Alone in Eden: Care Aides’ Perceptions of Consistent Assignments

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Abstract

The Eden Alternative® is a philosophy of care and transformational model aimed at increasing quality of life for nursing home residents by enhancing institutional environments and restructuring delivery of care. Three fundamental components of restructured care are resident care provided primarily by care aides, enhanced responsibilities for care aides, and consistent assignment of residents to care aides. Researchers have focused on resident and family satisfaction with the model, but there is limited research evaluating the impact of the model on nursing home employees. This article is focused on their experiences. Convenience and purposive sampling were used to recruit 22 care aides from five nursing homes in a western Canadian city. Experiential interview data were collected and analyzed utilizing constant comparison to identify common themes. Although care aides initially welcomed the restructuring, they described gradually becoming overwhelmed by the work, confined by consistent assignments, and isolated from colleagues and other residents.

Keywords

model of service delivery, care aides, nursing home, consistent assignment, focused ethnography, Eden Alternative®

The Eden Alternative® is an American philosophy of care and transformational model based on the belief that residents who live in nursing homes are receiving adequate assistance for their physical ailments, but are receiving inadequate assistance for their spiritual ailments. Residents feel lonely because they do not have true companionship, which is close, genuine, and continuous; they feel helpless because they receive care but are never able to reciprocate; and they feel bored because the institutional environments lack variety, the activities are meaningless to the residents, and are deliberate rather than spontaneous (Barba, Tesh, & Courts, 2002; Thomas, 2003; Thomas & Johansson, 2003). To counteract spiritual suffering, environmental transformations (Alternatives) that support and promote nature, gardens, and paradise (Eden) are introduced into the facilities (Barba et al., 2002). To reduce loneliness, residents are provided with easy access to bird and/or animal companionship, children are invited into the facilities, and close, continuous contact with care aides is established through consistent or permanent assignment of care aides to groups of residents. To ease helplessness, residents are encouraged to do what they can for themselves without having to work within time constraints. Residents are encouraged to interact with the children, participate in planning for meals and other social events, and to help with ordinary activities such as shopping for food and food preparation. To lessen boredom, spontaneity and variety are enhanced and predictability is reduced. Rigid schedules for meals, bathing, medications, shift changes, bowel care, sleeping/waking and other activities are eliminated (Thomas, 2003). The Eden Alternative® requires shifts in perspectives, organization, and culture of care. A transition toward the Eden Alternative® model involves significant changes in job duties and routines for all staff members.

This qualitative focused ethnographic study was directed toward exploring how the organization and transformation of care through a contemporary model of service delivery can affect care aides’ experiences and perceptions of their roles and relationships with residents. The focus was on the Eden Alternative® model as this was the context of care experienced by the participants. An integral component of this model is close and continuing contact between residents and care aides via consistent or permanent assignment (Thomas, 2003; Thomas & Johansson, 2003). In Canada, care aides provide basic care to nursing home residents and are equivalent in training and work role to American Certified Nurse Assistants (CNAs). Care aides are unregulated service providers and have the least amount of training. Legally, they always work under the direction of licensed practical nurses (LPNs) and/or registered nurses (RNs), but as a result of reduced recruitment of these professionals, care aides have become the most central and accessible service providers to nursing home residents. Limited research has been done to evaluate the impact of consistent assignments on care aides. This article is focused on their experiences.

Heavily promoted in the United States as a solution for long-term care institutions undergoing reform and restructuring, the Eden Alternative® has been growing in popularity in Canada, Europe, and Australia since 2002 (Brownie, Neeleman, & Noakes-Meyer, 2011). Current empirical research has focused on resident and family satisfaction with the Eden model. Bergman-Evans (2004), for example, found that after the Eden model was implemented in one state veterans’ home, residents reported significantly lower levels of boredom and reduced levels of helplessness. Similarly, residents living in an Eden nursing home reported better quality of life and significantly higher levels of satisfaction than residents living in a conventional nursing home (Kane, Lum, Cutler, Degenholtz, & Yu, 2007). Anecdotal evidence suggests that the transformational philosophy can be used to reduce costs and strengthen visions for quality improvements in long-term care (Monkhouse, 2003; Schmidt & Beatty, 2005).

