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EASTERN KENTUCKY UNIVERSITY

Nurses' Perceptions of Person-Centered Care in Long-Term Care

Honors Thesis

Submitted

in Partial Fulfillment

of the

Requirements of HON 420

Spring 2021

By

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Abstract

Nurses' Perceptions of Person-Centered Care in Long-Term Care

Sophia Lefevers

Dr. Christen Page, Department of Communication Sciences and Disorders

Over the years, the average lifespan of Americans has slowly increased, nearing almost 79 years of age. This increase has resulted in individuals ultimately becoming more likely to experience one of many underlying health conditions, such as dementia. The result of a condition like dementia is the requirement of more specialized care than an individual or their family can provide for them. This results in them seeking more skilled and focused care, such as within long-term care facilities. One of the goals of long-term care facilities is to provide individuals with a high level of care that promotes their quality of life and maintains their dignity. This care focuses on their individual needs and how they would like to be treated, and is referred to as person-centered care. This study explores the level of person-centered care being received by patients with dementia that are in long-term care facilities according to the nursing staff within the facility. Nursing staff in the facility view the work being done with the patients on a daily basis and are the best contributors to the level of person-centered care being implemented. Findings indicate that nurses in long-term care settings support the implementation of the person-centered care model within their facility, and if the PCC model is being implemented, they concur it is the most effective care model for individuals with dementia.

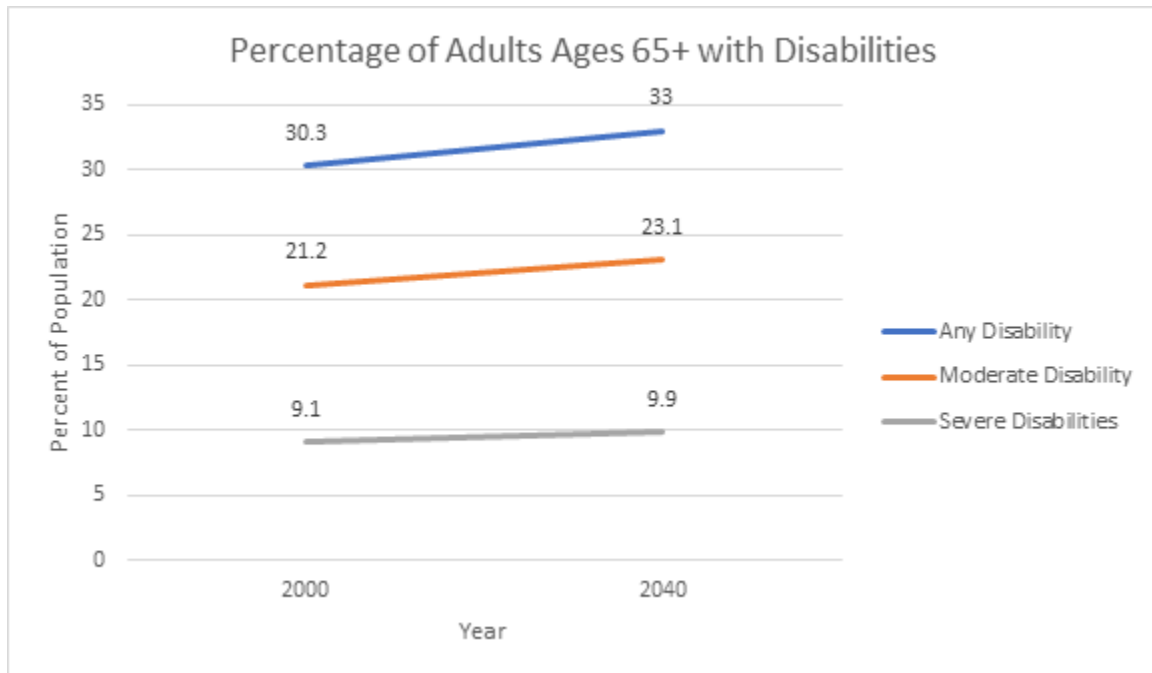
Keywords and Phrases: person-centered care, patient-centered care, long-term care, nursing home, assisted living, nurse, certified nursing assistant, dementia, Alzheimer's disease, speech-language pathologist

Table of Contents

| | |
|-------------------------|-----|
| Abstract | ii |
| Table of Contents | iii |
| Figures | 1 |
| Acknowledgements | 4 |
| Introduction | 5 |
| Methods | 15 |
| Results | 16 |
| Discussion | 25 |
| Limitations | 25 |
| Conclusion | 30 |
| References | 32 |

