resident was having difficulty and you report it to the nurse and your responsibility is done."

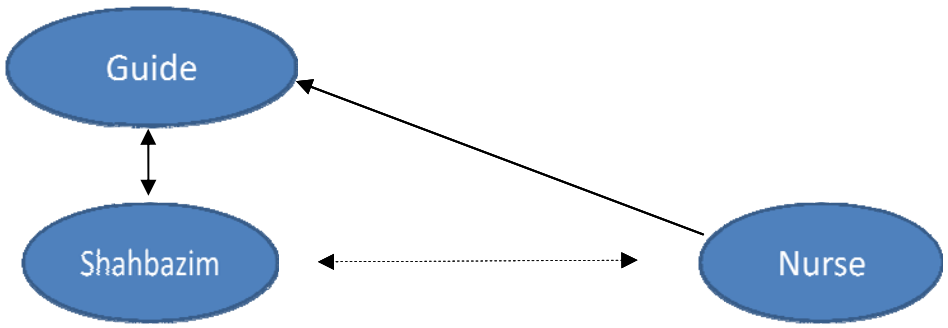

Figure 3. In the Parallel model, the nurses and Shahbazim see themselves as having very distinct roles, with little overlap. Communication is often routed through the Guide when there are problems. There are moderate amounts of daily communication between nurses and Shahbazim regarding resident care.

Clarity, Structure and Content of Roles

The Parallel model is characterized by a very clear distinction between the nurse's role and the role of the direct care workers. Nurses did "nursing" work and Shahbazim did "Shahbazim" work. In this model, the nurses have very little, or no, involvement in the daily operation of the homes. They do not directly supervise the direct care staff and do not generally see it as their responsibility to educate direct care workers, or even to identify educational needs.

> Nurse: *"We do our nursing duties and don't pay a whole of attention to what the Shahbaz are doing care-wise. I mean, we do, in a sense that if I see that there is a safety issue or I'm concerned about pressure relief or things like that, but for the most part their Guide is responsible for discipline."*

While nurses continued to see themselves as responsible for the clinical care, they saw a clear separation between what they did and what the Shahbazim. For example, Shahbazim are responsible for weights and vitals. Nurses did not check to be sure the work had been done. They believed, however, that nurses were primarily responsible for identifying clinical problems that needed to be addressed. They (the nurses) generally believed that the nurses were responsible for reading the charts and determining when their clinical intervention was needed. For the most part, nurses working within a Parallel model maintained responsibility for contacting families about resident concerns took responsibility for referrals and decided how to address clinical problems of residents.

Nurses in this model engaged in tasks that were clearly within the domain of the licensed nurse. Nurses in this model are unlikely to back up the direct care workers. That is, if a resident needs something that is generally seen as direct care worker responsibility, they are likely to inform the direct care worker. For example, if a resident needs toileting or assistance with other activities, the nurses are unlikely to do this. They will instead, inform a Shahbaz. The nurses do not see this as their role and do not have the time to do these things.

Nurses did not get involved in any of the daily operations of the home or Shahbazim activities. Shahbazim working within the Parallel model consistently agreed that the roles were clear. They knew what work was their responsibility and what belonged to the nurses. Both nurses and Shahbazim also agreed that Shahbazim immediately referred any resident clinical problems to the nurses and did not necessarily expect to be informed by the nurses about the outcome, unless it had relevance for Shahbazim work. Nurses had no involvement in daily operations. Shahbazim were responsible for managing the daily operations of the homes, for working out disputes among themselves and for determining work assignments. In general, the Shahbazim and nurses felt their relationships were quite positive.

Hiring and Filling In

While there was some flexibility, most nurses and Shahbazim, as well as administrators, believed it was important to have nurses who were familiar with the GREEN HOUSE® philosophy and

approach. In particular, they all agreed that the relationship between nurses and Shahbazim, with the Shahbazim having greater autonomy than in more traditional settings, was important. However, they also agreed that it was more important for Shahbazim to be familiar with the GREEN HOUSE® philosophy than it was for nurses.

