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From 'nursing home' to 'home': The small house movement
From the growing movement toward "small is better," notes from a conceptual leader

by Judith Rabig and Donald Rabig

Individuals who seek long-term care have three distinct needs: housing, assistance with activities of daily living, and chronic disease management. The goal of nursing home reform should be to provide satisfactory performance in each of these areas. While the culture change movement has provided the nursing home industry with many innovative, humanistic, life-enhancing approaches, it is a piecemeal tinkering with a delivery system that is fundamentally flawed. Culture change leaves largely in place the root cause of nursing home failure: the institution. To achieve the desired outcomes of good quality of care and good quality of life, the institution must be removed from the nursing home equation.

"Small house" is the generic name for a deinstitutionalized nursing home. Small house achieves deinstitutionalization by reframing the philosophical view of the person, changing the architecture, and reengineering the design of the organization. Small house programs have been implemented, thus far, in a variety of ways. Tightly defined registered trademarked models, such as the Green House®,¹ loosely defined consultant-led implementations that accommodate individual organization choices,² and internally envisioned and self-implemented versions all exist. While each organization has configured its implementation in a unique manner, there are a set of characteristics that define an implementation as a small house (table 1). A small house is an intentional community of 10 to 14 persons and a staff of highly trained workers who live and work in a well-designed environment organized and operated around the humanistic guiding principles of autonomy and dignity. When completely implemented, small house reframes the philosophical view of the person, restores the metaphysical and physical home, provides good chronic disease management, and supplies sufficient staff and equipment to support personal care.

Characteristics of a "Small House"

Architecture that includes:

- Conscious elimination of the signposts of the medical model
- Small, self-contained homes or communal apartments for 10 to 14 people
- Private room for each person
- Private bathrooms for each person with showers and sinks with grooming space tilt-mirror and storage
- Home configuration: front hall, living room, dining room, kitchen, and den
- Short walking distances from bedrooms to living areas
- The people who live in the houses have access to all areas of the house
- Residential finishes and hardware
- Access to outdoor space/connections with nature

Policies for people who live in the house that include:

- Participate in their own care planning meetings
- Participation in household activities of choice
- Resident selection of all bathing choices
- Decisions honored regarding all aspects of care
- Opportunity to "make home" by personalizing their space, including bringing their own furniture and belongings
- Opportunity to access outdoors easily, without barriers to navigate or the need to secure permission
- Food at will

- Accessible details—windows, faucets, light switches, doors, floor transitions, power outlets, switches, thermostats
- Driveways, sidewalks, and exterior lighting that are residential in size and configuration
- Interiors that echo the neighborhood
- Lighting that meets guidelines for the aging eye

- Visitors at will
- Greater community access at will

Staff structure that includes:

- The house as the operating unit
- Minimized bureaucracy
- Shared leadership and decision making
- Collaborative work processes
- Self-scheduling
- Interdisciplinary participation in quality assurance
- Self-directed learning

Staff training that includes:

- Change and its effect on people and organizations
- Safe restoration of choice
- The holistic view of all people who live in the house
- Maslow's hierarchy of needs
- Habilitation in ADLs
- Communication and collaboration
- Caregiving effectively for persons with cognitive impairment
- Alternate bathing practices
- Leading and being led
- Convivium, food practices, safe food handling

Dining that includes:

- A pleasant social dining experience
- Access to food and drink at will
- Choice of mealtime, food, and quantity of food
- Opportunities to participate in food prep or cleanup activities

Clinical care that includes:

- Advanced training in geriatric nursing for all nursing staff
- Evidence-based clinical protocols
- Management of polypharmacy
- Early identification of problems related to chronic disease
- A robust program of advanced directives discussion
- Therapies that are integrated into the household

Technology that includes:

- Electronic medical records
- Wireless call system
- Nurse-line staff voice communication system
- Lift-free environment
- Computer access for people who live in the house

Policies and practices that:

- Structure assessment and resourcing individual recreation and diversion
- Maximize the use of adaptive devices to support independence in ADLs
- Reduce polypharmacy
- Provide holistic management of depression
- Provide holistic management of pain

- Incorporate the use of complementary therapies

Small house rejects the notion that long-term care must eliminate the medical model and embrace the social model of service delivery and instead seeks to blend both in an integrated approach to care. It has been the mistake of the current system to focus on the medical model of service delivery, and also an error in logic to propose, alternatively, a strictly social model of delivery when recipients have multiple chronic diseases. The small house philosophy moves away from the ageist attitude that people who come to nursing homes are “broken,” unable, and in need of fixing, monitoring, supervising, and protecting. It embraces the individual as someone who has strengths and weaknesses; a person who is engaged in a personal and unique life journey, who has a rich life history, a future, wisdom, and knowledge; someone who seeks to be independent, to have a role, to be productive; someone entitled to autonomy, dignity, and choice.