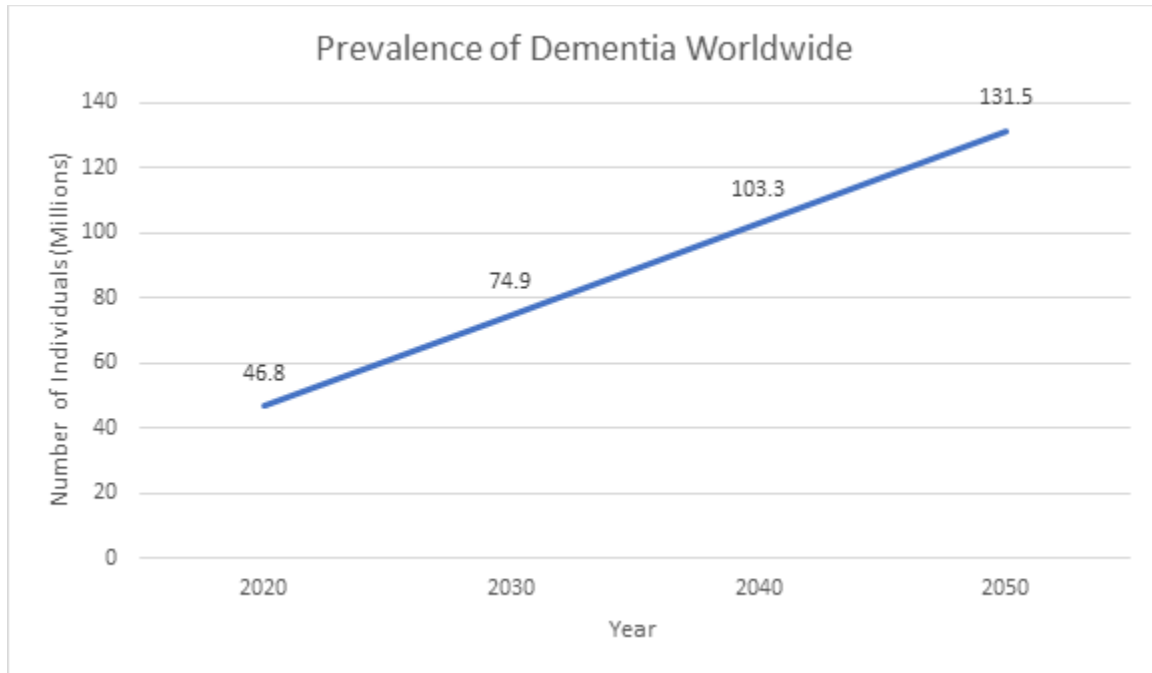
Figures:

Figure One



When referencing a disability in this analysis, Johnson defines it as a limitation with Activities of Daily Living, or ADLs. An individual is classified as having moderate disabilities if they report two or fewer ADL limitations, and severe disabilities if they report three or more ADL limitations (Johnson, et al., 2017, p. 14).

Figure Two



The number of individuals diagnosed with dementia worldwide is expected to increase from 46.8 million in 2020 to 131.5 million in 2050 (Kim & Park, 2017, p.381).

Table 1. Description of Included Studies

| Citation | Design | Participants | Measurement | Outcomes |
|-------------------------------|--------------------|--------------|-------------|---|
| Goh, A., et al (2017) | quasi-experimental | 17 | Surveys | Staff were more confident implementing the care |
| Burshnic, V. L., et al (2018) | quasi-experimental | 2,000 | surveys | Overall support of PCC model, but lack of support |

| | | | | |
|-----------------------------|--------------------|-----|-----------------------|------------------------------|
| | | | | from direct care staff |
| Chaudhury, H., et al (2017) | quasi-experimental | 17 | surveys | Support of PCC model |
| Chenoweth, L., et al (2015) | quasi-experimental | 70 | individual interviews | Overall support of PCC model |
| Burack, O. R., et al (2012) | quasi-experimental | 100 | surveys | Did not support PCC model |

Table 2. Factors Contributing to CNA Turnover as Reported by Director of Nursing

| Job Factor | Reported Percentage |
|----------------------------|---------------------|
| Trained Supervisors | 84% (0.84) |
| Workload | 83% (0.83) |
| Number of aides, RNs, LPNs | 57% (0.57) |
| Nurse aide's training | 71% (0.71) |

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I would like to say how grateful I am to have worked with Dr. Christen Page. She supplemented my research so much, and it wouldn't have been possible without her helping me along the way. I'm so appreciative of her passion for members of long-term care and just people in general. This population of people is very near and dear to me and it meant so much to me to complete my research on the care they receive, and hopefully educate someone who is interested in learning about person-centered care for those with dementia.

I also want to thank each of my professors, advisors, and mentors that I've had at EKU! I've truly enjoyed being in the Honors Program; I appreciate all of the challenges I've faced that have promoted growth.

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Introduction

There are many aspects of life to look forward to, including growing in age and experiencing the later years of life. This is often the time that many of us retire and begin things we've always wanted to do, such as traveling and spending more time with our families. However, many of us fail to think about the state of our health once we reach this time in our lives. According to present-day studies, nearly 30 percent of individuals over the age of 65 have been diagnosed with a disability and the size of the population with a disability is expected to grow by fifty percent between 2020 and 2040 (Johnson et al., 2017). This information can be viewed in Figure 1. A disability changes one's life dramatically. One of the most prevalent conditions for those over sixty-five years of age is dementia. Dementia affects approximately 46.8 million people worldwide and this number is expected to increase to 131.5 million by the year 2050 (Kim & Park, 2017). This trend can be viewed in Figure 2. Dementia is a group of symptoms caused by various diseases and conditions that affect the brain which lead to a progressive decline in cognition, language, and personality (Brookshire, 2017). The most widely used definition of dementia in the United States comes from the *Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV)*; American Psychiatric Association, 2013). According to this definition, individuals diagnosed with dementia must exhibit the following: impaired short-term memory; impaired long-term memory; and impairments

in at least one of the following areas: abstract thinking, personality change, judgment, constructional abilities, language, praxis, and visual recognition.

