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Initiating a Culture of Acknowledgement in the Nursing Home

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Initiating a Culture of Acknowledgement in the Nursing Home:
It's About Community!

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Section I

Goals: The primary goal for this project was to create a sustainable, values based, staff and resident centered culture within Daughters of Sara Nursing Center. While the primary focus for this initiative was the (then) new Memory Enhancement Unit, the investigators recognized that an isolated attempt at culture change was bound to fail. Accordingly the intervention was broadly based and directed towards the entire facility. We termed this new culture a “culture of acknowledgement.”

Objectives: Objectives were linked to the various structured teaching-learning opportunities (Appendix I). These objectives included the ability to:

- a. articulate a definition of culture
- b. explain how environment is a partner in work and care delivery
- c. articulate how physical environment can help them work “smarter.”
- d. describe physical changes associated with aging and how these impact on functional ability and independence
- e. articulate strategies for redirecting residents’ sexual behavior
- f. explain what happens to the brain of an individual with Alzheimer’s Disease
- g. explain how care delivery impacts on resident autonomy
- h. describe indicators of resident changes in ADL
- i. demonstrate understanding of using communication to foster a culture of acknowledgement

Research/Evaluation Questions: What is the impact of the Culture Change (educational program and coaching and mentoring on):

- a. Staff’s (specifically Certified Nursing Assistants) engagement in self-directed work planning?
- b. Staff’s Perception and experience of the facility community as open and a desirable place to work?
- c. Staff’s ability to recognize and respond to the needs of clients?
- d. Perceived communication among the various groups that live and work in the facility?
- e. Resident status as measured by MDS+ data?
- f. Family satisfaction and family participation in facility based activities?

Section II: Background and Rationale:

Our intervention was a response to the question posed by the Department of Health, “What would a nursing home look like if it were a place where people wanted to live and work?” In consideration of this challenge it seemed necessary to go a step beyond and inquire, “What would a nursing home BE like when it is a place where people want to both live and work?” This was the guiding question for the culture change initiative. At that time Daughters of Sarah Nursing facility was beginning a whole house physical renovation, toward a more home-like structure, including a state of the art Memory Enhancement Unit. These changes represented an opportunity to reflect on the direction for change; when planning culture change the opportunities are vast. We termed our initiative “*It’s About Community!*”

For the purpose of this proposal culture was defined as “...that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society” (Taylor in Fernandez, 1986, p.159). This anthropological definition supported our operational definition of organizational culture, “that (which) characterizes an established social group (and) denotes a moral framework and shared language, carrying key values, beliefs and assumptions that guide behavior (Coopey, 1995, p.57). This definition supports the understanding that culture is a construction, a set of meanings that is created by the participants who work or act within the culture itself, that culture can be altered and in some sense “corrected” to better meet the needs of it’s members, a process referred to as “reculturing” by Fullan, (2001).

Utilizing these definitions, four conceptual elements that would drive culture change were identified: environment, practice, communication-team-building, and

participants' shared understanding of what constitutes culture. These constructs all assumes that the nursing home will function as an open community environment, one that respects the rights of the participants, assumes collaboration and acknowledges that all members of the community bring their own set of values and customs. These constructs also served as the conceptual framework for the educational intervention, coaching-mentoring and targeted outcomes. The education sessions contained content in culture, environment, dementia care and communication-team building. For example, supporting culture change through enhancing staff's knowledge of dementia (a significant portion of the educational content) enhanced the staff's ability to engage in more autonomous work planning and recognize the needs of the residents more readily and promote an optimal level of independence.

It's About Community! was based on Schein's (1999) model for creating cultural competence. Schein addresses the element he terms "transformative change" a period where participants in the culture must unlearn and relearn culture. This model includes three states: unfreezing; creating the motivation to change; learning new concepts and new meanings for old concepts, and internalizing new concepts and meanings. In particular he identifies education and training as sources of anxiety for participants in a culture change initiative, and offers guidance for creating a sense of psychological safety. The precepts for this model were embedded in the structure of the initiative.

