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Jennifer L. Johs-Artisensi
University of Wisconsin - Eau Claire, johsarjl@uwec.edu

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Cover Page Footnote

Special thanks to the many University of Wisconsin – Eau Claire Health Care Administration practicum sites, preceptors, and staff for supporting the “Resident for a Day” experience and to the administrator-in-training practicum students for contributing the data for this project. This project was supported by grant funding from the University of Wisconsin – Eau Claire’s Center for Health Care and Aging Services Excellence, College of Business, and Office of Research and Sponsored Programs.

Operationalizing person-centered care practices in long-term care: recommendations from a “Resident for a Day” experience

Jennifer L. Johs-Artisensi, *University of Wisconsin - Eau Claire, johsarjl@uvec.edu*

Abstract

As the senior population continues to age, long-term care is positioned for growth and care recipients are demanding more person-centered care. While long-term care leaders may understand and believe in the value of person-centered care, sometimes operationalizing practices to ensure its delivery can be challenging. Using an ethnographic approach, over three years, 159 long-term care administrator-in-training practicum students each lived as a resident for 24 hours in a nursing home. Following the experience, using the Picker Institute’s framework, each participant identified and justified an Always Experience® – an optimal experience they believed should routinely occur for every long-term care resident. They then developed an action plan that identified several specific operational practices and measures to ensure that Always Experiences® could always occur for residents. A thematic analysis of these Always Experience® action plans was conducted. As a result, six amalgam exemplar Always Experience® action plans – for Admissions, Care Planning, Care, Dining, Activities, and Responsiveness – with desired objectives, specific operational practices, and relevant measures to evaluate outcomes were developed. These easy-to-implement action plans can help long-term care administrators put necessary practices into place to ensure they are consistently delivering high quality, patient-centered care to long-term care residents.

Keywords

Patient experience, person-centered care, culture change, resident perceptions, long-term care administration, nursing home, staff behavior, ethnography

Note

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Introduction

Although demand for person-centered care in long-term care settings is increasing, operationalizing practices to do so can be challenging. When administrators-in-training are given an opportunity to live as nursing home residents for 24 hours, they are in a unique position to experience dependency and the process of care with an administrative perspective. Drawing on these experiences, routinized procedures and practices that will enhance patient-centered care for residents can be developed.

Patient-Centered Care and Always Events®

An emphasis on patient safety emerged at the start of the 21st century, and from there, an emphasis on quality improvement and the patient experience began to gain traction. One effort to facilitate improved patient experiences has been to reorient the traditional medical model to a patient-centered care approach. This has the

effect of moving the care recipient from passive receiver to a more engaged partner in the care process, ideally facilitating improved outcomes.¹ Person-centered care requires a system-change that places greater emphasis on patients’ needs, preferences, and social context, through more proactive, enhanced patient-provider collaborations.²

In an effort to improve patient safety, the term “Never Event” was introduced in reference to serious medical errors that should never occur.³ Building on that nomenclature, the Picker Institute, whose emphasis was on promoting person-centered care, saw an opportunity to counterbalance the idea of “Never Events” by developing Always Events®. These refer to “aspects of the patient experience that are so important to patients and families that health care providers should always get them right.”⁴(p.4) In their quest to see Always Events® become widespread practices, Picker incentivized pilot providers to consider several key criteria, including 1) Identification of experiences that were fundamental to patients’ care; 2)

Evidence-based to optimize care and respect of patients; 3) Measurable and specific; and 4) Affordable, such that any organization could achieve them without undue burden.⁴