The cause of dementia can be reversible or irreversible. Reversible types of dementia occur if the patient's cognitive declines are related to depression, drug toxicity, infection, nutritional deficiencies, and other factors that can be treated pharmacologically or medically (Golper, 1998). However, dementia in most individuals in long-term care (LTC) settings is irreversible, progressive, and chronic. Irreversible dementia can occur from a variety of causes including Alzheimer's, Pick's, Creutzfeld-Jacob, Huntington's, Parkinson's diseases, multiple strokes (vascular or multi-infarct dementia), Lewy Body dementia, and Progressive Supranuclear Palsy (Brookshire, 2007). Rather than present information on the various forms of dementia, the focus will be on the single most common cause of dementia in individuals in LTC settings, Alzheimer's disease.

Alzheimer's disease (AD) accounts for approximately 80% of all cases of dementia in the United States and is the most prevalent diagnosis for patients in LTC settings (Alzheimer's Association, 2015). AD is considered to be a consequence of neuropathological changes in the brain over time. These include development of neurofibrillary tangles (twisting, tangling, clumping, and contorting of the threadlike structures found in cell bodies, dendrites, and axons), (Cummings & Benson, 1983), formation of neuritic plaques (small areas of tissue degeneration associated with granular deposits in cortical and subcortical regions of the brain), (Cummings & Benson, 1992), and granulovacuolar degeneration (creation of small fluid-filled cavities containing granular debris in nerve cells, particularly the hippocampus), (Tomlinson & Henderson, 1976). Over time, these disrupt neural communication to accelerate the patient's

cognitive and physical decline (American Psychiatric Association, 2014; Kimbarow, 2011).

Presently there is no cure or treatment to prevent the evolution of AD. Persons with AD usually die of infection or aspiration pneumonia five to ten years after receiving their diagnosis (Brookshire, 2007). Clinicians responsible for the management and care of individuals with AD usually adapt their cognitive-communicative treatments of persons with AD to the stage of the disease (early, middle or late). *Early AD* is characterized by lapses in memory, poor judgment, faulty reasoning, and alterations of mood. Language is less affected than memory, intellect, and cognition in the early stages of the disease. As the person with AD moves into the *middle stages* of the disease, difficulties in communication become more apparent. Word retrieval difficulties in spontaneous speech are obvious, and the patient's success in repairing them declines. Sentence fragments and other grammatical problems appear in spontaneous speech and conversations become difficult. For most patients, reading becomes impossible and is abandoned for recreational purposes. Most individuals retain a sense of when to talk and when to listen, but turn-taking violations become more apparent. Comprehension of non-literal material is markedly impaired. In the *later stages* of AD, communication in persons with AD is severely compromised. Most patients are nonfunctional conversationalists, fail to observe social conventions, and insensitive to conversational rules governing turn-taking, eye contact, topic relevance, and topic maintenance. Sometimes the patient will fixate on and even misinterpret salient personal experiences of the past. In the very late states of AD, some individuals become mute and others echolalic.

As dementia progresses, living independently becomes impossible, requiring more extensive care than they or their family can provide. By the final stages, individuals with dementia become dependent on others to eat, walk, and/or communicate. As a result, one in three senior citizens will enter an assisted living or LTC facility, also referred to as a nursing home, where they receive specialized care to meet their needs (Johnson, et al., 2017). Within a nursing home, an individual receives round-the-clock supervision and medical care. Some nursing homes may have special accommodations, activities and care services tailored to the needs of people with dementia.

Many individuals with dementia who still have prominent physical capabilities will choose to reside in an assisted living facility. An assisted living facility is best defined as a residential setting that provides or coordinates personal services, 24-hour supervision and assistance, and activities while also maximizing clients' dignity, autonomy, privacy, independence, and safety (Hawes et al., 2003). There are many beneficial services that may include an individual apartment or suite, meal preparation, housekeeping, medication management, and recreational or social programming. Another benefit of some assisted living facilities involves specialized dementia care referred to as "memory care" services. These facilities require specialized staff training in memory care, meaningful engagement and activities based on the individual's preferences and strengths, visual cues, such as signs or pictures, to support independence, and enhanced safety measures, such as secured exits.

Given the specialization of care in LTC facilities, their goal is to enhance an individual's life through daily individualized care. This creates a delicate relationship between the individual and their caregiver which fosters development of trust.

Establishing trust with a client with dementia differs from the trust within other relationships because often each interaction is a new introduction/first impression. Although it seems difficult because those with dementia may forget faces soon after a visitor leaves, this increases the value of each interaction. Each encounter with an individual with dementia must be healthy and beneficial to the client. The relationship a caregiver builds is often not based on an accumulation of many interactions, but rather how the client feels about the caregiver's energy and conversation at that moment. The way a caregiver approaches a client and interacts with him or her influences the quality of care. If the client feels that the caregiver is negative, this can often deter them from allowing the caregiver to help.

When considering the care being provided, caregivers implement different models whether it be intentional or subconscious. Approaching a client with the intention of completing a task is called task-centered care. The goal is to complete a designated task in a specific amount of time with lack of consideration for the client's feelings. It is primarily focused on processes, schedules, and staff and organizational needs (Fazio, 2018). Tasks completed by staff for individuals in LTC relate to activities of daily living, or ADLs (bathing, dressing, toileting, eating). If a caregiver approaches the individual with the goal of task completion, their language is very straight-forward and task-oriented. The goal is less about making the client feel comfortable and building rapport and trust, and more about completing the task and moving on. Task-centered care is considered to be a part of the "medical model" of care. Task-centered care is one of the most implemented approaches due to its simplicity with asking the patient to complete a

task without consideration of many other factors. This model ensures adequate physical health for clients but lacks personal connections.