Role of the Guide

Guides in this model were often involved in responding to nurses' concerns about Shahbazim work quality. The Guides in this model varied considerably in how they worked and in how closely they worked with the nurses. In some settings the Guide worked very closely with nurses, redirecting the direct care workers back to the nurses when they have questions related to any clinical issues and always conferring with nurses before referrals are made to other providers such as therapists. In other settings, the Guides were less active, allowing the nurses and Shahbazim to figure out how they would work together. The Guides were often instrumental in determining when Shahbazim needed additional education, sometimes working directly with GREEN HOUSE® nurses but more often organizing these activities on their own. In these homes, the Guides play a vital role in keeping an ear to the ground and assuring important information is communicated between nurses and Shahbazim.

Implications of Parallel Model

Nurse Work life Quality

The nurses practicing within the Parallel nursing model were generally very happy and comfortable with their roles, had extremely positive things to say about the rewards of the work and felt the quality of life and care for the residents was superior to that in the more traditional settings where they had worked. They were particularly supportive of no longer having to monitor the direct care workers, spending their time doing 'nursing' work rather than supervising other workers, and for many, spending more time in direct contact with the residents. They all believed that there was more family contact, for the staff as well as the residents, that the residents were happier and that the environment was more pleasant to work in. Many felt the workload was similar, but that more of their time was spent in direct contact with residents and less in other non-nursing activities. Some nurses working within this model described the workload as greater than previously, as they were so frequently paged to assess a resident's condition or to answer a question from families or doctors. This was particularly the case when nurses were responsible for multiple cottages and described difficulty completing their work as they were frequently called to another cottage.

Shahbazim Work life Quality

Shahbazim working in the Parallel nursing model were generally very positive about their work life. They felt empowered to make decisions about their work, identified many new skills they had developed, felt the work was more rewarding than previous CNA work had been, and could not imagine 'going back.' There was a high level of excitement about the work and the ability to provide high quality care and a more satisfying life for residents. They were quite positive about being responsible for completing their daily work without oversight from the nurses. Like Shahbazim working in the other nursing models, they sometimes felt challenged to complete all their work.

Some Shahbazim expressed disappointment that there was not more work sharing between the Shahbazim and the nurses. For example, as there is a clear separation between the work of nurses and Shahbazim in the Parallel model, nurses generally do not help with personal care tasks or answering lights. Some Shahbazim were quite disappointed about the absence of assistance and work sharing with the nurses.

> Shahbaz: *"They're just like 'we give the meds.' Sometimes they're right in front of a light and the resident just needs like water. I mean, something really basic."*

Resident Care Quality

Shahbazim saw themselves as responsible for identifying changes in residents' conditions and notifying the nurse when such changes occur. They were comfortable communicating directly with nurses about residents' conditions and saw it as an important part of their roles. At the same time, nurses saw each resident as they passed medications and completed treatments. We saw no instances of Shahbazim failing to pass information on clinically important information to nurses. Nurses routinely checked resident records for clinical information such as vital signs and weights that Shahbazim recorded. Reporting off was somewhat mixed, although in general, nurses reported off to nurses and Shahbazim generally reported off to Shahbazim. There was minimal nurse to Shahbazim or Shahbazim to nurse shift change reporting. Both Shahbazim and nurses described letting the other discipline know about things that were important to share and where work responsibilities overlapped. For example, if a resident was assessed to be dehydrated, the nurses would communicate to the Shahbazim that fluids should be increased.

As in the previous three nursing models, the nurses did not see themselves as responsible for identifying learning needs of Shahbazim, or to identify where staff development might be useful for the front line staff. Nor did they see themselves in a teaching role with the Shahbazim.