Long-Term Care

Although person-centered care has gained traction in acute care as part of the “Patient Experience” emphasis that value-based purchasing models demand and standardized surveys such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) measure, the concept has historically been less researched and promoted in long-term care. With 10,000 people in the United States turning 65 every day over a 19 year span, the senior demographic is poised to grow to 18% of the overall population.⁵ With similar patterns occurring worldwide,⁶ long-term care is positioned for growth. In addition to increased demand for more services, care recipients and their families are also demanding better service, increasingly expressing a preference for care to be more person-centered.⁷ As such, person-centered care is a growing trend in long-term care settings, such as nursing homes and residential care or assisted living facilities. As defined by Rosemond, et al.,⁸ (p.258) person-centered care is “...based on supporting positive relationships between care providers and residents by promoting daily routines for residents that are tailored to their life experiences, abilities, and preferences”. In short, person-centered care refers to empowering residents as decision makers in their own lives.⁹ With value-based purchasing poised to enter long-term care reimbursement,¹⁰ and increasing consumer demands for quality,¹¹ it is imperative that administrators implement practices that improve the resident experience. Beyond direct impacts a person-centered care approach has on residents, improving both quality of life and quality of care, it also helps reduce administrative challenges such as high staff turnover.¹² In a recent analysis of the long-term care administrator’s role¹³, knowledge and skills necessary to support quality resident care comprised 35% of the skill set required. This underscores the importance of both understanding care recipients’ needs as well as being able to implement systems with patients and their families at the center, so those needs can be well met.¹⁴

While long-term care administrators may understand and believe in the value of person-centered care, implementing it can be challenging due to potential barriers such as increased costs for staffing, equipment, or physical environment changes^{15,16,17}; regulations or legal ramifications¹⁸; or staff attitudes and education.^{19,12} However, as Press^{20(p. 6)} said, the “...keys to improving patients’ experience of care are neither obvious nor effortless...providers have to work at it. Everyone...must be accountable for the patient’s experience.” Thus, if all care providers must take responsibility for delivering person-centered care, and administrators are responsible for establishing both a culture that supports that

philosophy as well as systems that embody policies and practices to support such care, a key question is how to help long-term care administrators operationalize strategies to promote it within their care communities. The current study explores how the experiences of participants who spent 24 hours living as nursing home residents contribute to the operationalization of person-centered care practices in a long-term care setting.

Methodology

Health care leaders have been urged to re-conceptualize the patient experience as a vital form of “patient-based evidence” by studying patients’ experiences, and then collaboratively developing new models of care to offer practitioners clear guidance on what practices will enable a good patient experience²¹. Using the model of “Patients as Teachers”, administrators can incorporate patient experiences into service design and professional education²².

Although obtaining evidence directly from care recipients is an important tool, long-term care residents may have cognitive impairments that make communicating about their experience challenging. In addition, some residents may be habituated to lower expectations or may not vocalize complaints or dissatisfaction²³, but just because complaints have not been made, does not mean there is no room for improvement. Given these potential restraints, coupled with a desire to gain a deeper understanding of the culture and experience of long-term care residents, more common approaches to qualitative research, such as focus groups or structured interviews, were eschewed in favor of an ethnographic approach.

Ethnography & Experiential Learning

Ethnography and experiential learning share assumptions and approaches to learning about culture through the primacy of “everyday lived experience” (experiential learning) and learning through deep cultural immersion, observation, dialogue and interaction to gain a deeper understanding of another’s culture (ethnography).²⁴

Ethnography is a research method that is carried out in a natural setting, involves face-to-face interactions within the culture being studied, and aims to present an accurate reflection of members of that group’s perspectives.²⁵ It is an ideal method to more closely explore factors associated with the status quo in order to identify, understand, and change them. Thus, it can be a useful approach to help long-term care administrators develop a better understanding of their residents and how their organizations can best serve residents’ needs. Experiential learning through simulation is beneficial in helping administrators understand the values, beliefs, attitudes, and behaviors that facilitate person-centered care.²⁶ As a proxy for resident experience, administrators-in-training can live

as nursing home residents for 24 hours to experience, observe, document, and develop measurable action plans with operational practices that will promote positive resident experiences.