Individuals with dementia and their family prefer more personalized care. According to the Institute of Medicine, person-centered care (PCC) is defined as providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions (National Academy Press, 2001). It is a philosophy of care built around the needs of the individual and contingent upon knowing the person through an interpersonal relationship (Fazio, 2018, p. 10). Person-centered care can transform traditional care models from one in which the provider serves in the primary decision-making role to one that permits the individual to maintain their own autonomy and supports individual choice (American Geriatrics Society, 2015). Carl Rogers, a 20th century humanistic psychologist, founded the person-centered approach to care (Brownie & Nancarrow, 2012) and proposed that “a person-centered approach based on acceptance, caring, empathy, sensitivity, and active listening, promotes optimal human growth” (Brownie & Nancarrow, 2012, p. 2). Person-centered care includes the patient’s feelings at that time, their understanding of the task, their abilities or disabilities surrounding the task, and their current state of health. It is much more complex, but ultimately provides a greater standard of care for those living in long-term care settings.

This is why many facilities are converting their practices to PCC within the “social model”. Some of the common elements that make up the change in culture from the “medical model” to the “social model” include resident-focused care and daily activities, a home-like atmosphere in the facility, resident care, attitudes and roles of staff

and administrators, close relationships between residents, staff, and family members, staff empowerment, collaborative decision-making, and quality improvement processes (Alzheimer's Association, 2015). All of these changes contribute to a more well-rounded model of care that focuses on the person rather than the task. The focus transitions from the physical state of the resident to the relationships the resident is building during care. Their health is still the most important aspect, but more time is invested in building a relationship with the individual. When considering the example given earlier regarding the completion of ADLs, this looks quite differently when implementing the PCC model. Instead of approaching the client with task-oriented instructions, a caregiver approaches them discussing personally relevant information in the context of a conversation (family). Consequently, the client becomes comfortable and trusts the caregiver. This still allows task completion but the resident becomes more comfortable with an unknown individual assisting with a very personal and vulnerable task. Although this takes a longer amount of time and requires more effort from the caregiver, the client no longer feels as if a stranger is caring for them during delicate activities.

The importance in maximizing the resident's comfort relates to a number of aspects of life that have already been removed from them. They no longer live within their own homes, see their families frequently, or get to make many of their own choices. A client should be given as much control over their life as possible to enhance quality of care/life. Lubinski (1981) has described three significant changes experienced by individuals entering a LTC facility: loss of control, lack of privacy, and perceptual disruptions. LTC residents no longer control with whom they interact, when, what and where they eat, when they go to bed and when they wake up. If the resident enters the

facility unable to provide basic care for themselves and/or their conditions deteriorate to a point where they cannot attend to their basic needs (e.g., brushing one's teeth or going to the bathroom, and bathing), they suffer further loss of control. Privacy and protection of personal space are things taken for granted, but these are often lost in the LTC setting. Residents typically share a room with a person that is a complete stranger. The opportunities to perform many basic and daily routines in privacy (toileting, dressing, showering, having a conversation with a friend or relative, reading, talking on the phone, and having a quiet moment) are severely limited. Finally, individuals in LTC settings are exposed to a barrage of auditory (noises, voices, cries of pain, and equipment noise), visual (colors, bright lights, and new faces), and olfactory (urine, feces, vomit, and body odor) stimuli that are new to them. Space limitations requiring residents to share rooms and the necessity of having common areas for most functions (e.g. dining, recreation, and exercise) of LTC settings prevent residents from bringing personal belongings and beloved artifacts into the facility and further contribute to loss of personal identity.

In their systematic review, Brownie and Nancarrow (2012) sought to evaluate the impact of person-centered interventions on aged-care residents and nursing staff. This inquiry stemmed from several residential LTC facilities replacing the institutional, or medical, model of care to one that accepts PCC as the guiding standard of practice (Brownie & Nancarrow, 2012). Their systematic review included seven studies that evaluated the opinions of nurses and person-centered care. Findings revealed that the complexity of the interventions and range of outcomes examined limit accurate conclusions about the impact of PCC interventions adopted and implemented in aged-care facilities (Brownie & Nancarrow, 2012). Brownie and Nancarrow (2012) indicate

that further research is necessary to establish effectiveness of the elements of PCC, either singly or in combination.

In another systematic review, Kim and Park (2017) sought to investigate the effectiveness of PCC for people with dementia. Findings revealed evidence for PCC in LTC settings for people with dementia. Few studies were included for home-care settings. “Person-centered care interventions were shown to reduce agitation, neuropsychiatric symptoms, and depression and to improve the quality of life” (Kim & Park, 2017, p. 381). Kim and Park also determined that in order to efficiently implement the person-centered care model, “an educational strategy that promotes learning and skill development of internal care staff is needed to enhance the patient’s quality of life and to ensure the sustainability of the effects of behavioral problems” (Kim & Park, 2018, p. 393). The person-centered care model is evaluated from many different aspects, including those of the clients, their families, the caregivers implementing the care, and management within the facility. Each of these parties experience the care in different ways.