Critical to this project was the idea that everyone who worked at Daughters of Sarah needed to be an active participant and ultimately a stakeholder in this project. As a microcosm of cultural diversity, the nursing home brings together vastly different needs

and perspectives; accordingly all members of the community sat together in classes. This was perceived as “unusual” by some members of the community but was ultimately welcomed. This single action assured that all individuals were ultimately held accountable for the same content, actions and knowledge, created a linkage across their various roles, job descriptions and location of their work within facility.

Section III: Methods

Study Design: Culture change in nursing homes can be difficult to evaluate, due in part to the nature of nursing homes and the nature of dementia and other illnesses. The environment of the nursing home is such that change is ongoing, independent of a change initiative. Resident populations shift, disease is invariably progressive and there are no true clear markers for disease severity and progression. Utilizing a facility’s own data as a benchmark presents challenges as the characteristics of residents, including acuity of physical status, continues to increase. To capture as much meaningful outcome data as possible and expand the scope of the evaluation, the project utilized a descriptive triangulated methodology utilizing quantitative and qualitative data to evaluate culture change as a result of a series of educational sessions in which everyone within the facility was asked to participate.

Participants: The evaluation for the project encompassed multiple groups across the organization including Certified Nursing Assistants, nurses, family members, department leaders. Residents were not directly involved as a study population.

Data Collection: Evaluation strategies were designed to capture the evolving social culture as active education strategies are employed. The data collection plan was complex

and included multiple variables. Baseline interviews with department heads were conducted. Staff focused data included: in-depth interviewing using focus groups from selected units to capture shifting group insights, values and practices, case study interviews, observation of staff on the Memory Enhancement Unit, and quantitative data on turnover and absenteeism as these were identified as indicators of staff satisfaction and are related to quality of resident care. Resident outcomes were evaluated indirectly. Data from the MDS+ was collected quarterly for behavior problems, numbers of psychoactive medications, falls, change in ADL status and skin breakdown, all indicators of quality of care. In addition referrals to the Behavior Team were tracked. Data collected pertaining to family included tracking the number of grievances, response to the Quality of Life Questionnaire and participation in facility activities.

Qualitative/Quantitative Methods:

A total of 14 interviews were conducted including 5 single study interviews. The assumptions for the qualitative evaluation of staff outcomes were:

- a. Knowledge is dialogical and collective; therefore it occurs in conversation and relationships with others (Benner et al, 1996, Bernstein, 1983).
- b. Each person's thoughts and beliefs are valuable, and no one's view is held more valuable than another's.
- c. Notions of excellence are embedded in the social culture and shape a collective vision of excellence (Benner et al, 1996).
- d. Knowledge is invented and reinvented through human experience (Friere, 1990)
- e. Modeling and conversation are ways of shaping values.

The quantitative evaluation of the project, with the exception of the self-efficacy questionnaire, utilized data that was previously collected by the facility. Some changes were made to the Quality of Life Questionnaire already in use to enhance its utility for the purposes of this project and to enhance its use as an overall evaluation tool.

Data Analysis: Data analysis was appropriate to the data collection method. Descriptive thematic analysis was used for focus group and case study interviews. Data generated by the Self –Efficacy scale was analyzed (utilizing SPSS), by correlation matrix, factor analysis and ANOVA. MDS+ data was subjected to trend analysis by time. A correlation matrix was utilized to establish the sub-scales of the Quality of Life Questionnaire and these were compared using a factor analysis and ANOVA.

Conclusions: The initial belief, that culture change would be difficult to measure proved correct. While many of the variables yielded useful information each datum was limited in what it said about culture change at Daughters of Sarah, and out of context they would not seem to speak to culture change at all. These variables must be considered as a “whole” (and the whole is more than the sum of its parts) in order to derive any conclusions about the effectiveness of this culture change initiative.

Section IV: Results

Evaluation Question 1: How confident are the Certified Nursing Assistants in caring for residents and engaging in self-directed work planning?