Approach: Resident for a Day Experience

A 24-hour resident simulation experience was developed. Near the beginning of a yearlong academic administrator-in-training practicum, participants simulated the role of a nursing home resident for 24 hours—from admission to discharge—diagnosing themselves with a limitation that would require dependency upon someone else for care. Each participant designed their own “resident role”, where their mobility and senses would be compromised, and then devised ways to simulate relevant impairments. For example, those simulating a stroke may have restricted mobility by using a wheelchair with arm and leg weights to impair movement and/or worn eye patches to simulate a vision field cut. Others may have simulated a hip or knee replacement, and used bandages and a walker while following typical post-surgical precautions. Arthritis may have been simulated by taping finger joints or wearing gloves, yielding reduced dexterity or hand movement. Decreased senses were often simulated by smearing glasses with Vaseline to imitate cataracts or using earplugs to decrease hearing. Some participants may even have compromised their communication abilities, choosing to be non-verbal, or to simulate dementia by feigning confusion or engaging in mildly combative behaviors. Although each participant’s role was individually designed, and thus unique, the intent was to approximate the experience of a “real” nursing home resident as realistically as possible.

Participants began the 24-hour experience in social services, going through the admission process and interacting with all members of their care team. They ate meals, one of which was pureed, in dining rooms with other residents. They received help from nursing assistants with bedtime routines. Additional self-care assistance, along with other dependency activities such as using the call light, wearing an alarm to restrict movement, and being transferred were all included in their care plan. After sleeping overnight and going through the discharge process the next afternoon, they reflected on their experiences and observations in a slide show with an accompanying narrative. In their presentation, participants were instructed to chronologically describe specific experiences they had during the 24 hours, and how those experiences made them feel. Each presentation culminated in them sharing key “lessons learned” they believed would influence them as future administrators. Following their own 24-hour experience, and after viewing eight to ten peer presentations to further broaden their perspective on the resident experience, each participant was asked to identify an Always Experience® - an optimal way of experiencing care they believed every long-term care

resident should routinely experience²⁷. In addition, they each developed an action plan that outlined several specific operational practices, or Always Events®, which could be integrated into an organization’s staff training and expectations and routinely carried out by caregivers to ensure consistent, high quality, person-centered care. Finally, they suggested appropriate data sources to measure the occurrence and impacts of implementing such practices, and offered a justification that the proposed Always Experience® and Always Events® were meaningful, evidence-based, measurable, and affordable. These Always Experiences®, Always Events®, and suggested measures served exclusively as the data set for the current study

Sample Demographics

Over three years, from 2013 through 2015, 159 senior-level, undergraduate, long-term care administrator-in-training practicum students lived as residents for 24 hours in 93 different nursing homes. Participant characteristics can be found in Table 1. All participants were seeking completion of their baccalaureate degree in health care administration. Most were in their early 20s and there were significantly more females than males.

Characteristics of care facilities that hosted participants can be found in Table 2. Sites only hosted 1 participant at a time. Some sites participated only a single year, while others hosted participants multiple years. Sites were spread across the United States, but primarily clustered in the upper Midwest. Care facilities where participant experiences occurred represented a wide variety of ownership structures and were at varied stages of “culture change” – the heart of which is person-centered care.²⁸

Administrators at each care facility supervised the participants and were trained in how to structure and support the Resident for a Day experience. The University of Wisconsin – Eau Claire IRB approved this project as exempt since it only included a review of previously completed course assignments with no identifying information.

Data Analysis

Together, the researcher and a trained research assistant used a conventional thematic analysis approach to review the Always Experiences®, inductively reviewing content to identify various categories that emerged as being most important to participants³⁰ as optimal experiences that should be operationalized into a facility’s practices. Although many Always Experiences® reflected discrete care practices (e.g. Admissions, Dining), some focused on broader experiences (e.g. Dignity, Responsiveness). Subsequently, a further discourse analysis of action plans in these broader experience categories determined whether they were better re-categorized with items that matched the operationalized practices being espoused in the Always