When considering the nursing staff population, an included group is certified nursing assistants (CNAs). CNAs are considered the ‘backbone’ of hands-on care in long-term care (LTC) facilities (Wiener et al., 2009). They provide at least 8 of every 10 hours of care received by residents (Castle & Engberg, 2005; Meyer et al., 2012; Wiener et al., 2009) assisting with completing basic activities of daily living (bathing, dressing, toileting). Therefore, they become highly attuned to residents’ specific physical and communication behaviors. Although CNAs make up a large portion of nursing staff, some of the most valuable input also comes from nurses, either registered nurses or licenced practical nurses. Given there are very few nurses within one facility in any given

time, nurses play a critical role in the well-being of clients in LTC facilities. While providing care, nurses are responsible for both their own actions and also those of the CNAs who are also providing care. This requires the nurse to exhibit many supervisory characteristics to effectively monitor care of their clients and ensure they are receiving the best care possible. According to the McGilton et al. (2009), effective supervisory behaviors include “being reliable, empathic, and able to build connections with unregulated staff, treating CNAs as equal members of the health care team, being involved in front-line care and positively interacting with staff, demonstrating willingness, knowledge, and courage, etc” (McGilton, et al., 2009, p. 724).

Given the overarching responsibilities of nurses, along with their constant client interaction, this study will investigate nurses’ perceptions of PCC within LTC using a systematic review. The study aims to answer two questions: (1) do nurses feel person-centered care is implemented within long-term care facilities and (2) is this model of care the most efficient form of care for individuals with dementia. This study will provide healthcare providers with a different perspective regarding the care they choose to implement to enhance quality of life for individuals with dementia.

Methods

Search Strategy

Studies were included if they met the following criteria: (1) included nurses’ perceptions of person-centered care within long-term care, (2) included an experimental

design with a comparison-treatment or a no-treatment control, (3) provided original data, and (4) were published in English between January 1, 2010 and December 31, 2020 in a peer-reviewed journal.

Studies were excluded if they did not meet the inclusion criteria if they measured other staff members', family or residents' perceptions of care, did not take place in LTC, were published before or after the inclusion time frame, or were literature reviews.

A comprehensive literature search was carried out to locate articles that investigated nurses' perceptions of person-centered care in long-term care facilities. Authors searched for evidence in three electronic databases via *EBSOhost* (CINAHL, MEDLINE, and PsycINFO), PubMed, as well as Google Scholar. Authors used the following key terms "person-centered care," "nurse," "dementia," "aged care," "long-term care," or "nursing home."

Results

The database search yielded 41 articles. The titles and/or abstracts were reviewed and five met the inclusion criteria. PubMed produced 25 results with 21 being excluded and four remaining. Google Scholar produced 11 initial articles, with all 11 being excluded for not meeting the inclusion criteria. EbscoHost produced five results, with four being excluded and one remaining. Most studies were excluded because they did not include nurses' perceptions of person-centered care in long-term care settings or were literature reviews. This resulted in a corpus of five studies that met the eligibility criteria

and were retained for inclusion in the systematic review. Each study will be described below and is available in Table 1.

Studies included a total of 2,200 nursing staff members. Individuals considered members of nursing staff for the purposes of this research included certified nursing assistants (CNAs), registered nurses (RNs), and licenced practical nurses (LPNs). According to the Center for Disease Control, there are approximately 31,100 long-term care facilities and 971,900 beds. Given this large number, 2,200 nursing staff is not even a fraction of the number of staff that are employed within the thousands of long-term care settings. This small number is very indicative of the lack of research surrounding person-centered care, and the lack of representation from staff members who are implementing it.

When considering the types of studies included in my research, I found that each piece of research was a quasi-experimental study. A quasi-experiment refers to the application of an experimental mode of analysis and interpretation to bodies of data not meeting the full requirements of experimental control because experimental units are not assigned at random to at least two “treatment” conditions (Campbell & Riecken, 1968). Within my research, this means that the person-centered care framework is implemented within long-term care settings, but the individuals involved in the studies were informed prior to the research that it was taking place and were not chosen at random. Another characteristic that makes them quasi-experimental is the lack of a control group.

Goh et al. (2009) sought to educate healthcare staff on the use of touchscreen technology as a resource to improve the quality of life of residents with dementia within a PCC approach. A group of seventeen staff members from three different facilities

completed pre- and post-session questionnaires. The group included personal care attendants, registered nurses, enrolled nurses, allied health clinicians, and domestic staff. “As a result of the education seminar, they were significantly more confident in their ability to use touchscreen technology devices with residents” (Goh, 29, p. 2099). Thus, their confidence in implementing the PCC model increased following the post questionnaire in comparison to results of the pre-questionnaire.

This study describes how meaningful activity contributes to the quality of life and reduces behavioral and psychological symptoms while also promoting independence and reducing caregiver depression and stress. Residential care facilities can always benefit from having additional opportunities to increase the quality of life outside of their clients’ daily routines and activities. Knowledge of touchscreen technology provides them with many other interactive activities. This article also mentions that people with dementia spend approximately 70-90% of their time unoccupied. This also supports the reasoning for their research and establishes the usefulness of technology in this environment and its positive impact on the residents’ livelihood. Items such as tablets contain many different apps that relate to the person’s current and past interests, while also inducing interaction that requires minimum caregiver assistance. Other factors to consider include those consistent with technology use. Individuals in LTC often have deficits in vision, fine motor skills, and cognitive skills required to manipulate technology. Therefore, residents will require caregiver assistance manipulating the technology.