A Self Efficacy Questionnaire was developed and used to measure the CNAs confidence in performing resident related care. Fifty-one aides completed the pre-questionnaire and 41 completed the post questionnaire (N=92). Results of the survey showed no difference in confidence for all of the items prior to or after the educational sessions. There are several explanations for these findings: 1) we were unable to collect data using matched pairs which perhaps would have shown changes in the individual, 2) it was not possible to use a controlled setting to administer the questionnaire. The aides completed it between caring for residents and often talked among themselves, 3) the survey was long and complex for the time available for its completion. and 4) there was

some reluctance on the part of the aides to complete the survey in spite of the evaluators assurance of anonymity. After data analysis and review of the methodology a decision was reached to omit this instrument for the second educational series and instead use interviews and observations to assess the aides' confidence in caring for residents.

Evaluation Question 2: What are staff perceptions' of Daughters of Sarah as an open and desirable place to work?

Three sources of data were used to provide information on staff's perceptions of Daughters of Sarah as a positive place to work: pre and post focus group and individual interviews, absenteeism and turnover. Thematic analysis of focus groups revealed that while most staff believed that facility was a positive place to work perceptions of inadequate staffing was a persistent theme reflecting frustration. In CNA focus group data, being treated courteously, as in having someone say "good morning", or hello, or looking at you and making eye contact were seen as an important attribute of the facility. Focus group data from CNAs are captured in these comments below when asked about the outcome of the communication/team building classes:

Treating people with respect is important...wages are low.
It seems to be better ...atmosphere better... attitudes seem better, people smiling more ...moral is better, people seem more helpful in general...before it seemed like the whole place was down.
The classes have helped...particularly the office staff...people at least smile; they use to turn away.

Audits of the average absenteeism per quarter was provided by Nursing services administration except for the first quarter of 2004 when there was a vacancy in the director of nursing position. During the reporting period, there was a decrease in absenteeism for both nurses and certified nursing assistants. The average absenteeism for both groups varied from a high of 25% in the second quarter of 2004 to the current rate of

17.5 %. (Table XX, appendix X) .The average absenteeism rate for nurses ranged from a high of 9.9 percent in the second quarter of 2004 to the present rate of 3.2 and 3.9 for the first two quarters of 2005. A t-Test showed no significant difference in means ($t=1.16$, df 9, $p. = .28$).

The overall turnover rate for Certified Nursing Assistants (CNA) for the period of January – June 2005 was 8.2% compared to the overall turnover rate in 2004 of 5.9 % . The involuntary turnover rate for all CNA's in 2005 was for 35% compared to 44.5% in 2004. The voluntary turnover rate in 2005 was 8% compared to 22% in 2004. The major findings of these data are that fewer nursing assistants resigned voluntarily in 2005, which is one yardstick of job satisfaction. There were some problems with the reporting of this data from one year to another so no firm conclusions may be drawn.

Evaluation Question 3: To what extent are Staff Able to identify and Respond to Needs of Residents?

Pre-post focus groups and interviews revealed that staff sees themselves as able to identify and respond to the needs of the residents. The frequency with which they stated this did not change as a result of the educational intervention. What changed was the perceptions of what they offered to the residents. Staff referred to having familial relationships with residents and this characterized what they offered to the residents, kindness, caring. After the education sessions, in interviews and classroom discussions, participants were able to identify more specific, knowledge-based responses to the needs of the residents. For many workers, understanding dementia helped them plan their work, understand the resident's behavior, and in general provided a context for care. As one CNA said: “the most important thing is to make sure they still have their ability, can do things on their own”. This particular CNA, like many, came to understand the

downward spiral of the illness, and that their daily observations were important to determining the amount of assistance a resident needed, and reporting changes to the nurse. It was the understanding of dementia that helped them make sense of behavior, change, and their own level of care.

Evaluation Question 4: Perceived Communication among Staff, Residents and their Significant Others (families).