The architectural and environmental paradigm of the small house is rooted in home, the warm, private, familiar, comforting, safe, predictable, and convenient living spaces people have created for themselves all their lives.³ The goal of its design is to create a space that is a home, not a nursing home that is homelike.⁴ This requires those who design nursing homes to make substantial changes in their prevailing mind-sets; they must design the entire space as a home and then embed in that home the required staff areas. The small house should be a place where the best communal aspects of a home harmonize with the parts of home that promote privacy and individuality.

The design varies but key elements include the communal heart of the small house, or hearth; it also includes an open kitchen, a dining room with a large table where family-style meals are served, and a living room with a fireplace. Private rooms are configured around the hearth within short walking distance to eliminate nosocomial (i.e., facility-induced) wheelchair use. Rooms are equipped with a ceiling lift and a private bath with a shower. Other areas that are incorporated include a spa-like bathing room, a small office, a utility area, and a den, and access to outdoor space that is gated and fenced, with easy access for elders to move in and out.

Traditional nursing home staff have been organized in a 19th-century industrial model, with a steep bureaucracy, departmental structures, and disenfranchised direct-care workers receiving top-down communication. Staff is viewed as interchangeable, and their satisfaction is secondary to efficiency and completed work quotas and schedules. Staff work is focused on satisfying residents' physical and safety needs, with no time or institutional imperative directed at meeting their higher-level needs. A worker is valued for the ability to meet work quotas and schedules. The result has been to create high levels of job dissatisfaction and high turnover, which in turn produce poor quality of care.⁵⁻⁷

Small house redesigns the organization as a decentralized model that views each house as a self-contained, functioning unit. Each house is staffed by a self-directed work team of universal workers—certified nursing assistants (CNAs) who have had advanced training that includes CPR, first aid, culinary skills and food safety, teamwork, and communication skills. This team is empowered to make everyday decisions about workflow and house operation, and works collaboratively with a clinical support team of nurses and therapists to plan and deliver care and services for the people who live in the house. Direct-care staffing is enriched by shifting resources away from middle managers and into direct care. CNA staffing is provided at a ratio of four hours per person per day and licensed nursing at 1.3 hours per person per day.

The goal of the small house clinical team is defined as maintaining individuals with chronic diseases at their maximum state of wellness. Most healthcare professionals have been trained and are accustomed to working in the acute care model. Education for the clinical staff is necessary to assist them in transitioning to the chronic care model. The team is highly engaged in person-centered care planning, and delivers clinical services using evidence-based protocols. Nurses are given advanced education in the nursing process and chronic disease management. Technology is employed to support the work of the team. Electronic medical records ease the burden of documentation and free nurses to engage in direct clinical care. Wireless call systems and electronic beepers facilitate resident-to-staff and staff-to-staff communication.

Implementation

The process of implementing small house is fraught with challenges and obstructions. Implementation is not a grassroots process but rather a process led by strong leaders who can passionately articulate, lead, and role-model, using what Collins calls a BHAG—a Big Hairy Audacious Goal—a clear plan and a guiding vision for deinstitutionalization that leaders are able to communicate precisely to all members of the organization.⁸ Leadership must also be knowledgeable about the consequences of change and know that they, as leaders, will encounter inertia, fear, protection of self-interests, ingrained satisfaction with the status quo, and other deep challenges. Those leaders undertaking small house implementation might heed Machiavelli, who suggested that “the stake that the minority have in preserving their certain place in the status quo is far stronger than the stake that the majority have in bringing about an

uncertain alternative.”⁹

Implementation of the program is an orderly, well-defined series of steps that are necessary to achieve the desired outcomes. Leadership does involve staff in various aspects of configuring and implementing the plan, but does not surrender the plan to the staff. The process can be divided into four distinct phases: feasibility, conceptualization, strategizing, and implementation. Table 2 outlines the components of these phases.