A strength of this research is that three different long-term residential facilities were included. This increases the reliability and validity of the research and also of the educational course given that served the purpose of educating the staff on touchscreen

technology. Another strength was choosing facilities that already had touchscreen technology. I think this is a strength because they chose facilities that already had the resources so the researchers were not over-extending themselves by participating in the research, and resources that were previously not being used due to lack of confidence were now being used after the course. Because the researchers collected information from nursing staff within the facilities, it is valid to say that this form of technology and the confidence that nursing staff have while using it within their job supplements the daily living of the residents in the facility.

Burshnic et al. (2018) examined nursing staff and non-nursing staff's attitudes towards aggression of residents in LTC facilities and readiness for adoption of PCC. They administered a questionnaire to survey the attitudes of five employees within each nursing home located in Michigan. Given there are approximately 440 nursing homes in Michigan according to the Center for Disease Control, this results in around 2,200 participants. Participants included members of management, nurses, certified nursing assistants, and activities assistants. Results supported PCC in comparison to standard approaches. More than half of the participants were in support of implementing person-centered approaches within their facilities. "Job title was a significant predictor of paradigm support. Frontline employees were found to support person-centered attitudes the least. Wide-ranging responses were noted within employee groups" (Burshnic et al., 2018, p. 176). They elaborate on their results to say that an employee's job title may affect the degree of support that each employee has for PCC approaches. Employees with the most contact with residents of the LTC facility may be less likely to implement PCC approaches than those who have less contact with the residents. Given that more than half

of participants were supportive of the PCC model, this is indicative that the majority of participants were not direct care staff, such as nurses and nursing assistants. Years of experience did not impact employee's attitudes toward aggressive behavior (Burshnic et al., 2018).

This article provides mixed perceptions between staff about PCC. Overall, staff supported PCC, but frontline employees, such as nurses and CNAs, who interact with the residents most often do not support PCC. Furthermore, employees who interact with residents the most may be less likely to implement PCC approaches than those who have less contact with the residents. Although this could be a result of many different factors, nursing support could be minimal due to the amount of effort required to sustain a proper person-centered care framework. According to the Center for Disease Control, one resident spends approximately four hours of their day with a frontline worker, and only an average of around 15 minutes of their day with an activities director or staff (CDC). This difference in time spent is an indicator that the nursing staff who are around the residents a bit more than the other staff have a better idea of the best care although they did not support the person-centered care framework.

A strength of this study was the fact that they included all nursing homes in the state of Michigan. This makes for a strong foundation of information and gives a greater variety. A weakness, however, is that the questionnaires were distributed through mail. This is a weakness because it is unsure if there was tampering with the surveys. Five questionnaires were mailed to each nursing home, and relatively anyone could have completed them. It is unsure why only five participants were included from each nursing home, but it can be assumed that this is due to time or resource constraints, and to

maintain the feasibility of the study. It was not feasible to personally go to each nursing home and have individuals fill out the questionnaires in person, but they could have decreased the size of their survey participants so that they could have them filled out through a more reliable method. Limitations to this study are that the study focuses on nursing facilities within the state of Michigan, the questionnaires were mailed, and only five participants were included from each facility.

Chaudhury and colleagues (2017) examined the effects of person-centered care through environmental renovations during meal time on residents in two different LTC facilities. Data collection involved observation of ten residents of the nursing facilities before and after renovations. They used the Dining Environment Audit Protocol. Seventeen nursing assistants and/or nurses completed surveys. “Based on a systematic analysis of observational data and staff survey responses, five themes were identified: (a) autonomy and personal control, (b) comfort of homelike environment, (c) conducive to social interactions, (d) increased personal support, and (e) effective teamwork” (Chaudhury, 2016, p. 878). The following implications were found to be true: “Although the physical environment can play an influential role in enhancing the dining experience of residents, the variability in staff practices reveals the complexity of mealtime environment and points to the necessity of a systemic approach to foster meaningful culture change” (Chaudhury, 2016, p. 878). To summarize, although the renovations affected the residents, it was found that the practices by the nursing staff carried the most implications and had the greater effect on their dining experience.

This article utilizes many other sources to introduce PCC, examine the use of it in LTC facilities, and discuss the effect that mealtime can have on residents’ nutritional and

psychological needs. This article includes observations from the authors as well as answers to surveys from nurse aides and nurses. Including the opinions of the authors, nurses, and nurse aides decreases the likeliness of bias. Another strength is that they focused specifically on mealtime as this is a critical time for residents. It is the part of the day they look forward to the most so it is crucial that it is a good environment for them physically, mentally, and emotionally.

Chenoweth and colleagues (2015) sought to describe the influential factors associated with adoption of PCC in LTC. The author mentions that she believes the well-being and various forms of agitation in people with dementia can be improved in a person-centered long-term care setting. To conduct the study, data was obtained through individual interviews from the pool of participants consisting of 29 care managers, 70 nurses and care staff, 73 telephone surveys with family members, staff reports of care approaches, and 131 field note entries recorded by the researchers. Authors performed qualitative analysis to reveal themes related to perceptions of implementing PCC. Results revealed that when adopted, “the person-centered model increased the number and variety of opportunities for residential interaction, improved flexibility in care regimens, enhanced staff’s attention to resident needs, reduced resident agitation, and improved their well-being” (Chenoweth, et al., 2015, p. 2045). Some of the barriers and enablers of PCC included: leadership, managers, staff and family appreciation of the model, staff’s capacity, effective communication and teamwork among direct care staff, care service flexibility, and staff education on how to focus on the person’s well-being (Chenoweth, et al., 2015, p. 2045). The authors concluded that “Successful knowledge translation of the person-centered model starts with managerial leadership and support; it

is sustained when staff are educated and assisted to apply the model, and, along with families, come to appreciate the benefits of flexible care services and teamwork in achieving resident well-being” (Chenoweth, et al., 2015, p. 2045).