Integrated Nursing Model

"We have a resident that has been declining and falling. So we (nurse and shahbazim) talked about how we are going to stop this and try to get her out more…we started drawing up papers to get check on her every 30 minutes, bring her out to watch tv more with everybody else, and we're getting the family to come in more. So we've been communicating on that and getting ideas back and forth. We started finding a pattern. The nurse and us called the family up and talked to them to get ideas…"

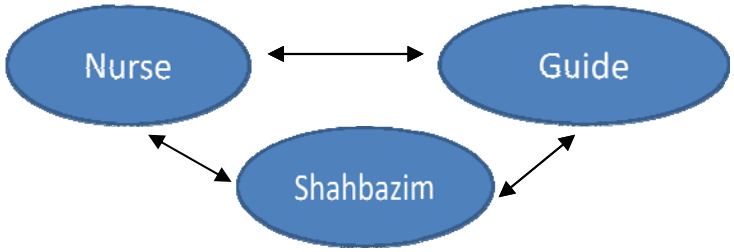

Figure 4. In the Integrated model, the nurses and Shahbazim work collaboratively to provide care to residents and problem solve. The Guide, who speaks frequently with nurses and Shahbazim, facilitates this relationship by

encouraging teamwork and a positive relationship. There is open and frequent communication among team members.

Clarity, Structure and Content of Roles

In the Integrated model, there is less formal division of labor between direct care staff and the nurses. This approach is characterized by a higher level of informal collaboration between direct care staff and the nurses and considerable shared responsibility. For example, the nurses in this model were generally quite willing to do 'Shahbaz' work. Nurses were seen to assist with feeding, toileting and bathing. If a resident asked for assistance and the Shahbaz was not present, the nurses respond to the residents' request. Nurses using this approach were very supportive of continuing this, as they described how much they learned about the residents by doing these things themselves. Sometimes nurses and Shahbaz did these things together.

Nurses working in this model were somewhat more likely to describe themselves as part of the team. While it was rare for nurses working in the other models to have meals with the Shahbazim and residents, nurses in this model had at least occasional meals at the home. As in the other models, Shahbazim viewed nurses as responsible for most clinical decision making. This model was different, however, in that both nurses and Shahbazim initiated contacts with family members. While many nurses and Shahbazim in the other three models considered initiating contacts with family as the domain of the nurse, Shahbazim in the Integrated model felt quite comfortable contacting family for a range of reasons. Similar to the other models, nurses always initiated contacts to discuss serious clinical events.

While the core work responsibilities for each worker type are the same as the other models, the Integrated model can be distinguished by the degree to which the Shahbazim and nurses collaborate and share work. For example, nurses often answered lights when they were closest to the resident's room. They might also respond to a resident's request rather than calling a Shahbaz.

Hiring and Filling In

Staff in the Integrated model, both Shahbazim and nurses, were most concerned about using backup staff who had experience in the GREEN HOUSE® model. It was generally accepted that only GREEN HOUSE® trained staff could be used to fill in as needed. They were the least accepting of nurses who did not collaborate or maintained a hierarchical approach to Shahbazim. Ability to work collaboratively and to share the work with Shahbazim is seen to be an important characteristic of GREEN HOUSE® nurses. Nurses who have histories of being very respectful to CNAs are considered most suitable. At the same time, as in other models, the DoN and other nurses generally see clinical skills as extremely important as well.

Role of the Guide

Guides at sites with a predominantly Integrated model tended to see themselves as resources for both nurses and Shahbazim. They also tended to be highly engaged, not just waiting for Shahbazim or nurses to contact them. They saw their role as developing the skills of the Shahbazim, directing them back to the nurses for issues they believed the nurses should be involved in, ensuring that the nurse was notified about any clinical issues, while also supporting Shahbazim to build the skills they needed for daily operations of the home. These guides encouraged staff to work out problems amongst themselves (nurses and Shahbazim), but offered

advice and assistance when it was clearly needed. The Guides often redirected Shahbazim to the nurses when the issue revolved around resident care. The Guides saw themselves as role models and facilitators to the entire care team. The Guide often worked collaboratively with the Director of Nursing or Assistant Director of Nursing to problem solve.

Implications for Integrated Model

Nurse and Shahbazim Work Life Quality

Both nurses and Shahbaz described the benefits of sharing work and time together. Their views of work life quality were almost identical. Nurses found this a good opportunity to teach the Shahbaz, while they were also making an important statement about a collaborative approach to care and a high level of respect for Shahbaz. Shahbaz in this approach felt the nurses were highly invested in the care and very respectful.