When a Canadian organization decides to implement the Eden Alternative®, two or three people are chosen to travel to Saskatoon Saskatchewan, where a 3-day training program is offered at the Sherbrooke Community Centre. After training, designates are certified and receive the title “Eden Associate.” They are responsible for implementing changes in the workplace and restructuring the delivery of care, which generally consists of three main strategies: consistently assign the same residents to the same care aides, avoid rigid scheduling in the lives of residents, and cross train care aides to do tasks normally associated with other disciplines and departments (dispensing medications, doing laundry, preparing food, organizing social activities and caring for the animals, plants, and gardens).

In the Eden model, a consistent assignment is called *a family* and cross-trained care aides are called *universal or versatile workers* (Kemp, Ball, Hollingsworth, & Lepore, 2008). In theory, consistent assignment supports companionship between residents and care aides; cross training extends the close contact between residents and care aides because the same care aides provide all of the services historically provided by many different people. Cross trained care aides should be able to provide more spontaneous services such as less rigidly structured medication administration and unscheduled meal preparation, and should be able to participate spontaneously in more personalized, unstructured, and unplanned social activities with residents (Thomas, 2003). When cross-trained care aides look after the animals and plants, in theory, they are providing residents with a more nurturing, home-like habitat. Therefore, these care aides should feel more fulfilled because they are caring for the residents’ bodies and their spirits (Thomas, 2003).

Recently though, some authors have suggested that the benefits and limitations of this model have not been explored adequately or carefully enough (Petersen & Warbuton, 2010; Rahman & Schnelle, 2008). Of the empirical research focusing on outcomes after implementation of the Eden Alternative® model (staff, resident, family, and economic outcomes), much of the evidence fails to support its effectiveness. For example, Coleman et al. (2002) found no statistically significant differences in infection rates, functional status, or costs of care post implementation. Similarly, Burgio, Fisher, Fairchild, Scilley, and Hardin (2004) found few differences in quality of care outcome indicators for residents between rotating assignments and consistent assignments. Even though the aim of the Eden model is to enhance companionship and reduce loneliness for residents, when Caspar, O’Rourke, and Gutman (2009) evaluated the effects of three different organizational models on employees in 54 nursing homes (Eden Alternative®, GentleCare, and Facility Specific Social Model), they found that the lowest levels of ability to provide individualized care to residents were reported by LPNs employed in facilities that had implemented the Eden Alternative®.

Method

The intent of this research was to focus on the care aides who are central to the provision of quality care for nursing home residents. Historically, care aides have been marginalized in their abilities to voice their views in health care organizational research. The method of exploration was based on the principles of qualitative focused ethnography. While this method adheres to the principles of qualitative inquiry, such as emic, cyclical, researcher as instrument, concurrent data collection and analysis (Hammersley, 1990), it does have a number of distinct features: A focused ethnographer generally has preexisting knowledge of the culture under investigation, begins a study with an actual issue or phenomenon in mind, and is skilled at rapidly creating a rapport with participants who are most familiar with the topic (Knoblauch, 2005). Participant observation is not a requirement (Higginbottom, 2011) and often not feasible due to the sensitivities and/or vulnerabilities of the participants and/or their discomfort with observational strategies. A single form data collection is typical (Agar, 2006). This method is a good fit for nurse researchers who are used to employing specific techniques to ensure the rapid establishment of close and personal relationships with others (via conversations) to learn how others feel, think, and make decisions.

As it is well established that care aides can feel vulnerable, hesitant to become involved in research, and uncomfortable with observational strategies for research (Aström, Nilsson, Norberg, & Winblad, 1990), data were generated solely through interviews that occurred in neutral locations away from their worksites. To ensure rapid establishment of close and personal relationships with the care aides to encourage them to share their stories and contribute valid experiential knowledge, we used several techniques. If two participants wished to be interviewed together to support each other, we encouraged that (this occurred twice during the study). We also offered a telephone interview as an alternative (this occurred only once during the study). All participants were provided with a $30.00 honorarium in the form of a gift certificate, as acknowledgment of their time and effort (Morse, 2005), which was equivalent to 1½ hr of work.