A strength of this research is the number of participants in the trials, as well as the different perspectives included. A large number of participants with various roles in LTC participated in the study. Families, management, and nursing staff were all included and this strengthens the credibility of the research due to having so many professional and personal opinions about this framework. This decreases the possibility of bias and broadens the feedback. Another strength is the use of multiple care sites instead of just one. The only weakness determined is the lack of comparison of other care frameworks. Because this article was focused only on PCC, this could be dismissed but it would have strengthened the argument and results, and provided the participants with the chance to express their beliefs regarding other care frameworks.

Burack and colleagues (2012) conducted a longitudinal study of five-years to assess changes within a nursing home as it transformed from a traditional hospital-type setting to a culture change model with the central principle of PCC. It consists of data collected from 13 long-term care facilities that were all following the traditional model of care framework. The data was collected at the baseline, after two years, and then after five years. At the two year mark, seven of the twelve communities had transitioned to culture change communities, while six remained traditional communities to be used for comparison. Both sets of communities were evaluated at the two- and five-year mark using the Duncan Choice Index (DCI). The DCI provides individuals with an assortment of tasks of daily living, such as taking a bath, having a meal, receiving assistance with

dressing, etc, and allows the individual to choose how confident they feel in the care they receive during that task. Results showed a positive increase for the test group from baseline to year two, and a positive increase for the control group from year two to year five. It can be concluded that individuals in the test group had a positive increase in confidence in their caregivers from baseline to year two, but the control group had the positive increase from year two to year five. This is indicative of an increase in confidence in the PCC model upon initial implementation, but presents challenges with sustainability over time. The initial benefits of the PCC model in this facility did not extend throughout the years of this study.

A strength of this article is that it maintained a control group of six long-term care communities, while the other seven were transitioned to the person-centered care model. Maintaining a control group increases the validity of the research and reduces the likeliness of influence from outside factors or unprecedented conditions. Another strength of this research is that it was conducted over a five-year period. This increases reliability and validity due to the length of time given to collect data.

Although there were staff who do not support person-centered care, the majority of the participants in the studies I have mentioned felt that it was beneficial to their long-term care communities.

Discussion

The study aims to answer two questions: (1) do nurses feel person-centered care is implemented with long-term care facilities and (2) is this model of care the most efficient form of care for individuals with dementia. Studies addressed nurses' perceptions of PCC in LTC, interventions associated with PCC (technology and mealtime), as well as effectiveness of PCC. Overall outcomes revealed that the majority of nurses who are already implementing the PCC model within their facilities feel that it is being implemented effectively. However, if the transition from the traditional care-model to PCC is only being discussed and is not yet in place, nurses are less likely to support the implementation of it. Regarding the most efficient model of care for individuals with dementia, nurses feel PCC is the more efficient model of care. However, similar to the transition from the traditional care-model to PCC, if PCC is not already being implemented, nurses are less likely to support PCC as the most effective care-model for individuals with dementia. Within the next section, I will discuss limitations within the research, adverse effects among participants and their causes, as well as interprofessional collaborations that would benefit from the implementation of the PCC model.

Although findings are promising, limitations must be considered. This systematic review consists of only five studies and 2,200 nursing staff. This is a fraction of CNAs, RNs, and LPNs employed within LTC settings, so their opinions can not be representative of all nurses' perceptions of person-centered care. Limitations of this study include the use of quasi-experimental studies and the instruments used to collect data. Quasi-experimental studies, although very informative and successful, lack control groups that provide their research with stability and validity. Having a control group, as previously mentioned, decreases the likelihood of research being affected by

uncontrollable elements. Another limitation is the instruments used to collect data. Many of the studies mentioned utilized paper surveys that were not presented directly to the population of interest, but were given to one individual or mailed to the facility. This is a limitation because it is unsure whether the appropriate individuals completed the surveys or if they were completed by an unrelated member or members that would contribute biased opinions.

When considering the individuals who were not in support of the person-centered care model, it is important to reference adverse effects. Based on the results, there is not a unanimous decision regarding whether person-centered care being implemented in every facility will provide residents with the best possible care according to nursing staff. Although the majority opinion does appear to be in support of the framework, there were still nursing staff who did not feel that it was sustainable within their long-term care settings. This should include the consideration of many factors that do not stem from the framework itself. Many nurses in nursing homes report feeling overwhelmed and overworked during their time on the job. Adding more demands, such as the extra expectations that accompany the person-centered care framework, would simply increase the amount of stress the nurses are feeling and also decrease the quality of care for the residents in a way. Implementing this framework in a facility that is understaffed would result in some residents receiving great care and other residents receiving less than satisfactory care. Spreading staff too thin results in mistreatment of the long-term care members, usually with lack of intention from the staff. Many long-term care facilities are understaffed, and the staff who are employed there overexert their time, energy, and effort to provide the residents with the best possible care. Although they want the best for

their residents, it is often impossible to meet their every need due to the number of people they are trying to do these many things for. Often only the basic needs are met, and supplemental activities are not completed for the day. According to the Nurse Journal (2021), many nurses who are required to have a large caseload experience “Nurse Burnout”. This can best be described as the emotional and physical exhaustion that comes with the stressful responsibilities of nursing (Nurse Journal, 2018). Although this is not a reason for a nurse to not provide the best standard of care, it is possible justification for the lack of support from frontline workers for the person-centered care model.