The primary source of data used to answer this question came from focus group and individual interviews as well as participant observation. Classes were held on acknowledgment as the corner stone of communication and a positive culture. This included communication across the organization such as saying hello or greeting people, making eye contact, and remembering people's names. Participants contracted in writing with the trainer for one week to practice a particular form of acknowledgement (their choice) in the facility. While this level of acknowledgement may seem simplistic, it is also fundamental to a strong organization. Staff perceived a difference in how people greeted and acknowledged each other as a result of this exercise (though initially many insisted that they were "doing it all" already). Families too appreciated the fact that staff greeted them and the residents by name. This fact was repeated several times in the focus group data. Other aspects of appreciation that families reported were the personalized care CNAs gave to their family members, such as taking time to talk with or sing with a resident; doing a favorite activity with the resident, and any form of care that recognized their family member as a person. Similarly, CNAs were sometimes surprised but appreciated being recognized by family members. While some CNAs often reported

feeling a bit wary of talking with family, for fear of violating resident's rights, etc., others recognized the value of creating a pleasant connection with family.

Evaluation Question 5: Resident Status as Measured by MDS+ and other data

A summary of Equip MDS data without resident identifying information as well as reports from social service, nursing and pharmacy were used to examine resident status. The researchers were aware that due to the natural history of dementia no expectation could be made to reverse any of the physical or mental changes related to the disease process in the residents. Use of this data however might show whether the culture change program was efficacious in maintaining or improving such sentinel events as falls, or behavioral symptoms.

Trend analysis for the 18-month period showed little or no variability for residents in any of these indicators. For example, residents exhibiting behavioral symptoms ranged from 8 percent of the population to 11% with the rate for the final quarter at 10%. Other psychological manifestations such as depression (range =1.8-5%, final quarter 2005=2.8%) showed similar variation. The rate of incontinence remained constant throughout the reporting period with approximately two thirds of the population affected. Incontinence remains one of the problems that forces families to ultimately opt for nursing home placement.

There was a decrease in both the number of grievances filed and reports of behavioral referrals. Behavioral referrals are defined by Daughters of Sarah as resident altercations. In 2004 there were 10, 8, 9, 3 referrals per quarter and there were 8 referrals in the first quarter and 3 referrals in the last reporting quarter in 2005. This represents a decrease from the previous year however the numbers are too small to draw any conclusions. A review of sentinel events by quarter from Equip data showed the

following: 1) some non-significant variability in trend data for prevalence of falls, behavior symptoms affecting others, weight loss and decline in ADLs. 2) Daughters of Sarah rates for behavioral symptoms affecting others and decline in weight were lower than other skilled nursing facilities; 3) residents decline in ADLs were slightly higher than the state rate but lower than the national rate and 4) only prevalence of falls showed slightly higher rates.

Evaluation Question 6: Family Satisfaction and Participation in Facility Based Activities

Analysis of Quality of Life Surveys, family participation in recreational activities, individual and focus group interviews were employed to answer the question regarding the impact of the culture change project on the satisfaction of families and significant others. The Quality of Life Survey was mailed to 200 eligible families or significant others. Seventy-nine surveys were returned in 2004 and 69 in 2005 leading to a response rate of 40% and 35% respectively. There were 18 Likert-type items related to satisfaction with services where 1 represented strong disagreement with the statement and 5 represented strong agreement. Two open-ended items asked for strengths of and recommendations for improving services at Daughters of Sarah. Items with the highest means, indicating greatest satisfaction, for both 2004 and 2005 included convenience of visiting hours, respect for resident and visitor's privacy, participation in the resident's plan of care and the courteousness and attention to the residents. Only participation in a support group was below the neutral point on the survey (3.0) indicating that a majority of respondents do not attend support group meetings.

There was no significant difference in the t-Test of the means between 2004 and 2005 on the majority of items with the exception of slight decrease in satisfaction in 2005 with recreation, religious and business office services. Thematic analysis of the open ended questions revealed positive feelings regarding the physical environment, overall satisfaction with staff and affirmative comments about social services, nursing, recreation, dietary, and housekeeping and rehabilitation departments.

The most consistent theme was that of a caring staff who treat residents with respect, compassion and affection: “Nurses are competent, sensitive to changes in the resident’s physical condition”. This was accompanied by a statement of the need for additional certified nursing assistants especially during the weekends. Families remarked as to the cleanliness, friendliness and physical condition of the facility. Impressive in face of the fact that during 2004- 2005 the institution was undergoing a major renovation and resident’s rooms and eating areas were disrupted during that time. Data were collected throughout the period of the study on family participation in recreational activities based on the premise that families who are more satisfied with care will participate to a greater extent in recreational activities.