Participants and Setting

We used convenience and purposive sampling (Strauss & Corbin, 1998) to recruit 22 care aides (20 female and 2 male) from one privately funded and four publicly funded nursing homes in one western Canadian city (for participant characteristics, see Table 1). All five homes had implemented the Eden Alternative® model and philosophy of care. The homes ranged in size from 65 residents to 213 residents. The care aides were not extensively cross-trained but were expected to do some light housekeeping (cleaning equipment and tidying, garbage disposal, cleaning drawers, folding clothing, and linen). They were not involved in dispensing medications, laundry, food handling, or pet care. The average assignment was 11 residents per care aide for a day shift. None of the care aides described having any choice about their assignments. All of the care aides worked full-time; 2 worked in the privately funded nursing home, while 20 worked in the publicly funded nursing homes.

Data Collection and Analysis

The study received ethical approval by the appropriate academic agencies. To maintain anonymity and confidentiality, each participant was assigned a pseudonym. The average length of an interview was 70 min. Initially, we relied on guiding research questions that were wide ranging to enable/support the care aides to talk about what was most important to them (Morse & Richards, 2002). It became quickly evident that most participants wanted to discuss their experiences of the transition toward the Eden model, and specifically their experiences with the consistent assignment component of this model. The interviews were transcribed verbatim and qualitative software (NVivo 8) was used to manage the data. Data analysis was based on the principles of constant comparison (Corbin & Strauss, 2008): We analyzed

Table 1. Characteristics of the Participants.

|  |  |
| --- | --- |
| Characteristic | *n* = 22 |
| Age | |
| 20-30 years | 3 |
| 31-50 years | 16 |
| 51-60 years | 3 |
| Nationality | |
| Non-Canadian ethnic heritage (actual nationalities deleted to protect identities) | 9 |
| Canadian | 13 |
| Training | |
| Completed part of a BSN program and dropped out | 2 |
| Completed part of an LPN program and dropped out | 1 |
| Certified on the job after completing training modules | 1 |
| Completed a 5-9 month college program | 18 |
| History of involvement in care aide work | |
| Needed a job/a well paying job | 19 |
| Previous work in dietary | 2 |
| Looked for job requiring a short training program | 1 |
| Years of Experience | |
| 1 year | 2 |
| 2-5 years | 3 |
| 6-10 years | 1 |
| 11-15 years | 4 |
| 16-20 years | 2 |
| 21-25 years | 8 |
| 26-30 years | 1 |
| >30 years | 1 |

*Note.* LPN = licensed practical nurse.

data already gathered, reflected on the analysis, and decided what data needed to be gathered next to answer certain questions that have arose from the analysis and reflection. Constant comparison is a cycle that is completed over and over until a researcher feels that his or her questions have been answered and that continuing to interview new participants will reveal no new information. A coding process described by Charmaz (2006) and Boeije (2002) was used to identify categories, themes, and relationships. To ensure rigor, we employed the model of verification (Morse, Barrett, Mayan, Olson, & Spiers, 2002). Investigator responsiveness (careful, conscientious, attention to decisions), methodological coherence (a recursive process of checking), sampling adequacy (targeting certain participants to follow leads), an active analytic stance (discussing and confirming themes), and saturation (recurring patterns, no new codes) are components of the model of verification.

Results

Twenty-two care aides described their experiences of being consistently assigned to specific residents. Seventeen participants were employed as care aides before and after the Eden Alternative® model was implemented in their facilities. They were able to reflect on the transition, which required shifts in perspectives, organization and culture of care, and involved significant changes in job duties and routines for all staff members. Five themes emerged: Focusing on My “Family,” Alone with My “Family,” My “Family”—My Burden, My Extended “Family,” and Coping with My “Family.”