Though nurses working in the Integrated model were satisfied with their roles, many believed that the model resulted in a significantly increased workload. Because nurses (willingly) shared in some of the Shahbazim work, either instead of Shahbazim (in the spirit of partnership) or along with them (to teach or to gather clinical information about the resident), the workload of the nurses increased. While both Shahbazim and nurse found this to be an excellent model for both care and staff development, it clearly has implications for nursing workload. At the same time, nurses in the Integrated model felt more comfortable with less nurse staffing on the night shift, as they highly trusted Shahbazim to quickly summon a nurse when needed.

Resident Care Quality

Of all the models, the Integrated model facilitated the most timely identification change in resident condition. Shahbazim and nurses worked together most closely and collaboratively in this model. Much of the communication about residents was informal, occurring during daily conversations as they worked in the same vicinity or worked together with a resident. Shahbazim saw it as their role to participate actively in identifying resident clinical needs and were more likely than in the other models to offer their opinions. For example, in one home with a predominantly Integrated model, a Shahbazim was observing a resident as the nurse was helping the resident take a medication. The Shahbazim noted to the nurse that the resident seemed to be ‘leaning to the right,’ while taking the medication, and that this was unusual for this particular resident. She continued to observe the resident as the nurse escorted the resident back to her room, later sharing her observations with the nurse.

One nurse explained in detail how well the model was working and how much more effective this model was for promoting quality of care. She described how she sometimes answers lights and takes residents to the toilet as it gives her the opportunity to observe how they ambulate, to directly view their skin, and to detect any odor from their urine. Doing ‘Shahbaz work’ gives her a tremendous amount of clinical information that she might otherwise not have.

Several, but not all, of the nurses in this model engaged in some teaching of the Shahbazim as they worked together. While the nurses did not see themselves as responsible for educating the Shahbazim, they often explained what they were doing and why, described new treatments, demonstrated techniques for lifting, moving, transporting.

Shahbaz: *"When I worked up at (legacy home), I never did the glucose scans and she kind of expects that here, you know, like at 4:00 two of them might need a glucose scan and she's over at the other house."*
Interviewer: *"Do you feel comfortable doing that?"*
Shahbaz: *"It's no big deal."*
Interviewer: "So how did you learn to do those?"
Shahbaz: *"The nurse showed me."*

Some of the Shahbazim talked about how they were taking on increasing responsibility for learning about clinical conditions and becoming better collaborators with the nurses. They described their skill levels as increasing over time.

Shahbaz: *"We know when she's (elder) starting to act a little restless, and she's on the light all the time, we quickly check her blood sugar or her oxygen, because we know that's a sign of…maybe blood sugar or an oxygen issue."*
Interviewer: *"How did you learn that might be a sign of that?"*
Shahbaz: *The nurse, actually. We work very, very closely with the nurses….so if someone just isn't acting normally, I'll say, 'Hey (nurse), this person over here has been crying a lot lately, or they're very restless…' and the nurse will come over and say, 'Well, hey, this is usually the case when this happens…' Especially when you work so closely with the nurses, you learn."*

One nurse described how taking a resident to the toilet *with* one of the Shahbaz allows her to observe the clinical skills of the Shahbaz and to teach the Shahbaz about more effective strategies. It also gives the nurse an opportunity to teach the Shahbazim about new treatments and clinical problems with a specific eye to clarifying what the nurse should be informed about.

An In-depth look at the Role of the Guide

While there were many factors influencing the implementation of the nursing model, the role of the Guide had a significant impact. In particular, Guides had a clear influence on how well the Shahbazim developed both individually and as a team. Shahbazim in the GREEN HOUSE model are expected to perform in a range of areas that are not traditionally components of CNA work. When guides who are aware of these new skills and take the initiative to coach, nudge and support Shahbazim, the teams appeared to develop and run more successfully. Some of the most useful skills for these Guides were: coaching, team dynamics, interpersonal skill development, problem solving and conflict resolution.