The total number of family members participating in recreational activities averaged 325 per quarter with a high of 463 and low of 303 (mean ranged from 62 -77) Analysis of variance for means showed no significant difference ($F=.33$, $P=.88$).

Section V: Strengths and Limitations and Barriers

Strengths: The strength of this project was the conceptualization of culture change as driven by four elements: culture, communication/team building, environment, and

practice and the extent to which these concepts supported the delivery of a broad educational curriculum. The complex nature of culture changes is such that it needs to be accomplished simultaneously at many levels. And, at the same time, it needs to be reinforced. Each of these elements complemented the other. For example an initial discussion of culture provided the opportunity to talk about “acknowledgement” or saying thank you as a cultural value one, (as revealed in class discussions) everyone agreed with. Implementing that aspect of culture with the “contract” or homework reinforced the action and was a initial way to implement behavioral change around communication. Later on in the sessions the idea of a culture of acknowledgement was reintroduced as an intervention for residents to help manage certain behaviors and as an intervention for working with families. The comprehensive curriculum, based on the four elements of culture changes allowed for an integrative process of discovery that might not have happened with a more static concept of culture change.

The opportunity to educate everyone in the organization in “mixed” groups was another strength of the project. One effect of this was the opportunity for non-direct care staff to ask questions about dementia and the behaviors of the residents. For example, many of the staff from environmental services had questions about the illness, and shared instances of resident behavior they had not previously understood. A recommendation from the project would be to consider non-direct care staff as benefiting from this type of information, both in understanding their work environment and the residents with whom they come in contact. One LPN spoke about how she was glad to see all the departments attending the classes, so that “they knew what our priorities are; we know what we’re doing”. This comment was made in reference to how other departments don’t seem to

understand or appreciate the complexity of resident care and the work of the nursing staff. For this nurse, classes provided the opportunity for others in the organization to recognize and acknowledge nurses' work.

Limitations and Barriers: Initial “buy-in” among nurses, who were responsible for assuring that the CNAs attended the sessions, was limited; there was significant resistance (or indifference?) to the project. To overcome this barrier we held information sessions with nurse leadership and special sessions were offered to the nurses (the target audience being the LPN) on leadership for culture change and dementia care. The hoped for outcome was an enhanced sense of professionalism on the part of the participant to foster professional commitment to the grant. This strategy yielded some positive results, as evidenced by participation in the education by some individuals who had initially been resistant. The sessions served as a public relations endeavor for the project as well an educational opportunity for staff.

The initial curriculum developed for the project consisted of 12, 30 minute education sessions offered over the course of 6 months, for all three shifts, several times a week. During that first session a total of 1280 units of education were delivered with 63 staff completing nine or more classes. The effort required to coordinate and deliver this content was enormous. Staff resisted attending sessions every other week and said it disrupted their work. Staff participation was dependent on a champion, during the specific shift, to promote attendance and active participation. This was available to us on the evening and night shift but there was a lack of such a “cheer leader” for nursing staff, during the day shift. The consequence of this is that attendance during the day shift was,

comparatively lower, especially for nursing staff. In an effort to establish a better schedule for the next round of class, staff opinion was elicited prior to setting up the second schedule of classes. Based on feedback the second round of educational sessions was condensed to 5 sessions of 45 to 50 minutes each. The overall response to this change was positive and staff appeared to be better able to participate in classes consistently. There were 223 unit of education delivered and 46 of the 90 individuals completed four or more classes. Overall with the two sessions over 60 % of the staff completed the sessions with many more completing several of the classes.

The need to address on-going concerns expressed by staff concerning sufficient staff numbers and salary cannot be underestimated in a project such as this one. While these are not issues that are the focus of the culture change initiative they mold and color staff perceptions. It was necessary to develop a script to address these issues/questions as they arose frequently in discussion about making Daughters of Sarah a place where everyone want to work.