Focusing on My “Family”

All of the care aides in the study indicated that they had formed many constructive, positive relationships with residents assigned to them. They also shared their beliefs about an ideal occupational purpose or state, which involved humanitarian ideals and values, occupational ideals such as altruism and compassion, and explanations of why they chose the job in the first place or why they continued to stay in the job. During the initial stages, the shift to consistent assignment (referred to as “families”) was seen as a welcome development:

Quite frankly I was quite happy because before that . . . they were filling (staff vacancies) with casuals (who) didn’t want to do any care. They wouldn’t help. Then I was doing basically fourteen residents . . . And I was at the breaking point to be honest . . . So then they announced we were going to Eden! So it was good for me, I liked it! (Susan)

Each “family” assignment was regarded by most people working within the facilities as a distinctly separate unit so the care aides were able to focus exclusively on their own “families” and their own responsibilities:

Before that (implementation of the Eden Alternative®) they had three care aides at one end (of the facility). So we did everyone. We kind of mixed it up. Now I have a specific family. (Mary)

This fostered the development of relationships between care aides and residents that were marked by duration and consistency of thought or concern about the well-being of residents. Some care aides described becoming especially dedicated to residents who were rejected, alienated, neglected, or forsaken in some way by others. Other care aides described becoming alternative or surrogate family members for residents who had no close relatives, or whose relatives were nonresponsive or living far away. Many of the care aides created individual routines for residents that helped to reduce stress, and preserve peace and tranquility. They described pride in their experiential knowledge of the residents consistently assigned to them. They also designed strategies that helped them to overcome predictable obstacles such as a resistance to bathing.

Alone With My “Family”

Over time, new policies and procedures were implemented in the facilities, which meant that the care aides could provide care to even the heaviest of residents by themselves, without having to seek assistance from other care aides. For example, new turning sheets were introduced and policies pertaining to mechanical lifts were changed. The “family” members (residents) tended to be grouped in the same location/wings of the facilities so that care aides often found themselves working alone with their “families,” with minimal contact from the other care aides:

Well, now that we have the ceiling lifts, we are allowed to do (the lifts) by ourselves. And we have these green turning sheets now. That we use to roll people. So . . . mostly you work by yourself. (Judy)

One thing I did notice is that you are pretty much on your own . . . it was quite a long ways back I think . . . we worked together doing the lifts and stuff. There was more teamwork. It was much more manageable. Now they have kind of separated everybody . . . it separates everybody more. (Linda)

The culture gradually became one of independence and self-reliance: care aides described feeling not only that they were expected to manage alone, but discouraged from seeking assistance in activities that traditionally relied on teamwork. Care aides who reported working alone with residents also reported greatly reduced avenues for collegial advice and support:

You know you *can* call for help but you know you don’t *want* to . . . because the other care aides have their work to do to. So you do the best you can on your own. (Linda)

Eventually, the care aides realized that they knew less and less about the other residents who were not consistently assigned to them:

We used to laugh, and work together. That doesn’t happen anymore. We are so isolated. You have got your own people. And the other girl does her thing, and you just go. I don’t know nothing about the other people on the other side. That is a bad thing . . . I don’t know what they do on the other end. I don’t even know. (Doris)

But before . . . it was easy to know everyone. You could still remember their care. Naturally, you would just know. (Now) you don’t know . . . You lose that. After a while . . . you don’t actually know the other people anymore. (Mary)

Losing contact with other residents and not knowing enough about the other residents made some care aides feel sad, unsure, incompetent, or inadequate:

Somebody will come in and they will say, “Oh what room is that person in?” And I will say, “I don’t know.” I don’t! Even though I have been there for 25 years! . . . Sometimes you feel really down when somebody comes in and you don’t know the person. (Judy)

Others suggested that knowing less and less about the residents not consistently assigned to them made them reluctant to provide ad hoc care. Some suggested that it was possible for residents to suffer because they had to wait for their own care aides to provide care:

We know who each other’s people are, but we really don’t answer each other’s bells unless we absolutely have to. (Diane)