As the homes attempt to work out the details of their implementation, Guides were also quite instrumental in determining how, how often, and in what way the Shahbazim and nurses would interact. Guides had a clear influence on how Shahbazim thought about their relationship with nurses (other than the hands off Guides who left this mostly to the Shahbazim to figure out). Guides could also be quite influential in bringing nurses and Shahbazim together, identifying the most effective ways to collaborate.

Although the role of the Guide was not the focus of this study, the Guide was so integral to operation of the homes, and the relationship between Shahbazim and nurses, that further exploration is warranted. The four typologies that emerged are explored below. Each Guide often

used a mix of skills from multiple typologies. The following descriptions are designed to help staff think about the impact of various approaches to Guiding.

Hands-Off Guide

Guides using the "hands-off" approach to their work in the GREEN HOUSE® homes felt it was primarily their role to be a resource for the Shahbazim as needed, and to relay important policy and regulatory information to staff. These Guides would often do "rounds" in the cottages each day, bringing new pieces of information from the legacy nursing home (often new policies that would impact staff, news of an admission, or relaying information from legacy dietary or maintenance staff) and asking if staff needed anything. The Guide would say hello to residents and gather small informal meetings of staff to relay info, often in the kitchen.

If issues were brought to these Guides from Shahbaz, the Guide would encourage the staff to work it out amongst themselves. If issues were brought to the Guide by the nurses (for example, a nurse had an issue with Shahbaz not keeping water sufficiently available to elders), the Guide would often bring this up to the Shahbazim at the next "rounds" and ask them to work out the problem.

Guides cited this style as very empowering to staff and found they generally worked things out when pushed to do so on their own. Shahbazim reported feeling overwhelmed by having to work out problems they were unsure how to solve. They often wished there was more assistance from the Guide in working through problems. They did not want the Guide to step in and solve the problem, but felt more help with thinking through solutions would be helpful. Shahbazim did feel the Guides using the "hands off" style were still good resources for getting anything the cottages needed.

Nurses often felt perplexed by the "hands off" Guides. They felt this style made their own role as nurses in the cottages even more confusing. Nurses were unsure what authority they had over things occurring in the cottages, how much they should get involved in Shahbazim issues, and where they had influence over Shahbazim resident care issues. When there was an issue, nurses tended to either resort to the traditional nurses hierarchical role, or did not say anything at all. When they did bring something to the Guide, they trusted the Guide would take care of the problem. There was little interaction between the Guide and Nurses.

Guides using this style rarely interacted with the Director of Nursing or Assistant Director of Nursing around issues in the cottages. They viewed their domains as quite separate.

Protector Guide

The Protector Guide saw their role as making sure the Shahbazim were supported in their more autonomous roles in the cottages. These guides were very supportive of empowering Shahbazim to problem solve and operate the GREEN HOUSE® cottages in their own way, while reminding them of regulatory and GREEN HOUSE® philosophy information.

In this model, Guides positioned themselves as the gateway between nurse/Shahbazim and legacy home/Shahbazim interactions, particularly when there were potential disagreements. They tried to shelter Shahbazim from potentially negative interactions and information. Guides

genuinely felt bad about having to convey anything negative or disruptive to Shahbazim, fearing it would undermine efforts to empower the staff and hurt morale.

The Protector Guide would often field issues brought forward by the nurses. The Guide would look for ways to gently approach the particular issue with the involved Shahbaz, and would minimize the involvement of other staff. This may have been a method of protecting the Shahbaz from embarrassment, scrutiny from other staff, or preventing conflict among staff (as there were instances of staff feeling they were "better" than other Shahbaz, which is not uncommon among staff in healthcare settings). The Guide would then tell the nurse the issue had been dealt with and to report back again if there was still a problem.

The Protector Guide had a sense Shahbazim were very busy, and hesitated to burden them with extra meetings, trainings or projects. Therefore, as mentioned previously, issues were often dealt with on an individual basis. While this had the least intrusive impact on the cottage in the short term, and often solved the immediate issue, this may not solve systems issues or elevate quality improvement efforts.