A significant limitation to the evaluation plan was the Self-Efficacy Questionnaire developed for use with the Certified Nursing Assistants; the conceptual constructs of the questionnaire were too complex and intrinsically threatening to many of the CNAs. Although paired samples would lead to stronger data the CNA's fear of testing speaks against its utility. Another method might be simple a pre and post test of content which the aide group is perhaps more used too than the concept of "confidence."

Considerable staff effort was exerted to collect certain MDS data which although important as a baseline for this project did not yield any dramatic results and could be eliminated from future similar projects to make them more manageable. I would

recommend that an alternate quantitative means of evaluating the impact of the educational sessions be identified for future use

Although the time required for, planning, conducting and analyzing material from the focus groups was intensive it not only yielded rich data but was also a positive team building exercise for the CNA group and should be continued with other similar projects.

In general a recommendation could be made to develop a less complex means of evaluating a culture change initiative such as this. Consideration should be given to developing “pulse” or “real time” short surveys of all members of the community to elicit data related to the discreet variables associated with the elements of culture changes: practice, environment, communication and culture.

Section VI: Conclusions

Discussion of Results:

As presented in Section IV (Results) quantitative data or resident status indicated little or no significant variability in outcomes during the course of this intervention. Interpreting these outcomes is difficult; while they can be seen as an indicator that the project had little or no impact on resident status the fact that the results or neutral (no change) may speak to the value of the interventions as creating sufficient change in conditions at the facility that residents showed less decline and problems than they would have otherwise. Audits of absenteeism yielded similar results. The decline in voluntary staff turnover offers a stronger measure of the success of the intervention. According to the administrator of Daughters of Sarah the drop in turnover signaled a dramatic shift for the facility.

The strongest indicators of the success of the project are found in the qualitative data. A prime example was the observation of staff-resident interactions during coaching-mentoring sessions which provided another source of data by which to evaluate staff responsiveness to residents. These sessions primarily took place on the Memory Enhancement Unit over the course of the project. One of the most significant changes observed was the difference in how staff worked with and treated the residents on this unit. Over time staff came to recognize that these individuals with dementia required more engagement in meaningful activities and those daily activities on the unit were meant to engage residents in a life-affirming, meaningful way. Many of the staff, (unaccustomed to working with higher functioning residents when they come to work on the unit) have a misperception that working with this population is “easy” because it requires less arduous physical labor. Effective teaching and learning on this unit helped to correct this perception as the staff learned more effective ways to engage residents and create an interactive community.

Qualitative data revealed that focused educational content, specifically communication and dementia, had an impact on staff perception of the facility as a “good place” to work. This might not have happened had not the teachers (the investigators) dealt directly with the issues of numbers of staff and salary. Acknowledging these as significant contextual issues was a helpful tactic; otherwise it would have been difficult to move forward with any effort at culture change. Certified Nursing Assistants and nurses were able to provide examples of how new knowledge about dementia had enhanced their ability to care for residents. The idea of enhancement is significant; most

staff thought they were providing good care before; the new knowledge just made the care that much better.

At the start of this project the researchers made certain assumptions about achieving culture change through teaching-learning strategies. These assumptions were embedded in the intervention as well as the evaluation. The activities chosen for the project actively involved the learner in applying new material to their immediate situation. By allowing the learner to shape the knowledge, new knowledge is invented, values are revealed and explored, and learners personally develop insight into their thoughts, assumptions and actions. These beliefs continue to be supported by the outcomes of the grant, as evidenced in the qualitative data.

What Should Happen Next:

Dissemination of the materials from this grant is already started. In May 2005, Daughters of Sarah Nursing Center hosted a conference for area nursing homes to begin to share our theory of culture change, the educational curricula and evaluation plan. The project coordinators will disseminate the educational curricula; it will be made available to other facilities on CD- ROM so that the content can be easily adjusted to meet each nursing home's unique needs. The researchers plan to respond to the RFP to formally present the project at a Department of Health sponsored conference in June 2006. Finally, the researchers are in the throes of writing two articles on the lessons learned from this project, specifically 1) the application of educational strategies to the culture change model and 2) simple evaluation measures for culture change in nursing homes.

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