They will say, “That is not my resident.” (And) I will know that (my) resident is ringing to go to the bathroom and my whole break that is on my mind. And I will know that the other care aide has not answered that bell. And that would be for half an hour. (Judy)

My “Family”—My Burden

When a nursing home functions as described in the Eden Alternative® literature and the care aides take on more roles, it becomes no longer the ideal or even desirable for an RN to be continuously present. Instead, the RNs become visiting professionals who visit intermittently to provide skilled services. One of the most prominent features of the consistent assignment model was the increased sense of responsibility the care aides felt (in the absence of the RNs) for monitoring and reporting changes in health status of residents to regulated professionals:

You are assigned to these people. They are your responsibility. You are the eyes for everything, everything there. (Linda)

So the care attendants are really taking on a big role. And sometimes they can feel the burden of it. Because you are so responsible. I feel really responsible for their well-being . . . And for nine people, and sometimes 15, you know, that is a lot. (Jane)

Because they provided care to residents alone, without collegial support and advice from other experienced care aides, inexperienced care aides had no way of knowing if the information they gathered and communicated to the regulated professionals was the right information because no other person was readily available to verify the information. This caused them to feel very anxious:

To me I go back and forth in my head. I don’t know what is right so I will just take care of the resident and hope for the best. (Mary)

Many reported that the heavy burden of responsibilities was difficult for them to bear consistently:

And the RNs and the LPNs if they want information, cause they don’t tend to have any hands on, they come to you and want to know, and the families come to you and want to know . . . so there is a lot of pressure. A lot of pressure! And that is part of why I have to leave. Because I am not myself anymore. It is changing who I really am! (Cheryl)

My Extended “Family”

From the residents’ and family members’ perspectives, a consistently assigned care aide became the central hub or conduit of information. Some families came to rely so much on the care aides for information that they began to believe that the care aides assigned to their loved ones would know about, and be accountable for anything and everything that happened:

You are definitely way more accountable. You are absolutely accountable for everything. Even when you are not there, you are accountable . . . You are it. They know you are it. It is a lot of pressure. I mean, when you have your days off and you come back, something is missing. “What is this, where is that?” . . . They think that you are there 24/7. You are just magically going to have all the answers for them. (Jennifer)

As a result, some care aides described an overwhelming sense of dread when residents’ family members visited because they fielded many of the family members’ complaints:

They (the residents’ families) complain to us about the food. And I tell them I have no control over that. But they complain to us about the food . . . And sometimes they come to us about complaints about medication, or questions about medication. And that is the LPN’s job and they are still going on and on about it. So they don’t understand. They think that we are doing everything. They are asking about medications. Complex questions about the resident’s conditions and so on . . . They expect us to be doctors sometimes. To know everything. (Shirley)

Conflict with family members also occurred when care aides formed a vision of care for their residents, but their visions of appropriate care and/or their concerns for the residents contrasted with the family members’ views. These care aides seemed to be in a state of continuous conflict with certain family members because they could not provide care the way they felt best (from their perspectives). For example, Shirley was tired of struggling to dress one of the residents consistently assigned to her. She wanted the resident’s clothing to be split up the back to ease the dressing process. While she reflected that the family probably refused split clothing because it was a sign that the resident’s condition was deteriorating, she felt frustrated that the family did not see how much work it was for her to struggle everyday with an activity that could be easily modified. The outcome of the same stressors from the same residents over time resulted in lack of concern, reduced levels of patience, exhaustion, and frustration:

And when you have to work 6 days in a row, on the sixth day, you are not very patient anymore. (Betty)

You see a staff member need a break. Need a break . . . I see staff members really getting exhausted and wanting to give up. Give up in the sense of not wanting to do (the resident’s) care. (Mary)

Many care aides described keeping tight control over their natural feelings while trying to meet the needs of residents consistently assigned to them and many freely expressed that they did not feel as if they were receiving enough managerial support, considering that they asked for, but were unable to obtain temporary relief from their consistent assignments. They described these types of conversations with managers as extremely difficult, so they stopped going to them for help when they had relational conflicts with residents and/or family members:

It is never their (the resident’s or family member’s) fault. It is never their fault! It is always, the way you walked into the room. It is, “Could have you done something different when you walked into the room?” The managers do not listen to us at all. At all! It is always, “What could you have done differently? Yeah, so it is always pushed on us. Always. Always, always, always! It is always what you did . . . And it is always your fault. So you never really go to them for problems. Because they blame it on you.” (Michelle)

The care aides described feeling frustrated and powerless. The sense of powerlessness was so firmly rooted that work life could be filled with bitterness and resentment, which were not good companions for caring relationships:

One of the other (care aides) . . . she has so many lifts. And she had a guy who was walking—her only independent resident—which is like a treat right? He had a heart attack and died. And she ends up getting this other heavy lift. She is my age and she said that she was just bawling. (Judy)

Coping With My “Family”

For some care aides, coping meant reducing residents to perceptual “loads”:

You are assigned these people and that is all there is too it. (Judy)

We just do our load. And we just suck it up. Because that is the way it is. (Barbara)

Others coped with consistent assignments by using banked sick time:

It is the families that never stop . . . They (residents’ family members) are at you! They are at you! They are at you! And that is where it just drives you sometimes to mad. And that is why people take so much sick time. It is because if you don’t take that sick time, you are afraid to go to work! Because they drive you crazy! And they (management) don’t get that. They just don’t get it! They just don’t get it! . . . And this is the stress! (Michelle)

Participants stressed the importance of shared tasks, interchangeable tasks, and joint decisions, and described a strong need for collegial fellowship and friendship. They reminisced fondly about teamwork and indicated that they needed to work together again to find fulfillment and purpose together:

We knew each other. How we worked. We worked as a great team. There was never “Oh that is your resident” or “that is your person” . . . We were never sick . . . We were always there. We had each other. We worked well together. (Paula)

Betty (a relatively new care aide) compared working by herself with residents in a nursing home that subscribed to the Eden Alternative® model (including consistent assignment component of service delivery) to working as a team member in a nursing home that embraced a team model of service delivery. She could compare the two approaches because she had recently worked in both types of facilities. She much preferred working at the nursing home that supported teamwork because she felt supported as a team member and she was able to form close connections with her colleagues, which she described, incidentally, as “family”:

I have worked at (X nursing home) and personally, I don’t like it there. Because it is not a family. They don’t have teamwork there . . . I didn’t know what teamwork was until I came to (Y nursing home). Like you can ask for help at (X nursing home) but . . . it seems like no-one wants to help me. But at (Y nursing home) it doesn’t matter if you are new or if you are old, you all work together . . . I love (Y nursing home). (Betty)

The mode of assigning residents to care aides had an important impact on the workplace norms and culture, resultant workplace practices and eventually, quality of care, and work satisfaction. Some of the care aides in this study indicated that they were already in the process of giving up on the consistent assignment component of the Eden Alternative® model in their facilities and reverting to teamwork.

Discussion

The provision of services to residents in nursing homes has changed dramatically in recent years. While residents and their families may hope for close and caring relationships with care aides who believe in them, act as advocates for them, and provide the help that they need on a daily basis, we are still unsure how to best shape and sustain these types of relationships. Residents and families may appreciate sustained contact and feel confident when the care is predominantly managed by a very small number of care aides. We found, however, that the care described was not consistently of high quality. When small numbers of care aides consistently provided care to the same residents, the relationships between care aides and residents or between care aides and family members was not consistently pleasing or agreeable to both parties. The majority of care aides reported that they did not enjoy working in an independent manner, nor did they feel fully capable or competent with their assessments and/or confident enough to report their assessments and/or problems to the regulated professionals. They also described feeling reluctant to provide ad hoc care to residents not consistently assigned to them because over time, they no longer knew much about those other residents. Some described residents waiting for care. These key finding can be summed up by the words of one care aide: “If you have happy caregivers you have happy residents . . . there is a lot of unhappy people right now” (Kathy).