The Shahbazim with a Protector Guide had an amicable relationship with the Guide, generally feeling supported. The nurses in this model had mixed feelings about the Guide. Some were thankful the Guide was there to deal with Shahbazim issues and as the nurse, they could focus on direct care of the elders. Others felt some issues were really never resolved well enough and that the Guides "protection" of the Shahbazim put them in an adversarial role with GREEN HOUSE® nurses.

Enforcer Guide

The Enforcer Guide appeared to take on what might be considered a more traditional charge nurse role in the legacy nursing home. These guides saw their roles as assuring compliance and making decisions when problems arose, rather than helping the staff develop their own solutions.

Guides in this role tended to field complaints from nursing staff about Shahbazim work. The result of this was often the Guide reminding Shahbazim about the right way to do something or instituting a new policy, and checking in on the cottage more frequently to assure the issue was resolved to their satisfaction.

Shahbazim did not feel as close to enforcer guides as other guide roles. They did not feel as supported by management, feeling they had little input to policies and changes, and often were suspicious of why new policies were handed down. There was a sense of hesitancy to ask the Guide for help with anything that could be seen as a sign of "weakness" in the group of Shahbazim.

Nurses in this model felt they could bring problems with a Shahbaz's work to the Guide and it was the Guides job to resolve that problem. The nurses were thankful it was not their problem to deal with personnel and quality of care issues, as it was when they were a charge nurse in the nursing home. However, the nurses also saw this as a drawback at times, as they didn't feel they could say something to the Shahbazim "in the moment" when something had been done

improperly or needed to be done. They did not feel it was their right to say something in the GREEN HOUSE® model.

Facilitator Guide

Facilitator Guides operate as part of the cottage team. Guides check in with the cottages to see how things are going, but focus on spending time with elders and having both social and work-related conversations with employees. They might bring a new item over to the cottage for elders to enjoy, or ask how a new process is working out among employees. The Facilitator Guides may offer suggestions for an activity, or may simply bring helpful news from the legacy home. News or policies that may be considered "bad" news, was framed in a useful way for staff. The Guide would approach the issue as how can "we" best handle this in the cottages?

Visits from the Guide were welcomed by staff in this model. Staff felt very supported by the Guide and had few complaints about how the GREEN HOUSE® operated in tandem with the legacy home. Shahbaz displayed good problem solving ability for basic issues, and felt confident the Guide would help them work through more complex issues.

The Guides in this model vary considerably in how they work and in how closely they work with nurses. In some settings the Guide works very closely with nurses, redirecting the direct care workers back to the nurses when they have questions related to any clinical issues and always conferring with nurses before referrals are made to other providers such as therapists. In other settings, the Guides are less active, allowing the nurses and direct care workers to figure out how they will work together. The Guides are often instrumental in determining when direct care workers need additional education, sometimes working with GREEN HOUSE® nurses to clarify needed training and how nurses could informally help, but more often organizing these activities on their own.

The Facilitator Guide appeared to be the most beneficial for GREEN HOUSE® Homes. Nurses felt respected and involved, Shahbazim felt supported and empowered, elders had a high level of interaction with the Guide, and staff education needs were often identified and supported on a consistent basis.

Common Challenges to Implementing the GREEN HOUSE® Model

Some challenges were relatively unrelated to the nursing model. These are challenges that have been identified by the GREEN HOUSE® homes and which they are currently addressing. These include: 1) integrating new staff into the GREEN HOUSE® model, 2) development of new skills required of Shahbazim, 3) addressing interpersonal problems among coworkers, and 4) creating sufficient opportunities for residents to engage in meaningful activities. Each of the sites has struggled with how to bring in new workers, familiarize them with the concept, assist them to fit into the new work routine, and learn the new skills required of Shahbazim in particular. In particular, the GREEN HOUSE® model requires a high level of flexibility from Shahbazim.