Table 1. Participant Characteristics

Characteristics	n (%)
(N=159)	
Degrees	
<i>Seeking 1st Baccalaureate</i>	155 (97.5)
<i>Seeking 2nd Baccalaureate</i>	4 (2.5)
<i>Possessed or Seeking Master's</i>	0 (0.0)
Race	
<i>White</i>	147 (92.5)
<i>Asian</i>	8 (5)
<i>Hispanic</i>	2 (1.2)
<i>Black</i>	1 (0.6)
<i>Other (Egyptian)</i>	1 (0.6)
Age (in years)	
<i>≤24</i>	148 (93)
<i>25-35</i>	9 (5.6)
<i>>35</i>	2 (1.3)
Gender	
<i>Male</i>	46 (28.9)
<i>Female</i>	113 (71.1)

Table 2. Care Facility Characteristics

Characteristics	n (%)
(N=93)	
Ownership	
<i>Profit</i>	40 (43)
<i>Nonprofit</i>	50 (53.8)
<i>Government</i>	3 (3.2)
Chain Status	
<i>Independent</i>	20 (21.5)
<i>Small Chain</i>	47 (50.5)
<i>Large Chain</i>	26 (28)
Culture Change Status*	
<i>Below Average (<200)</i>	23 (24.7)
<i>Average (200-299)</i>	46 (49.5)
<i>Above Average (>300)</i>	24 (25.8)
Site Location	
<i>Wisconsin</i>	49 (52.7)
<i>Minnesota</i>	31 (33.3)
<i>Illinois</i>	5 (5.4)
<i>Massachusetts</i>	2 (2.2)
<i>Iowa</i>	1 (1.1)
<i>Michigan</i>	1 (1.1)
<i>New Mexico</i>	1 (1.1)
<i>Oregon</i>	1 (1.1)
<i>Pennsylvania</i>	1 (1.1)
<i>South Carolina</i>	1 (1.1)

*Artifacts of Culture Change Overall Score.²⁹ For sites hosting a participant in more than one year, whose ACC score changed, averaged scores were used.

Events[®]. Ultimately, several categories materialized, with six emerging as the most heavily populated. Next, for each of these six commonly identified categories, researchers examined their Always Events[®] action plans. Initially, the intent was to select a single exemplar plan from each category; however, there were a myriad of rich ideas represented across several plans in each category.

So, instead, an amalgam of exemplar ideas were culled from within each category to create a single, recommended action plan. First, the exemplar that seemed to best embody the spirit/intent of the majority of the action plans within each category was chosen to represent the desired Always Experience[®] for each category. Next, all of the suggested Always Events[®] within each category were reviewed. Criteria were inductively developed to guide selection of four to six actionable practices to include in the exemplar. Criteria included practices that were most likely to contribute to achieving the desired Always Experience[®], that staff could be trained on, that would require few or no financial resources, that were easy to implement, and that could be generalized to various settings. Finally, the suggested measures of intended outcomes for each category were reviewed. One to three data sources that were either already being collected or were likely to be readily available, were selected.

Findings

As a result of the thematic analysis and amalgam process, six exemplar Always Experience[®] action plans were developed in the areas of Admissions, Care Planning, Care, Dining, Activities, and Responsiveness. The plans included desired objectives, specific operational practices, and relevant measures to evaluate outcomes to facilitate person-centered care for long-term care residents.

Admissions

Participants often reported feeling overwhelmed during the admissions process. They felt strongly that there was an opportunity to make a positive first impression on new residents, which could increase comfort and trust as they began transitioning into their new home. They suggested that a positive admissions process could set the tone for future relationship building, which is a key element to person-centered care and helps to open the lines of communication between residents and staff.

Always Experience[®]

“Residents should feel welcomed and comfortable when they first arrive.”

Always Events[®]

- Have a greeter in the lobby, with a wheelchair available, when the resident comes in to the facility.

- Welcome the new resident with a smile and a genuine, warm greeting.
- Give the resident a tour of the facility with introductions of all key staff.
- Assign each new resident a staff “buddy” to help get them settled in with their belongings and to periodically check in on them during their first few days/weeks.
- Provide an easy-to-read summary of key information along with a list of department contacts for residents and families in case they have any questions.
- Complete the majority of admissions paperwork prior to admission whenever possible.