Some service delivery models, though attractive to organizations working within current fiscal restraints, address what is important to residents and families, but fail to address what is important for the largest, female dominated sector of the workforce: The care aides who carry out the majority of the care services for residents. When considering whether or not to implement consistent assignments, managers should take into account the individual strengths, capacities, and abilities of individual care aides and review workloads. The care aides who described coping with feelings of loneliness, isolation, uncertainty, and frustration day after day, also described reduced levels of concern for their residents, reduced levels of patience, and exhaustion. If the decision is to implement consistent assignments, managers must make provisions for care aides to obtain periodic relief from their consistent assignments if the work burden proves excessive.

Previous researchers have found that care aides’ feelings more strongly determine whether they become dissatisfied than the more objective features of the job and care aides are more likely to be retained by their employers if they report feeling valued and acknowledged by *others* when they are at work (Bowers, Esmond, & Jacobson, 2000; Parsons, Simmons, Penn, & Furlough, 2003). The care aides in this study described a strong need for collegial fellowship and friendship; they stressed the importance of shared tasks, interchangeable tasks, and joint decisions. Consistent assignments associated with decreased teamwork resulted in decreased quality of care. The importance of camaraderie or group cohesiveness should be of concern to management if transitioning from traditional teamwork to individual specific assignments. The care aides reminisced fondly about teamwork and indicated that they needed to work together again to find fulfillment and purpose together. Self-managed teams, used almost exclusively in the manufacturing industry, have been suggested as a method to increase productivity and reduce sick time in the health care industry (Yeatts, Cready, Ray, DeWitt, & Queen, 2004) because shared decisions result in greater satisfaction at work and enhanced commitment to the organization (Erikson, Hamilton, Jones, & Ditomassi, 2003; Laschinger, 2008).

Historically, care aides have been marginalized in their abilities to voice their views in health care organizational research and their voices are generally absent in existing research about the Eden Alternative® model and philosophy of care. Further research is needed to determine if feeling overloaded, stressed, and burdened is predominantly a characteristic of care aide work per se, or if these feelings are exacerbated by consistently assigning the same residents to the same care aides without regard for the care aides’ preferences or need for relief. There is an urgent need for research that explores the advantages and costs of this approach to care organization and the kind of clinical and management support needed to assist care aides when they take on more responsibilities in cultures that support self-reliance. Finally, the number of empirical studies reporting benefits and/or disadvantages of consistent assignment for residents and families is small. Additional outcome studies need to be done to strengthen or refute our results.

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References

Agar, M. (2006). Culture: Can you take it anywhere? *International Journal of Qualitative Methods, 5*(2), 1-11.

Aström, S., Nilsson, M., Norberg, A., & Winblad, B. (1990). Empathy, experience of burnout and attitudes towards demented patients among nursing staff in geriatric care. *Journal of Advanced Nursing, 15*, 1236-1244. doi:10.1111/1365-2648.ep8529474

Barba, B., Tesh, A., & Courts, N. (2002). Promoting thriving in nursing homes: The Eden alternative. *Journal of Gerontological Nursing, 28*, 7-13.

Bergman-Evans, B. (2004). Beyond the basics: Effects of the Eden Alternative® model on quality of life issues. *Journal of Gerontological Nursing, 30*, 27-34.

Boeije, H. (2002). A purposeful approach to the constant comparative method in the analysis of qualitative interviews. *Quality & Quantity, 36*, 391-409.

Bowers, B. J., Esmond, S., & Jacobson, N. (2000). The relationship between staffing and quality in long-term care facilities: Exploring the views of nurse aides. *Journal of Nursing Care Quarterly, 14*, 55-64.

Brownie, S., Neeleman, P., & Noakes-Meyer, C. (2011). Establishing the Eden Alternative® in Australia and New Zealand. *Contemporary Nurse, 37*, 222-224. doi:10.5172/conu.2011.37.2.222

Burgio, L. D., Fisher, S. E., Fairchild, J. K., Scilley, K., & Hardin, J. M. (2004). Quality of care in the nursing home: Effects of staff assignment and work shift. *The Gerontologist, 44*, 368-377.