Although facilities are experiencing many issues with nurse retention, another prominent concern is the turnover rate of their certified nursing assistants. As mentioned, CNAs do spend the most time with residents (Winchester, 2003); however, many report they do not feel appropriately prepared or included in important caregiving decisions regarding the individuals they care for. They also lack information needed to provide appropriate care for their clients because this is not communicated to them. CNAs assist with all ADLs, meals, activities, and frequent instances of mobility. Given the responsibilities of CNAs in caring for their clients, it is important for other aspects of their job to be both stable and healthy. This can include their workplace relationships with coworkers, nurses, members of management, activities assistants, therapy services, as well as their workload and wages. Diane Brannon and colleagues (2002) examined the factors that distinguished nursing facilities with very high CNA turnover rates from those with a lower turnover rate. Within 288 facilities, each director of nursing was interviewed regarding their turnover rate and their causes. According to Brannon et al. (2002), of the 288 interviewed, 25% experienced more than 63% turnover within their nursing

assistants, and 15% reported more than 90% within the previous six months. As presented in Table 2, four of the most influential factors that contributed to turnover were the trained supervisors within each facility, lack of involvement in care planning, lack of aides, RNs, and LPNs, and the level of nurse aide training provided (Brannon et al., 2002).

Although these are not issues that can be remedied overnight, there are many different outcomes that would result in greater nurse and CNA satisfaction within their careers. Alternatives to increase the fluidity of the relationship between CNAs and other members of the facility include a retention specialist (Pillemer et al, 2008) and a peer-mentoring program (Hegerman, 2005). When a retention specialist was utilized, CNA turnover reduced by 10.54% in comparison to the control group (2.64%) over a one year period (Pillemer et al, 2008). When a peer-mentoring program was implemented, Growing Strong Roots, retention of CNAs increased by approximately 25 percent over the course of a month (Hegerman, 2005). The success of the implementation of these options should be worth consideration for many facilities. Not only does employee retention benefit each member of the facility, it also benefits the individuals receiving care. High CNA turnover rate results in frequent hiring of new aides. This is a loss to those being cared for because along with the CNAs who are finding employment elsewhere goes the knowledge they have acquired about their clients over the period of time they've cared for them. CNAs form profiles of each of their clients and remember important information that increases their quality of care. This can include their likes, dislikes, favorite meals and activities, important family members, their previous occupations, and so on. There are many aspects of an individual, especially an individual

with dementia, that affect their daily lives and ultimately the care they need to receive. With CNAs constantly relearning new clients, they are ultimately not able to provide the standard of care their clients could be receiving had they been cared for by consistent CNAs. Thus, one way to enhance person-centered care is to increase continuity of care by increasing support given to CNAs in the workplace.

When considering PCC within LTC, consider the collaboration among direct care providers and rehabilitative staff. Speech-language pathologists collaborate with nursing staff to improve patient care in many ways. Benefits of nurse and SLP collaboration include increased awareness of client actions, wants and needs, as well as possible areas they could benefit from improving to increase their quality of life. SLPs provide therapy for 30-60 minutes of the day, while nursing staff provide care for nearly every minute of the time they are awake. Nurses can communicate with SLPs to provide information that they may miss when they are not around. Not only does this help the SLP understand what's going on with the individual, it is a form of PCC. This is considered PCC because the core of this model is establishing the best possible environment and level of care for the client through the building of relationships with those around them. If there is a close collaboration between nursing staff and the speech-language pathologist, the needs of the client are being put first and they are more likely to receive the help they need.

Not only does this benefit the client, it also helps the nurses who provide care for them. A client experiencing an increase in their quality of life often sees improvement in their health and they can be relieved of varying health concerns they are experiencing. Given so, this would permit nursing staff to spend their time caring for clients in other ways due to their client experiencing an increased level of confidence and independence

completing specific tasks. It may also make certain processes easier depending on the type of therapy implemented. For example, in an article from Kaitlin Dondorf (2018), individuals who may have dysphagia could have trouble swallowing food, water, and medication. If an individual has difficulty swallowing their medication, this creates a certain level of stress for the nurse because instead of just having the client swallow the pills, they may have to wait a few minutes for them to swallow them to make sure they don't choke on them, or they may have to take time to make the medication easier to swallow. Many individuals in LTC settings require medication adjustments to enhance swallowing safety. Given the specialization of training received by SLPs, they can not only enhance communication skills, but train nurses and CNAs about specific strategies to reduce communication breakdowns during daily care. This could also reduce the amount of effort and time needed to complete a task.

Conclusion

Given the growing number of individuals being diagnosed with a disability each day, the importance of long-term care settings is higher than ever. The specialization of care given in LTC settings creates the most optimal environment for an individual experiencing difficulty in one or more aspects of their everyday life. Although the implementation of the person-centered care model is supported according to present-day research, there is still room for improvement regarding the literature surrounding the PCC model. More widespread research would further establish the principles associated with the model and also educate more facilities and providers of care on the benefits of its

implementation. Care implemented is ultimately left up to the facility, but knowledge of all care models would only enhance the care being provided regardless of the model chosen.

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