Suggested Measures

The Admissions Always Experience[®] could be measured by resident (and/or family) satisfaction surveys of the admission process within 72 hours of admission.

Care Planning

Participants felt strongly that residents needed both to be well-informed and to have input into driving their care plan. This was especially true when physical or cognitive limitations made it necessary for them to depend on others to meet their needs. Knowing that they had choices about how, what, and when care was provided, including being told they had the right to refuse care, was very important to them. Even if they did not exercise that right, just knowing they had that level of control felt empowering to them.

Always Experience[®]

“The resident should be involved, informed, and have input in all decisions about their care.”

Always Events[®]

- Invite the resident (and family) to attend all care conferences held with their care team.
- Allow the resident to voice their opinion.
- Develop individualized care plans that incorporate the resident’s preferences and communicate them to all caregivers.
- Inform the resident (and family) when the resident’s treatment changes.
- Properly document all care provided.

Suggested Measures

The Care Planning Always Experience[®] could be measured by regular resident (and/or family)

satisfaction surveys or through a short interview process by the care team, following formal care planning. In addition, chart audits could be conducted to ensure there is documentation that the above steps are being followed.

Care

A common report from participants was that their dependency needs made them feel like they were a burden on the staff. Residents they interacted with during the experience also echoed this sentiment. The emphasis on the importance of dignity, privacy, and autonomy were repeatedly highlighted as critical to counteracting negative emotional reactions associated with transitioning to living in a new environment and being dependent on others for personal care.

Always Experience®

“Residents should always be given the best care possible while respecting their dignity and autonomy.”

Always Events®

- All staff should answer call lights or any resident requests/concerns in a timely manner.
- Before entering a resident’s room always knock, wait to be invited in, and be polite.
- Accommodate the resident’s preferred schedule such as, waking up, eating, activities, toileting, and going to bed.
- Staff should talk the resident through any procedures being performed so they know what to expect.
- Staff should respect the resident’s privacy by shutting doors, pulling curtains, and covering parts of their body not being addressed during provision of care.

Suggested Measures

The Care Always Experience® could be measured via annual inspection results and deficiency citations related to quality resident care. In addition, regular resident (and/or family) satisfaction surveys will validate whether staff are routinely following these practices and whether residents are satisfied with the level of autonomy and dignity in their care.

Dining

Many participants noted how important mealtimes were to residents’ daily routines. For some, they were key opportunities not just to eat, but also to socialize with peers and interact with staff. For others, mealtimes served

as a way to break up the monotony of the day. Participants also pointed out the varied impacts that a positive or negative dining experience could have on a resident’s mood or emotional well-being or, potentially, even their physical health. One participant cited an NIH study³¹ which validated the relationship between the dining experience and perceived quality of life for both lucid and cognitively impaired residents as further justification for inclusion of a positive dining experience as an Always Experience®.

Always Experience®

“Resident preferences should be considered and respected so that the dining experience is comfortable and enjoyable.”

Always Events®

- Give residents choices of multiple meal options and dining times.
- Deliver food to residents in a timely manner and allow them ample time to eat so they do not feel rushed.
- Check on residents multiple times during meals to ensure they are enjoying the food and environment, and accommodate any requests promptly.
- Communicate to residents that they are allowed to ask for additional portions, substitutions, or snacks at any time.
- Document resident food preferences in their chart so they are easily understood by all caregivers.

Suggested Measures

The Dining Always Experience® could be measured via annual inspection results and deficiency citations related to quality resident care and dietary services. In addition, regular resident (and/or family) satisfaction surveys will validate whether staff are routinely following these practices and whether residents are satisfied with their dining experience. In addition, chart audits could be conducted to ensure that resident food preferences are documented and being carried out by the care team.