Caspar, S., O’Rourke, N., & Gutman, G. M. (2009). The differential influence of culture change models on long-term care staff empowerment and provision of individualized care. *Canadian Journal on Aging, 28*, 165-175. doi:10.1017/S0714980809090138

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London, England: SAGE.

Coleman, M., Looney, S., O’Brien, J., Zeigler, C., Pastorino, C., & Turner, C. (2002). The Eden Alternative: Findings after one year of implementation. *Journal of Gerontology: Medical Sciences, 57A*, M422-M427.

Corbin, S., & Strauss, A. L. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. New York, NY: SAGE.

Erikson, J., Hamilton, G., Jones, D., & Ditomassi, M. (2003). The value of collaborative governance/staff empowerment. *The Journal of Nursing Administration, 33*, 96-104.

Hammersley, M. (1990). What’s wrong with ethnography? The myth of theoretical description. *Sociology, 24*, 597-615.

Higginbottom, G. (2011). The transitioning experiences of internationally-educated nurses into a Canadian health care system: A focused ethnography. *BMC Nursing, 10*, Article 14. doi:10.1186/1472-6955-10-14

Kane, R., Lum, T., Cutler, L., Degenholtz, H., & Yu, T. (2007). Resident outcomes in small-house nursing homes: A longitudinal evaluation of the initial Green House program. *Journal of the American Geriatric Society, 55*, 832-839. doi:10.1111/j.1532-5415.2007.01169.

Kemp, C. L., Ball, M. M., Hollingsworth, C., & Lepore, M. J. (2008, November). *We do it all: Universal workers in assisted living*. Symposium paper presented at the 61st Annual Scientific Meeting of the Gerontological Society of America, Atlanta, GA.

Knoblauch, H. (2005). Focused ethnography. *Forum: Qualitative Social Research, 6*(3), Article 44.

Laschinger, H. (2008). Effect of empowerment on professional practice environment, work satisfaction, and patient care quality: Further testing the Nursing Worklife Model. *Journal of Nursing Care Quality, 23*, 322-330. doi:10.1097/01.NCQ.0000318028.67910.6b

Monkhouse, C. (2003). Beyond the medical model—The Eden Alternative® in practice: A Swiss experience. *Journal of Social Work in Long-Term Care, 2*, 339-353.

Morse, J. M. (2005). The paid/unpaid work of participants. *Qualitative Health Research, 15*, 727-728. doi:10.1177/1049732305277430

Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods, 1*(2), 1-19.

Morse, J. M., & Richards, L. (2002). *Read me first for a user’s guide to qualitative methods*. Thousand Oaks, CA: SAGE.

Parsons, S. K., Simmons, W. P., Penn, K., & Furlough, M. (2003). Determinants of satisfaction and turnover among nursing assistants. *Journal of Gerontological Nursing, 29*(3), 51-58.

Petersen, M., & Warbuton, J. (2010). The Eden model: Innovation in Australian aged care? *Australasian Journal on Aging, 29*, 126-139. doi:10.1111/j.1741-6612.2010.00419.x

Rahman, A. N., & Schnelle, J. F. (2008). The nursing home culture-change movement: Recent past, present, and future directions for research. *The Gerontologist, 48*, 142-148. doi:10.1093/geront/48.2.142

Schmidt, K., & Beatty, S. (2005). Quality improvement: The pursuit of excellence. *Quality Management in Health Care, 14*, 196-198.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures of developing grounded techniques* (2nd ed.). Thousand Oaks, CA: SAGE.

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

Thomas, W. H., & Johansson, C. (2003). Elderhood in Eden. *Topics in Geriatric Rehabilitation, 19*, 282-290.

Yeatts, D. E., Cready, C., Ray, B., DeWitt, A., & Queen, C. (2004). Self-managed work teams in nursing homes: Implementing and empowering nurse aide teams. *The Gerontologist, 44*, 256-261.