Phases of Small House Implementation

I. Feasibility 3 months – 1 year

- Exploration of the small house program by principle actors & decision makers
- Financial feasibility analysis
- Selection of consultants

II. Conceptualization 3 – 6 months

- Identify site/ land
- Select architect and designers
- Preliminary design
- Regulatory review
- Secure financing
- Map project activities & create timeline

III. Strategizing 12 – 14 months

- Construction
- Systems mapping
- Staff reconfiguration
- Design policies & procedures
- Training
- Quality assurance design & configuration

IV. Actualization 1 year:

- Move in
- Survey for licensure and certification
- System refinement & evaluation

Organizations interested in implementing small house face many challenges, including regulatory, financial, and change management. Yet experience has demonstrated that the greatest challenge to full implementation is the long history of leaders and staff with the prevailing paradigm. The decisions needed at each phase of implementation can easily slip back into the institutional way of doing business. Outside advisers and consultants with experience in implementing and operating successful small houses can prevent costly errors or a partially successful implementation.

National Alliance of Small Houses (NASH)

To assist others who are contemplating small house adoption, innovators who are currently operating houses have formed the National Alliance of Small Houses (NASH). NASH is an affiliate of the nonprofit Institute to Transform Senior Life (ITS Life), and is exclusively for those operating or planning to operate a small house. NASH will provide access to in-depth information and a network of support, as well as foster a comprehensive research initiative, collaboratively refine those systems and processes that support the model, create opportunities for staff at various sites to easily interact and exchange information, sponsor conferences, Webcasts and other learning opportunities, and provide a database of suppliers, materials, and products with user comments about their experiences using products.

While early results have been promising, the ability of the small house model to improve quality of life and quality of care consistently and in a sustained manner over time, and in a variety of leadership, ownership, and case-mix situations, is untested. There is an obligation on the part of adopters to gather data and to report results. NASH intends to establish a database of information about existing small houses and to foster and support research initiatives to examine the various outcomes and analyze the various components of the program.

While solid evidence is needed to promote widespread adoption of a small house, there is certainly an incentive to create sufficient numbers of operating models in various locations so that adequate research can be undertaken. Only then can well-grounded assertions be made about the wisdom of widespread implementation of the small house.

Judith Rabig, RN, PhD, is President of Rabig Consulting in New York City, and Executive Director of the National Alliance of Small House Projects (NASH). For more information, please phone (212) 933-0645, e-mail jrabig@nyc.rr.com, or visit <http://www.smallhousealliance.org>. Donald Rabig is Vice-President of Rabig Consulting. He can be reached at (212) 933-0645 or e-mail drabig@nyc.rr.com.

To send your comments to the authors and editors, e-mail jrabig0308@ltlmagazine.com.

References

1. Rabig J, et al. Radical Redesign of Nursing Homes: Applying the Green House Concept in Tupelo, MS. *The Gerontologist* 2006; 46. 4:533–9.
2. French Liz. "A Step Ahead." *Health Executive* 2006; 12:118–21.
3. Watkins J, Hosier A. Conceptualizing Home and Homelessness: A Life Course Perspective. In: Rowles G, Chaudhury H. *Home and Identity in Late Life*. New York:Springer Publishing Company, 2005.
4. Rabig J, Rabig D, *Small House Design Manual*. Vol. 1. Salt Lake City, Utah:Aardvark Global Publishing, 2008.
5. Rantz MJ, et al. Nursing Home Quality, Cost, Staffing and Staff Mix. *The Gerontologist* 2004; 44:24–38.
6. IFSA. *The Long Term Care Workforce: Can the Crisis be Fixed?*. National Commission for Quality Long Term Care, 2007.
7. Weiner J, Friedman M, Brown M. *Nursing Home Quality Twenty Years After the Omnibus Budget Reconciliation Act of 1987*. The Henry T Kaiser Family Foundation, December 2007.
8. Collins J. *Good to Great*. New York:Harper Collins, 2001.
9. O'Toole J. *Leading Change*. San Francisco:Jossey Bass, 1995.
10. Kane R, Lum T, Cutler L, Degenholtz H, Yu T. Resident Outcomes in Small-Group Home Nursing Homes: A Longitudinal Evaluation of the Initial Green House Program. *Journal of the American Geriatrics Society* 2006; 55:837–9.