Responsiveness

Participants indicated that when things did not happen as they felt they should, they experienced emotional consequences such as feeling unsafe, uncomfortable, or even uncared for. Additionally, participants noted feelings of respect and inclusion when they or other residents were listened to and their concerns or suggestions were validated by staff. They felt strongly that if a facility purported to offer person-centered care, and a resident

took the time to verbalize a concern or request, it was imperative to acknowledge and act upon it quickly.

Always Experience®

“Residents’ concerns and requests should be promptly addressed by staff.”

Always Events®

- Make resident-centered care part of your organizational mission, vision, and values.
- Establish an open door policy with staff and administration that is clearly communicated to residents.
- Host regular resident council meetings facilitated by a manager where residents can share issues and potential solutions.
- Ensure hospitality is a part of all staff orientation programs and annual in-service training.
- At routine staff and management meetings, go over concerns residents may have within each department regularly to find and implement solutions.

Suggested Measures

The Responsiveness Always Experience® could be measured by regular resident (and/or family) satisfaction surveys and/or measuring complaints or reports of outstanding or unresolved issues.

Activities

Participants commonly experienced periods of boredom and loneliness throughout the day. They recognized the importance of offering opportunities for social and cognitive engagement. Many of them attended every activity offered, even though many were not in alignment with their own personal interests, just to avoid monotony and isolation. They stressed the importance of involving residents in activity programming decisions as well as enlisting staff to help ensure residents do not miss out on opportunities they might enjoy.

Always Experience®

“Resident should have the option to participate in meaningful and enjoyable activities that align with their interests.”

Always Events®

- Conduct a resident assessment to figure out which activities coincide with lifelong interests and hobbies.
- Host a variety of activities on different days and at different times.

- Be sure to invite and remind residents of the activities that occur each day to make sure that they are participating in activities that they enjoy.
- Help the resident get to the activity and document whether they enjoyed it.

Suggested Measures

The Activities Always Experience® could be measured via regular resident (and/or family) satisfaction surveys to validate whether staff are routinely following these practices and whether residents are satisfied with their options for and levels of engagement in meaningful activities. In addition, chart audits could be conducted to ensure that resident activity preferences are being assessed, documented, and accommodated.

Discussion

Providing patient-centered care for long-term care residents requires a comprehensive understanding of the resident experience so that specific practices can be developed and implemented to best meet their needs and accommodate their preferences. The ethnographic approach of embedding administrators-in-training into resident culture via the Resident for a Day experience yielded rich data. It proved to be a valuable way for individuals educated and trained in long-term care administration to gain firsthand knowledge about the experience of and feelings associated with being a care recipient, thus developing a unique perspective on what person-centered care should look and feel like. Not only did participants gain insight into how organizational practices impact residents, but they were also able to translate those insights into practical protocols to guide organizations’ culture orientation, staff training, and care practices to drive person-centered care outcomes.^{16,12,32} Each Always Experience® action plan has a well-defined objective, contains specific steps or actions that are affordable to implement and that care team members can be trained on and held accountable to, and suggests reasonable data sources for measuring its effectiveness.

Demand for person-centered care has never been higher, from customers, payers, and regulators alike, but there can be barriers to its implementation.¹⁹ One important component in advancing person-centered care is strong leadership,^{19,33,8} so it is imperative that leaders advancing person-centered care have a keen understanding of what it is and why it is important.²⁶ However, as Staniszewska & Churchill²¹ stated, “there is a need to consider how to best implement patient-based evidence...as...few studies have focused specifically on the best ways of implementing interventions that enhance a good patient experience.” The contribution the current study makes is in the templates it offers long-term care leaders, helping them to

operationalize their vision and embracement of a person-centered care philosophy into actionable practices that will promote specific approaches to achieving person-centered care outcomes.

The majority of the Always Experiences[®] that emerged from this study are heavily influenced by the behavior of the nursing assistants and other staff. Consistent with previous research,^{15,34} the current study also underscores the influence of nursing assistants' behavior on the resident experience and emphasizes the importance of administrators integrating education about person-centered care into staff orientation,³³ and establishing protocols for behavior with clear expectations of what is expected of staff.