Unlike many nursing home settings, the Shahbazim do not have individual resident assignments. They are all responsible for all residents. This requires Shahbazim to create a work flow between them, to consider other staff and general house responsibilities as they go about their work. The good worker who focuses on getting the work done, working alone, does not fit well

into the GREEN HOUSE® model. This requires some getting used to as well as support and coaching from the other Shahbazim. Coaching skills are also useful for Shahbazim, although many have never been called on to engage in coaching activities. Shahbazim are also expected to be cooks and housekeepers, to keep residents continually engaged in activities, to create a family atmosphere to interact continually with family as well as completing the work that CNAs are expected to do. For many, this requires the development of a new set of skills.

One of the most difficult challenges, observed in every GREEN HOUSE® home, is the difficulty confronting coworkers when interpersonal or work performance issues arise. No one found this easy. However, all Shahbazim agreed that it was important for them to make it clear when there were problems, and to address the problems. As several Shahbazim stated, it was easy to ignore these problems in traditional nursing homes. It was the nurse's problem when a CNA had performance problems or did not complete the work assigned to them. Also, in more traditional settings, it was often possible to avoid interactions with CNAs who created interpersonal problems. In the GREEN HOUSE® homes, neither is possible. Performance issues such as not completing the work or not doing Shahbazim work to an acceptable standard required other Shahbazim to identify and openly address the problem. This continued to be difficult for most Shahbazim, although was more effectively addressed with coaching from Guides.
Finally, a challenge in almost every GREEN HOUSE® home was finding ways to engage residents in meaningful activities throughout the day. Some of the difficulties observed were: Shahbazim who had no experience planning activities, a philosophy that individual residents would select and request an activity, the pull of other responsibilities. Most, but not all, Shahbazim had little or no experience planning, developing or carrying out activities for elderly residents. In a few places, there was formal coaching from an activity therapist, but in most homes the Shahbaz was left to figure this out. Some elders expressed a desire for more activities, for 'something to do.' A few expressed a desire to return to the legacy home in order to attend group activities that they missed.

Some Shahbazim believed that being in a natural home setting allowed the residents to simply do as they pleased during the day. For many elders this worked well. However, there were some elders who were unable to find something meaningful or interesting to do when left on their own. This is an interesting 'artifact' of efforts to create a very natural environment, to avoid large group activities that were not responsive to individual requests. Finally, keeping residents engaged, particularly residents who needed a high level of support or structure, was difficult in the context of many other competing demands.

There were many examples of how these challenges are being addressed innovatively and effectively. For example, several Shahbazim have integrated elders' preferences into the routine of the day. Some elders help in the kitchen. Some elders can be seen assisting other elders with activities. Some fold laundry and deliver clothing to other residents. These are resident choices and are often similar to past familiar activities. Other Shahbazim seem to be quite naturally skilled at stimulating conversations among elders. In some places there were predictable structured activities such as exercise, news reviews, or card games. Some elders counted on these activities.

Summary and Implications

Each of the GREEN HOUSE® sites has faced many decisions and challenges as they implement the GREEN HOUSE® model. Factors such as available workforce pool, pay scales, organizational resources, resident mix, and the evolving GREEN HOUSE® training all influence implementation. However, there are also many factors that result directly from decisions made by the organization, such as Guide responsibilities, selection of workers to staff the GREEN HOUSE® homes, and structures of staff meetings and problem solving.

The willingness of GREEN HOUSE® homes to open their doors and examine, with us, the nuances of model implementation have provided important insights that others can benefit from. The GREEN HOUSE® homes have demonstrated successful risk taking that has empowered CNAs and shown that a homelike environment can be achieved for elders. The nursing role continues to evolve as GREEN HOUSE® homes recognize the importance of nursing expertise, yet seek to redefine traditional staff reporting structures and shift the focus to resident quality of life beyond traditional medical care. It is apparent that a balance can be found, where nursing expertise is respected and integrated into the daily care of residents, yet CNAs are empowered to self-organize and respected for the intimate knowledge they bring to daily care. The GREEN HOUSE® organization has unique environments to coach Shahbazim and nurses about true collaborative caregiving, where both quality of life and quality of care are shared domains that can both be improved with exemplary communication, shared decision-making, and reciprocal teaching and learning.