Consistent with Van de Ven^{35(p. 137)} who stated, "Patients seek a relationship of respect and trust with a provider who involves them in a two-way flow of discussions, explanations, and decision-making...", these findings also emphasize the importance of having good processes for care planning in place to ensure that resident preferences are obtained, integrated into the care plan, and clearly communicated to all potential caregivers. In addition, education about and mechanisms for documentation are also necessary to ensure that all care delivered is accurately recorded as provided to serve as evidence that patient-centered protocols are being followed.

Finally, these findings also highlight how critical it is to have systems in place for obtaining feedback and tracking data. Beyond inspection results and chart audits, several participants suggested measures that included resident and/or family satisfaction surveys. It is worth noting that in the United States, there is currently no standard assessment tool of "resident satisfaction" or "the resident experience," such as CAHPS which is used with various other health providers. Although there has been increased emphasis on person-centered care, customer service, and hospitality in long-term care, there remains a lack of standardization or agreement as to how these outcomes should be measured. Despite the fact that "satisfaction" and "experience" have different meanings, this study suggests that the primary measure being used in long-term care continues to be "satisfaction". In fact, out of 159 action plans, 100% of the time when "perception" data was to be solicited directly from residents or family members, the participants suggested measuring "satisfaction" rather than the resident/family member "experience". This suggests that long-term care may be lagging behind other areas of health care which have recognized that "satisfaction" can be inflated due to reduced expectations or gratitude bias, and that a more appropriate measure may simply be whether people are experiencing certain care processes.³⁶ In any event, these findings underscore the importance of organizations

putting methods in place to assess resident and/or family feedback as a measure of the care process.

Although resource constraints may inhibit the ability to make radical changes such as increasing staff or changing the physical environment, if even modest resources can be devoted to staff education to reorient the culture toward supporting person-centered care practices by changing staff behaviors, some common barriers can be overcome.¹⁹ The easy-to-implement action plans recommended in this study can help long-term care administrators put necessary practices into place to ensure they are delivering patient-centered care to nursing home residents.

Although some recommended practices may seem idealistic (e.g. always offering residents choices, or meeting individual requests), as Johs & Lentz²⁶ stated, even idealistic person-centered care practices "are potentially realistic if [leaders] can motivate people within their organizations to adopt a similar resident-centered philosophy of care." There is evidence that staff training on person-centered care practices has been demonstrated to have lasting effects on actual behavior.^{37,38} Long-term care providers who want to advance person-centered care should consider using the Always Experience[®] action plans proposed here to establish similar objectives, protocols, and measures in alignment with their own organization's and residents' goals. They can embrace the objectives as part of their organizational culture, and train staff on the actions and behaviors necessary to implement them.

Limitations

Limitations of this study include the fact that participants' simulated Resident for a Day experience was just that, a simulation which only lasted 24 hours. There are likely other issues that actual care recipients, often of a different generation than the study participants, experience as true long-term care residents, with actual care and dependency needs. Furthermore, participants' experiences surely varied among sites, including the extent to which their sites may (or may not) have already adopted and implemented person-centered care practices. In addition, the contents of these proposed Always Experience[®] action plans are based on participants' recommendations and have not been implemented and tested. In future research it would be beneficial to study the practicality and effectiveness of implementing the proposed Always Experience[®] plans and whether implementation of the operationalized practices indeed facilitates positive impacts on the patient experience. Additionally, researchers may also consider soliciting suggestions for Always Experiences[®] and Always Events[®] from actual long-term care residents.

Conclusion

As person-centered care gains traction in long-term care, the need for administrators to be able to translate a philosophy of care into actual practices that change the experience of their care recipients is critical. The current study demonstrated that the ethnographic approach of embedding administrators-in-training into resident culture via the Resident for a Day experience was beneficial to understanding what person-centered care should look and feel like. It also yielded six evidence-based, measurable, easily implementable action plans to advance person-centered care in nursing homes or assisted living communities.

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